Medical Necessity under OPPS: a Look at the Challenges

by Darren Carter, MD

The outpatient prospective payment system (OPPS) has dramatically changed claims processing by introducing an automated system. Medical necessity validation has also been automated as a result, leaving hospitals with increased rejections. This article explores how OPPS impacts the medical necessity process.

Medical necessity validation has become a powerful cost control measure of the Medicare program in the last decade. According to the Medicare Act of 1965, "no payment may be made under part A or part B [of Medicare] for any expenses incurred for items or services which...are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."[1] As a result, the Centers for Medicare and Medicaid Services (CMS) created a regulatory apparatus that is highly automated and complex and underscores the need for complete and accurate diagnostic coding. Diagnostic service providers, such as labs and radiology departments, are especially affected because a patient may arrive with a signed order for a test without diagnostic information.

With the August 2000 implementation of the Outpatient Prospective Payment System (OPPS) medical necessity edits have been expanded for adjudication of hospital outpatient services. This article will examine the ramifications of medical necessity and the Claims Expansion Line-item Processing (CELIP) claims system implemented by Medicare Fiscal Intermediaries (FIs) to administer OPPS.

Who Makes the Rules?

Within local medical review policies (LMRPs) written by Medicare contractors across the country are diagnosis and procedure code pairs that determine the "necessity" of several thousand medical procedures. These policies actually delimit complex eligibility determinations. The policies answer the question, "Is a patient with a particular diagnosis and disease acuity eligible for Medicare coverage for the ordered procedure or test?"

According to the Medicare Program Integrity Manual (PIM), contractors (FIs and carriers) must author policies for services that:

- are being furnished to an extent that raises questions of abuse or overutilization
- appear to have been furnished under conditions inconsistent with standards of practice or accepted technology, and/or
- appear not to be medically reasonable and necessary[2]

The contractors also write policies to reflect national coverage rules, which are created by Congressional laws and CMS administrative policies. The contractors have the authority and responsibility to interpret national coverage policy and apply them to individual cases. Some contractors have authored more than 500 medical necessity policies covering thousands of procedures to meet their obligations to the Medicare program.

Rejections due to LMRPs can cost hospitals millions of dollars, and some procedural medical specialties such as radiology face surprisingly frequent rejections. Medical necessity checking exacerbates problems inherent in the care-to-billing continuum. Because medical necessity is determined by the diagnostic codes describing a patient's illness, accurate assignment of those codes is critical. Unfortunately, accurately assigning diagnostic codes can be difficult for providers who haven't been trained in diagnostic and procedural coding systems. Further, because patient care and the coding process occur separately, incomplete or unclear documentation from the physician can lead to coding inaccuracies.

How OPPS Affects Medical Necessity

With the advent of the OPPS, hospitals reorganized their approach to billing for Medicare outpatient services. While Ambulatory Payment Classifications (APCs) determine the reimbursement in the OPPS, a hospital does not list these classification codes on the UB-92s submitted to its FI. Instead, the outpatient UB-92 is a line-item bill of CPT codes. As such, this format opens up the door to a host of prepayment edits that were not possible before.

While physicians have been performing line-item CPT code billing on the HCFA-1500 form for years, hospital outpatient services did not need to reflect the CPT system. For physicians, submission of the HCFA-1500 meant not only including the services performed but also linking them to a diagnosis for which the procedure was done. Having line-item bills based on procedural and diagnostic code pairs meant that carriers could perform prepayment rejections and denials according to the Correct Coding Initiative, which determines the appropriate billing of bundled services, and according to LMRPs that determine medical necessity.

Enter Automated Processing

In October 2000, CMS mandated that FIs, which bill for Medicare hospital care, implement the Claims Expansion Line-item Processor (CELIP) claims system.3 In many ways, this system is similar to those that process HCFA-1500 forms. The CMS documentation sent to the FIs stated the CELIP system must be able to perform the following functions:

- add the ability to assign medical policy reason codes to the line level for all claim types
- ensure the ability to perform manual medical review denials at the line level for all claim types
- add the ability to automate medical review and medical policy denials at the line level for all claim types
- ensure all reports affected by these changes work correctly
- add ability to increase efficiency of medical review claim and line level processing
- ensure ability to report all medical review workload
- ensure the ability to appropriately re-code claims and capture both the old and new codes, including revenue codes and Health Care Financing Administration Common Procedure Coding System (HCPCS)codes
- add the capability to perform ad hoc reports

The majority of these capabilities relate to improved and automated medical review made possible by the requirement that hospitals report line-item CPT codes rather than APCs. According to the CMS transmittal, “In accordance with these changes, intermediaries must evaluate their current medical review strategies to determine the appropriate operational changes needed to effectuate the line-item medical review process. Intermediaries must assure appropriate reporting of costs, workload, and savings associated with line-item medical review.” The FI for New Jersey and Tennessee, Riverbend Government Benefits Administrator, already informed its providers that it has implemented an “artificial intelligence system” loaded with its LMRPs.4 This type of automated checking for medical necessity will result in many more immediate denials.

Necessary Notices

Most patients have conditions that make them eligible for Medicare reimbursement for the procedures ordered by their physicians. The challenge is selecting the correct code prior to sending the bill. The best place to clarify these issues and ensure that the documentation reflects the correct diagnosis is at the point of care. Patients leaving their doctors’ offices with orders for further testing should have accurately coded diagnoses or complaints indicating the reason for the prescribed test. With accurate medical necessity policy information at the point of care, physicians can prepare Advance Beneficiary Notices (ABNs) for their patients for whom Medicare will not cover medical care. As discussed in “Who Enforces these Laws?”, investigation into the proper preparation of the ABNs is an OIG priority.

To obtain the ABNs appropriately, the patient must be present to consent to pay for the non-covered charges. CMS has forbidden the use of blanket ABNs, that is, providers cannot obtain an ABN for every service provided to a Medicare patient. In the end of 2001, CMS published several standardized ABNs, making it no longer necessary for individual providers to create their own ABNs. These ABNs can be found on the CMS Web site at www.hcfa.gov/medicare/bni/. The general form is called CMS-R-131-G and is for use by physicians, hospitals, and other providers. Form CMS-R-131-L is to be used for laboratory services only.

Support for the Process

CMS' requirements for automated line-item medical review and FIs' decision to use "artificial intelligence systems" to determine medical necessity put providers in a difficult position. Computerized solutions may help to avoid substantial losses. Fortunately, several hospital information system vendors have already incorporated the functionality required to perform medical necessity checking into their existing products. However, there are differences in how each health information system implements the checks: some perform the checking at order entry and some at registration. Some of the systems will also produce and manage ABNs, flagging the charges through their financial systems if installed.

While the internal tables and functionality may exist in several hospital information systems to perform medical necessity checking, no vendor has included the data to populate the tables to power the medical necessity checks, largely because the number of policies for each contractor can be more than 500 and the number of individual code pairs can approach 500,000. LMRPs and the codes that comprise them are also in a constant state of change, so maintaining the database is a serious job that requires medical and regulatory experience. Complicating the maintenance of medical necessity rules is the fact that some systems do not provide an easy way to upload such a large amount of data, requiring users to manually key the codes. Thus, hospitals would likely need to outsource the maintenance and preparation of the medical necessity data files and may require computerized solutions to upload data into their systems. Several medical software companies have provided stand-alone solutions for medical necessity checking. The functionality of the applications varies from networked diagnostic coding and regulatory support tools for front-end processes to claims editing engines that can check the validity of codes on the back end.

Medical necessity validation is a multifaceted process with implications for several parties. The introduction of OPPS complicates the situation: line-item CPT billing and the CELIP system can lead to automated rejections and denials. Although APC payments were expected to have a neutral impact on hospital reimbursement, improved medical review systems that check for medical necessity and CCI bundling may actually decrease reimbursement by increasing denials. In response, hospitals need to have computerized systems ready to meet these regulatory challenges or look toward vendor solutions. As always, claims processing should begin with accurate and ethical coding.

Who Enforces These Laws?

The Office of the Inspector General (OIG) is the enforcement arm of the Department of Health and Human Services (HHS) and can bring both criminal and civil charges against Medicare providers who commit fraud or abuse. The most recent OIG Semi-Annual Report details successful investigative and administrative actions.5 For fiscal year 2000, the OIG estimated Medicare fee-for-service payment errors to be $11.9 billion, or about 6.8 percent of the $173.6 billion in processed fee-for-service payments. However, in the first half of fiscal year 2001, the OIG estimated savings of $10 billion, comprised of $9.5 billion in implemented recommendations and other actions to put funds to better use, $335 million in audit disallowances, and $249 million in investigative receivables. The OIG made 213 convictions of individuals or entities that engaged in crimes against departmental programs and filed 209 civil actions. The result of these actions has had impressive results: the estimated rate of improper payments dropped from 14 percent in FY 1996 to less than 7 percent in FY 2000.

Besides the emphasis on the criminal and civil investigations, the OIG is committed to ensuring that systems are in place to perform ongoing audits. In its 2002 work plan, the OIG will be investigating the proper use of Advance Beneficiary Notices (ABNs) for physician offices.6 Providers are required to obtain these waivers of liability when they have reason to believe that a service will be non-covered. The reason is almost always medical necessity. Providers cannot obtain a waiver for Correct Coding Initiative (CCI) bundling and do not have to obtain a waiver to bill a patient for a service that is not a Medicare benefit, such as non-covered screening tests. The OIG will also be focusing on the provision of ABNs for non-covered lab services, which will affect hospital laboratories as much as ordering physicians.

The OIG is also interested in exploring and comparing different payment safeguard activities including the use of prepayment screens, targeted medical reviews, and the establishment of special investigative units. They hope to bolster the ongoing anti-fraud efforts of the contractors' own fraud units, many of whom rarely begin investigations or even report areas of possible vulnerability.

What Does It All Mean?

The business of healthcare is loaded with acronyms and abbreviations. Here's a brief review of key terms and common abbreviations.

ABN (Advance Beneficiary Notice): a form used to notify Medicare beneficiaries of suspected non-coverage of procedures that are usually Medicare benefits

APC (Ambulatory Payment Classification): a grouping of CPT codes that are paid at one price for hospital outpatient care. Each CPT code is assigned to an APC

CCI (Correct Coding Initiative): the CCI determines whether two or more CPT procedures can be billed together. It is used in editing both physician and hospital out-
patient claims

CELIP (Claims Expansion Line-item Processing): CELIP is an expansion of the OPPS OCE that includes line-item medical necessity editing capabilities

FI (Fiscal Intermediary): large insurance companies, almost exclusively Blue Cross organizations, that contract with CMS to administer hospital claims on the Medicare program

HCFA-1500: the billing form used to prepare physician claims (now CMS-1500)

HCPCS (HCFA Common Procedure Coding System): a coding system used to bill federal health entitlement programs and maintained by CMS for services such as medicines, durable medical equipment, and dental and other allied health professional services

LMRP (local medical review policies): these policies contain a list of procedures and the diagnoses for which the procedures will be reimbursed

OCE (outpatient code editor): software that performs claims edits on hospital outpatient charges (including CCI, medical necessity, and code validity) with the form of line-item CPT codes on a UB-92. The remaining codes and flags are then priced with the APC system

OIG (Office of the Inspector General): the enforcement division of the Department of Health and Human Services

OPPS (Outpatient Prospective Payment System): the OPPS replaced the charge-based system for hospital outpatient reimbursement in August 2000. Now hospitals are paid a fixed amount for outpatient services according to the APC fee schedule

PIM (Program Integrity Manual): one of the latest additions to Medicare program documentation. This manual was created with sections from other program manuals to consolidate the approaches and requirements to control costs and prevent fraud and abuse

UB-92: the billing form used by hospitals for both inpatient and outpatient billing. The National Uniform Billing Committee, an organization formed by the American Hospital Association, maintains this form

Notes

1. USC 1395i(a)(1)(A).
2. Health Care Financing Administration. "Identification of Services for Which a Local Medical Review Policy is Needed." Medicare Program Integrity Manual. Washington, DC: US Government Printing Office, 1999.
3. Health Care Financing Administration. "Line Item Denials and the Reporting of Savings Generated by Claim Expansion and Line Item Processing." Transmittal A-00-37, June 2000. Available online at www.hcfa.gov/pubforms/

transmit/A003760.pdf.
4. Riverbend GBA. Medical Review Quarterly 8, no. 1 (2000).
5. Semi-Annual Report. Office of the Inspector General, Department of Health and Human Services (March 31 2001).
6. Fiscal Year 2002 Work Plan. United States Department of Health and Human Services, Office of the Inspector General (October 2000).

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Article citation:
Carter, Darren. "Medical Necessity under OPPS: a Look at the New Challenges." *Journal of AHIMA* 73, no.2 (2002): 44,46-47,51.