Who Answers the Medical Necessity Question?

by Cheryl Gregg, RHIA, CCS-P, and Sherri Mallett, MEd, RHIA, CCS-P

Medical necessity issues can lead to reimbursement and billing difficulties. Here are some basic principles to help you master this hot-button issue.

How many rejected claims are sitting on your desk waiting for you to play the appeals game? If medical necessity is the culprit, then you need expertise to negotiate the appeals process. This article will explain the terminology surrounding the questions of medical necessity.

Medicare and other health plans will only pay for services that meet their medical necessity standards. For payers, verifying medical necessity is a cost-saving measure with big implications: last year, the Department of Health and Human Services (HHS) reported that Medicare paid approximately $7 billion for medically unnecessary services.[1]

In recent years, medical necessity has become a compliance issue as well as a hot-button topic for providers, payers, and patients. For HIM professionals, the debate underscores the necessity of clear documentation to support provided services. It also speaks to the importance of understanding certain trouble spots.

What Is Medical Necessity?

Medicare defines "medical necessity" as a determination of a service that is reasonable and necessary for the diagnosis or treatment of illness or injury.[2] Some insurance providers have more comprehensive definitions.

The term is a controversial one in healthcare. Debate has raged in legal, medical, and political circles throughout the 1990s. Ultimately, two issues emerge: what makes a medical procedure reasonable and necessary, and who decides?

In healthcare settings, the lack of agreement on what constitutes medical necessity can create difficult situations. For example, a healthcare provider may consider certain patient services clinically necessary, but third-party payers may not deem them medically necessary. Or a provider may feel that a single service is medically necessary for patient A, but not necessary for patient B. Or it may be a matter of semantics—the provider considers all clinically necessary services to be medically necessary.

How Is Medical Necessity Determined?

Although most third-party payers abide by Medicare's definition of medical necessity, there is plenty of room for interpretation. Each insurance company may determine, by the assigned CPT code, which diagnosis(es) will justify the medical necessity of a service. Companies may also determine a specific allowance for frequency of a given diagnosis or service (and they may develop and amend the frequency at which services may be performed as they choose).

Additionally, medical necessity is established with the use of specific ICD-9-CM diagnostic codes. Local medical review policies (LMRPs) define ICD-9-CM codes that support medical necessity for many provided services.

For example, the placement of a urethral stent by endoscopy is considered medically necessary in the treatment of certain ICD-9-CM diagnostic codes. But a claim may be rejected if ICD-9-CM codes such as V16.1-V18.4 (family history) are used in conjunction with certain laboratory tests. As a result, reimbursement specialists must stay current with Health Care

Financing Administration (HCFA) regulatory requirements and revisions contained in third-party payer administrative manuals to reduce rejected claims.

What Is a Covered Service?

The first step in determining medical necessity is to determine whether services are covered or noncovered. (To tell the difference, see "Are You Covered?" on page 52.) Covered services are deemed reasonable and necessary for the diagnosis and treatments of the patient's disease or condition. Covered services are represented by CPT codes, and diagnoses are represented by ICD-9-CM codes.

Covered services may be diagnostic or preventive. Although Medicare reimburses for very few preventive services, many third-party payers share the philosophy that keeping patients healthy will reduce medical expenses in the long run.

Remember, services are either covered or noncovered. Once that determination is made, covered services can be judged medically necessary or not medically necessary. Every third-party payer has different, but similar, rules for determining medical necessity. Some payers provide written coverage policies pertaining to a given CPT code. However, payers do not have medical coverage policies for all services.

Specifics for medical necessity are not typically located in managed care contracts. Instead, they may be located in administrative manuals, policy manuals, or Internet sites. "Stop and Go: Medical Necessity and The Billing Process," on page 53, gives a graphic explanation of the billing process.

Not Medically Necessary

Payers use the terms "medically unnecessary" or "not medically reasonable or necessary" to describe covered services (CPT codes) that are not reasonable or necessary for the diagnosis and treatment of a disease or condition.

The process has numerous ins and outs. For example, a service that is normally considered covered may be deemed medically unnecessary if it is provided for the convenience of the patient.

For example, after viewing a television program about hyperlipidemia, a patient asks the physician to draw a lipid panel. While the third-party payer may generally cover lipid panels as a medically necessary procedure, this particular patient does not have a valid medical condition that warrants such a test. If a patient does not have a medical reason to have a service or treatment performed, then these services, although covered, are "medically unnecessary" or "not medically reasonable or necessary" for a particular patient.

Another trouble spot is the identification of a service as either screening or diagnostic. Physician documentation will determine this identification. For example, a screening test is preventive in nature and may be used in the early detection of potential diseases. It is performed without evidence of signs or symptoms of a disease.

For patients with a diagnosis or symptom, the appropriate ICD-9-CM code, not the screening code, should be assigned. The proper assignment of ICD-9-CM codes must be based solely on documentation, not on the arbitrary assignment of an ICD-9-CM code that will be reimbursed by the insurance company. For example, if a Medicare patient has anemia and stool incontinence, then a sigmoidoscopy would be performed for diagnostic, not screening, purposes.

Sign Here: The Advance Beneficiary Notice

For anyone involved in the reimbursement process, a thorough knowledge on the proper use of advanced beneficiary notices (ABNs) is critical.

If it is likely that proposed tests or services will be found "medically unnecessary" by Medicare, the patient must be asked to sign an ABN. This document informs the patient that if the services are denied, he or she will be responsible for the bill. If an ABN is not completed, the provider may not bill the patient for those services. Note: an ABN must be signed after the service or test is ordered, yet before it is performed. An ABN should contain:

- clear description of the specific service or test
- physician notice, as defined in the Medicare Part B Medical Policy Manual
- date of service
- reason why services will likely be deemed medically unnecessary
- statement that patient understands that Medicare will probably not pay for the services and that he or she will assume financial responsibility for payment of denied service (see beneficiary agreement as defined in the Medicare Part B Medical Policy Manual)
- patient's signature (if another person signs for the patient, the name and relationship to patient should be stated)
- date of patient's signature

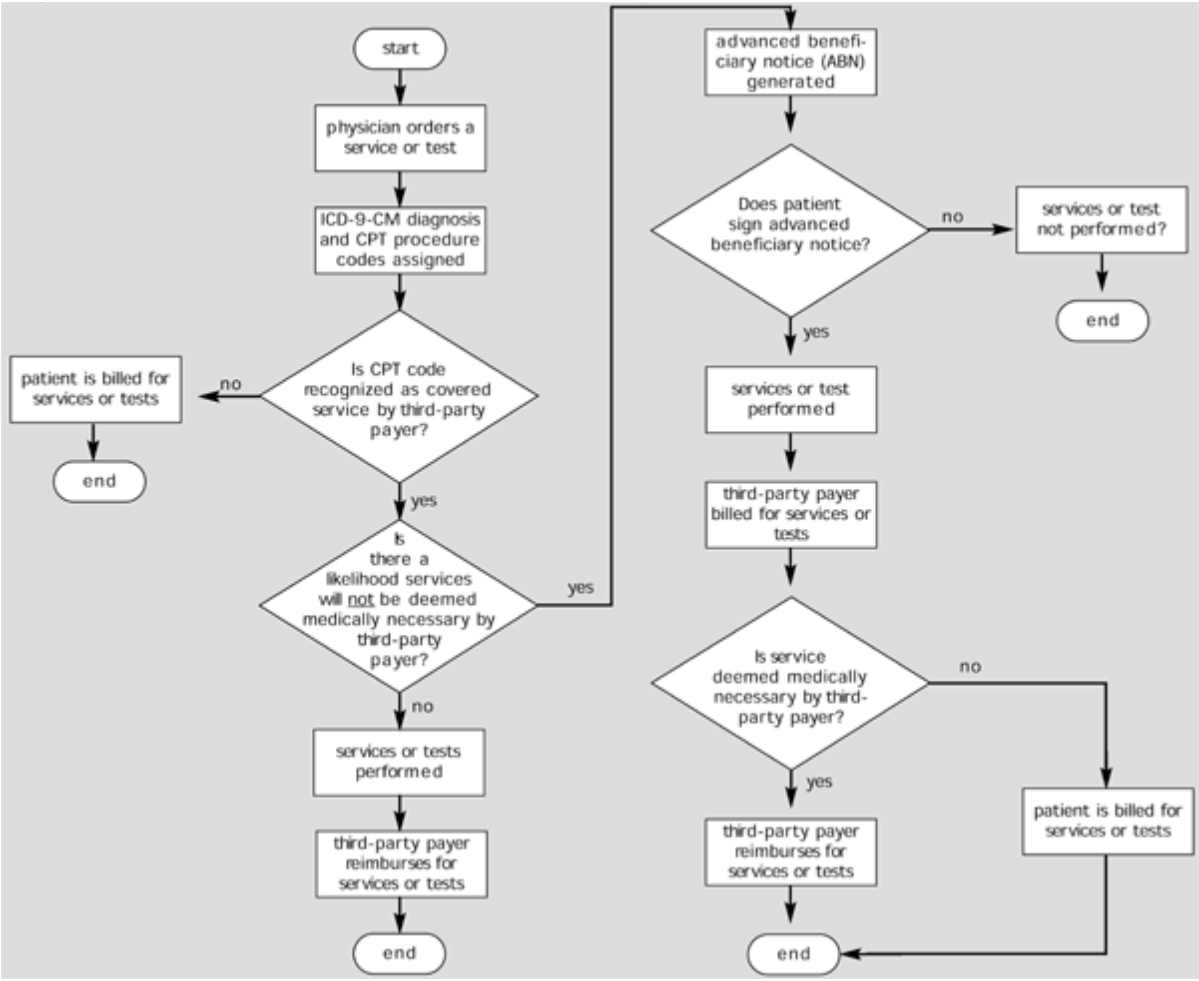
A patient should never be asked to sign a blanket ABN. A blanket ABN neither specifies the test/service to be provided nor provides the reason why the particular claim is likely to be denied. Therefore, the patient is unable to make an informed decision.

A request for an ABN is not necessary if a service is likely to be denied because of statutory exclusions. Examples of such services include cosmetic surgery, routine physicals, and most screening tests. (Exceptions include those screening tests identified in Section 1862(a)(1) of the Social Security Act as eligible for Medicare payment, such as mammograms, pap smears, pelvic exams, and colorectal tests.)

When the order identifies tests or services that will be provided over an extended period of time, one ABN may be executed. This will cover the ordered services as long as no change is made to the course of treatment. If a change becomes necessary, a new ABN is required.

Even if a provider believes that services will not be reimbursed and an ABN is signed, a bill may be submitted to Medicare. The CPT code should be appended with the modifier -GA (waiver of liability statement on file) to notify Medicare that a signed ABN is available.

Submission of this service (CPT codes) with the appended -GA modifier does not guarantee payment by the third-party payer. When the service is determined to be medically unnecessary and the -GA modifier is used to indicate the proper execution of an ABN, the patient is held responsible for payment. If an ABN is not properly completed and the -GA modifier is not submitted on the claim, the provider is not permitted to bill the patient for this service. In effect, the provider has just delivered a free service.



Know Your Terms

The medical necessity issue isn't going away. As laws continue to change, the issue will remain a hot topic and an important one. Those involved in the reimbursement process will need to be able to negotiate the fine points of medical necessity issues.

Notes

1. Hallam, Kristen. "Lawmakers Define Medical Necessity." *Modern Healthcare* 29, no. 10 (1999): 5.
2. Health Care Financing Administration, Medicare Policy Manual. Available at www.hcfa.gov/pubforms/p2192toc.htm.
3. AdminaStar Federal home page. Available at www.astar-federal.com.

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Managing Medical Necessity Issues

Medical necessity issues can be confusing. Here are some ways to dispel the confusion:

- **Make sure HIM professionals have input in the design of test requisition forms.** The form should include the date, order, and the diagnosis that relates to the ordered test. It is also recommended that the form contain a

statement indicating that Medicare generally does not cover routine screening services.

- **Consider installing one of the available medical necessity software packages.** At the time of the order, the software compares the CPT code to the ICD-9-CM code to determine medical necessity. If the test is deemed medically unnecessary, some packages will automatically generate the ABN.
- **Ensure that only trained personnel are permitted to assign CPT and ICD-9-CM codes.** Payment of a claim depends on the accurate use of these codes. Coders should be knowledgeable about outpatient coding guidelines (in particular the use of V codes), including the use of screening codes.
- **Make sure staff members are up to date.** In-services should focus on compliance issues and updates on changed rules and regulations. Coders should also have access to LMRPs and third-party payer manuals.

Are You Covered?

The first step in determining medical necessity is to know the difference between covered and noncovered services. Noncovered services are never covered by a third-party payer, regardless of diagnoses or circumstances. Medicare documents noncovered services in the Social Security Act under Section 1862. Other payers individually determine what services they define as noncovered.

Items documented as noncovered by the Social Security Act in Section 1862 are:

- personal comfort items (e.g., toothbrush)
- routine checkups, including lab tests and x-rays (when the patient has no complaints or underlying disease)
- routine foot care
- routine eye exams and refractions for the purposes of prescribing or fitting eyeglasses or contact lenses when eye disease is not present
- routine pap smear (if billed more frequently than every three years)
- routine screening mammography (if billed more frequently than every year)
- hearing aids or examinations for the purposes of prescribing hearing aids
- immunizations (except pneumovax, influenza, and hepatitis B)
- treatment for teeth and supporting structures
- self-administered drugs or biologicals
- supportive devices for feet
- cosmetic surgery (unless it is needed because of accidental injury or to improve the function of a malformed part of the body)
- custodial care (e.g., preparing meals)
- charges paid or expected to be paid by workers' compensation, auto liability insurance, or government agencies
- charges for services provided by immediate relatives or members of the household
- services not provided in the United States or services for which the individual has no legal obligation to pay
- services required as a result of war or an act of war

The following V codes represent noncovered services on Medicare claims:
V16.1-V18.4 Family history
V18.6-V19.8 Family history
V21.0-V21.9 Health supervision of infant or child
V25.0-V25.9 Encounter for contraceptive management
V50.0-V50.9 Elective surgery for purposes other than remedying health status
V60.0-V60.9 Housing, household, and economic circumstances
V65.0-V65.1 Persons seeking consultation without complaint or illness
V68.0-V68.9 Encounters for administrative purposes
V70.0-V70.9 General medical examinations
V77.0 Screening for thyroid disorders
V77.1 Screening for diabetes mellitus

V82.6 Multiphasic screening

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