Medical necessity training handbook for physicians

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Medical necessity training handbook for physicians

Introduction

Medicare only pays for services it considers to be medically necessary for diagnosing and treating an illness or injury or to improve the funtioning of a malformed body member. Because Medicare's definition of "reasonable and necessary" can be difficult to interpret, medical necessity is one of the greatest challenges healthcare professionals face.

To further complicate this issue, federal and state payers and managed-care organizations each have their own definitions of medical necessity. Payers often require specific diagnoses or different levels of treatment before they will consider a service medically necessary.

This handbook focuses both on diagnostic services provided to Medicare beneficiaries and on the process of checking for medical necessity, including how to document it.

Why you should care about medical necessity

Providers are seeing an increase in denials related to medical

necessity, even for legitimate services. Because appealing claims is often burdensome, many organizations choose instead to write off these denials. Doing so, however, represents a loss of revenue and can put the organization at risk for fraud and abuse charges.

For example, consistent denials for a single test could cost a facility millions of dollars each year. To provide your patients with the highest quality of care and to facilitate the addition of new services and/or equipment to treat your patients, hospitals and testing facilities must remain financially viable. Your assistance is vital to these goals. In addition, if such medical necessity denials are received but the facility consistently fails to both obtain an advance beneficiary notice (ABN) and bill the beneficiary, the government could cite the facility for offering patients inappropriate incentives by providing "free" care.

Therefore, the facility should use an effective medical-necessity screening process to maintain compliance and reimbursement. It will allow you to determine when Medicare is likely to deny payment for a test or service so your facility can obtain an ABN.

Your role in the medical-necessity process

Part of your job is to ensure that the facility only bills Medicare for medically necessary services, so it is essential that you understand medical necessity. Although you may order any test you feel is necessary to appropriately diagnose and treat a patient, Medicare will only pay for those tests and services that meet its definition of medical necessity. That is, what you consider medically necessary from a clinical perspective may not match what

Medicare considers medically necessary from a reimbursement perspective, and you need to be aware of the difference.

What Medicare covers

Medicare has never paid for every item or service that a patient may receive. For example, it does not cover certain screening tests, appearance-enhancing surgeries, vaccinations, or self-administered outpatient medicines. Medicare benefits do change to keep up with scientific advances, however, and it now pays for influenza and pneumonia vaccinations; cervical, colon, and prostate cancer screenings; and monitoring and self-management training for diabetes patients.

Many medical advances, from devices to surgical approaches and pharmaceuticals, enter the market every day. If Congress does not explicitly mandate coverage for a particular service, the Centers for Medicare & Medicaid Services (CMS) must evaluate it before deciding whether to cover it.

Medicare coverage policies

CMS uses two kinds of documents to grant, limit, or exclude Medicare coverage for a specific service, procedure, or device: national coverage determinations (NCDs) and local medical review policies (LMRPs).

National coverage determinations

NCDs are nationwide policy statements that apply to all Medicare claims. They determine the extent to which Medicare will cover

specific services, procedures, or technologies. For items or services not specifically excluded or limited by an NCD or that don't have an NCD, Medicare contractors may make decisions in the form of LMRPs.

Local medical review policies

LMRPs are coverage guidelines issued by a Medicare carrier or fiscal intermediary (FI) for a particular item or service. They only apply to the carrier or FI's service area.

LMRPs explain when an item or service is covered and, in some cases, how providers should code it. They usually contain descriptions of the procedures, indications and limitations of coverage/medical necessity, reasons for denials, noncovered/covered ICD-9-CM codes, current procedural terminology (CPT) coding guidelines, and documentation guidelines. Not only do LMRPs designate which diagnosis codes will justify the medical necessity of a service, they may also limit the frequency of a given test or service.

Contractors are beginning to replace LMRPs with local coverage determinations (LCDs), which contain only "reasonable and necessary" information. By October 2005, contractors must convert all existing LMRPs into LCDs, and contractors will have to communicate any additional information other than "reasonable and necessary" language through articles.

How to change LMRP and NCD content

Providers and beneficiaries may submit requests for new/revised LMRPs to individual Medicare contractors. They may ask for mod-

ifications to a section of an LMRP, additions or deletions to diagnoses that support medical necessity, and changes in indications and limitations for coverage.

General guidelines for submitting a request for reconsideration are as follows:

- Must be in writing
- Must be supported by medical evidence usually in the form of peer reviewed medical literature or other published studies

Submitting such a request may be worth your time if Medicare repeatedly denies a specific test for a common symptom or condition found in your patient population. Getting a diagnosis code added to the list of covered ICD-9-CM codes for a particular test can boost your revenue and save time appealing claims on the back end.

Note: Refer to your FI or carrier's Web site for instructions on the request process.

NONCOVERED SERVICES V. COVERED SERVICES

1. **Noncovered services.** Medicare contractors don't pay for non-covered services, regardless of a patient's diagnosis. Because they are never covered, you don't have to make a medical-necessity determination for statutorily excluded services. Such services include but are not limited to the following:

    - Appearance-enhancing surgeries
    - Screening tests other than those added to Medicare by law
    - Dental care and dentures (in most cases)
    - Investigative drugs and treatment
    - Personal-comfort items

2. **Covered services.** Covered services can be either medically necessary or not medically necessary. Medicare won't pay for a covered service when it is provided

    - solely for the convenience of the patient
    - more frequently than allowed by Medicare
    - when the patient's signs, symptoms, or diagnosis do not support the test's medical necessity

Medical-necessity criteria for covered services is usually set forth in an NCD or LMRP.

What information is needed to determine medical necessity for diagnostic tests?

To prove medical necessity when you order a diagnostic test, the following must occur:

1. **Referring physicians must order** all x-rays, diagnostic laboratory tests, and other diagnostic tests. Tests not ordered by the physician treating the beneficiary are not reasonable and necessary.

2. **Referring physicians must provide diagnostic information** to the testing entity when ordering the test. Referring physicians do not have to include diagnosis codes on referral slips or requests for radiological or other diagnostic tests, but they must include a narrative of the reason for the test.

3. **Providers must report information on the patient's diagnosis** when billing Medicare. In most cases, Medicare uses either the ICD-9-CM code assigned to the signs/symptoms or the definitive diagnosis to determine medical necessity. Medicare gleans this information from the test or order, so always include a diagnosis or a list of signs/symptoms with all orders.

Criteria for ordering tests

The *Medicare Claims Processing Manual* (*MCPM*) provides instructions on ordering diagnostic tests. Treating physicians can order tests via

- **written document**—Signed by the treating physician. May be hand delivered, mailed, or faxed to the testing facility.

- **telephone call**—From the treating physician or his or her office to the testing facility. Both parties must document the phone call and the required information in their copies of the patient's record.

- **electronic mail**—From the treating physician or his or her office to the testing facility.

When you do not provide diagnostic information that documents the reason for the test, the facility may take this information directly from the patient or the patient's medical record. However, the facility must contact you to confirm the information.

Note: When referring to an independent diagnostic testing facility the order must be submitted in writing and specify the diagnosis or other basis for testing.

INFORMATION IN EVERY REFERRAL

At a minimum, referrals should include the following information:

- Name
- Date
- Test ordered
- Reason for test
- Ordering physician's signature or signature of another allied health professional allowed to order tests

A physician's order is not required for screening mammography services or for administration of the influenza and pneumococcal pneumonia vaccines.

Maintain adequate documentation

According to CMS, both you as the ordering physician and the testing facility must maintain medical-necessity documentation in the patient's record.

Ordering physicians

Make sure you have the following documentation:

- A copy of the test order or requisition, including procedure ordered
- ICD-9-CM code or a description of the signs, symptoms, or diagnosis that prompted the test

- Progress-note documentation of the test order, including clinical indications (e.g., signs/symptoms, diagnosis) for ordering the test in the patient's medical record

Testing facilities

Testing facilities must maintain documentation supporting the claim. This documentation includes the following:

- Test order, requisition, or other documentation from the ordering physician including the procedure ordered and the reasons (e.g., signs/symptoms, diagnosis) for ordering the test
- Written report documenting the test results or interpretation of the exam
- For incorrect ICD-9-CM codes submitted by physicians, documentation of a physician query, which may be either a copy of the corrected order sent via fax or documentation of the outcome of a conversation with the physician

Other documentation requirements

For many tests, NCDs and LMRPs include specific documentation guidelines, which may require the following:

- Progress notes or medical-record documentation supporting the order for the test in a physician's office
- Documentation supporting the frequency of tests, with number limits

PET scan documentation requirements

An example of a test with specific documentation requirements is a positron emission tomography (PET) scan. One LMRP for a PET scan requires the following documentation:

- Medical-record documentation kept by the physician and the testing facility, demonstrating that the required conditions for each of the PET scans performed has been met. *Note: The "indications and limitations of coverage and/or medical necessity" section of the LMRP will contain these required conditions.*
- Standard medical record information (e.g., age, sex, height).
- Documentation of any annotations regarding body size or type that indicate a need for a PET scan to determine the patient's condition.

Note: Consult your carrier or FI to learn the specific LMRP documentation requirements for each test you order or perform.

How to perform a medical-necessity check

Before performing a medical-necessity check, review test orders for all required elements and identify the reason for the test. Then use the following steps to verify medical necessity:

1. Determine whether the test/service ordered has an NCD or LMRP/LCD.

2. If the test or service *does not* have limited coverage under an NCD or LMRP/LCD, facilities can proceed and perform the test(s) ordered.

3. If the test or service to be performed *does* have limited coverage under an NCD or LMRP/LCD, review the signs, symptoms, or diagnosis you have provided and determine whether your documentation supports medical necessity by reviewing the list of ICD-9-CM codes that support medical necessity.

4. If the test or service provided *does not* meet medical-necessity requirements and is not on the list of covered ICD-9-CM codes, complete an ABN.

5. For those tests that have frequency limitations, review the appropriate section of the NCD or LMRP for those specific limitations. Obtain an ABN when the patient exceeds frequency limitations.

Note: Many healthcare providers have purchased software to automate this process.

Case study #1

Mr. Smith has been on medication for hypercholesterolemia. His physician orders a lipid panel to assess the effectiveness of his medication regimen. Use these steps to determine whether the test is medically necessary:

1. Identify the procedure code for the lipid panel and the diagnosis code for hypercholesterolemia.

- CPT code: Lipid panel (80061)
- ICD-9-CM code: Hypercholesterolemia (272.0)

2. There is an NCD (titled "Lipids") for procedure code 80061. Review the section entitled "ICD-9-CM Codes Covered by the Medicare Program" for the code 272.0.

ICD-9-CM CODES COVERED BY THE MEDICARE PROGRAM

270.0	Disturbances of amino-acid transport
271.1	Galactosemia
272.0	Pure hypercholesterolemia
272.1	Hyperglyceridemia
272.2	Mixed hyperlipidemia (tuberous xanthoma)
272.3	Hyperchylomicronemia

3. Because code 272.0 is listed in the NCD, the lipid panel is considered medically necessary. An ABN is not needed.

Case study #2

Mr. Jones presents with a history of frequent headaches. To determine the cause of these headaches, his physician orders a magnetic resonance imaging (MRI) of the brain with and without contrast. Use these steps to determine whether the test is medically necessary:

1. Identify the procedure code for the MRI and the diagnosis code for a headache:

- CPT code: MRI of the brain w/ and w/o contrast (70553)
- ICD-9-CM code: Headache (784.0)

2. Let's assume that there is an LMRP for procedure 70553. Review the section of the LMRP "ICD-9-CM Codes that Support Medical Necessity" for the code 784.0.

ICD-9-CM CODES THAT SUPPORT MEDICAL NECESSITY

781.0–781.8	Symptoms involving nervous and musculoskeletal systems
781.94	Facial weakness
781.99	Other symptoms involving nervous and musculoskeletal systems
784.2	Swelling, mass, or lump in head or neck
784.3	Aphasia

3. Because code 784.0 is not listed, the MRI is not considered medically necessary. An ABN should be completed and should state "According to local coverage guidelines, Medicare does not pay for this item or service for your given condition(s)."

Case study #3

A physician orders a screening mammogram for Mrs. Roberts, who is 65 years old. Use these steps to determine whether the

test is medically necessary:

1. Determine the procedure code for a screening mammogram and the diagnosis code for a screening exam.

   - CPT code: Screening mammography—76092
   - ICD-9-CM code: Screening mammogram—V76.12

2. Let's assume that there is an LMRP for procedure 76092. Review the section of the LMRP titled "ICD-9 Codes that Support Medical Necessity" for the code V76.12.

3. Assume code V76.12 is listed. However, note that screening mammograms have frequency limitations as outlined in the section of the LMRP "Indications and limitations of coverage/medical necessity."

INDICATIONS AND LIMITATIONS OF COVERAGE/MEDICAL NECESSITY

Age	Screening Period
35–39	Baseline—only one allowed
Over age 39	Annual—11 full months must have elapsed following the month of the last screening

For example, if the patient has a screening mammography in July 2003, start counting months with August 2003.

4. Mrs. Roberts' past medical records are unavailable, so the date of her last mammogram cannot be determined.

5. Because the date of Mrs. Roberts' last mammogram cannot be determined, an ABN should be completed and should state, "Medicare does not pay for this item or service more often than once per year."

What to do when tests are not medically necessary

Medicare beneficiaries cannot be billed for denied charges without obtaining a signed ABN in most cases. Two types of financial-liability provisions protect Medicare beneficiaries:

1. **Refund requirement (RR)**—Affects medical-equipment claims and nonassigned Part B claims. Under this provision, beneficiaries must sign an ABN to be held liable for items or services. Nonassigned claims come from providers who have not signed a Medicare agreement. In such a case, they bill the patient directly, and the patient submits the claim to the Medicare program to receive payment.

2. **Limitations on liability (LOL)**—Affects Part A and assigned Part B claims. Physician providers who participate in the Medicare program submit assigned claims and accept Medicare reimbursement as full payment for care provided to Medicare beneficiaries. Under LOL, providers must give a patient an ABN for denied services, but a patient signature is not required.

Under both provisions, Medicare pays claims for services when neither you nor the beneficiary could have known that Medicare would not cover the service.

Discussing Medicare coverage with beneficiaries

CMS and program administrators believe that publishing NCDs and LMRPs meets their obligation to notify providers of medical-necessity rules. However, beneficiaries do not receive NCDs or LMRPs, and they do not know that Medicare will not pay for a service due to lack of medical necessity.

Medicare makes providers—not contractors—responsible for explaining medical-necessity coverage rules to beneficiaries. Medicare's LOL and RR clauses require beneficiaries to know that Medicare may deny a service because it does not meet the medical-necessity rules. That's why Medicare requires providers to give beneficiaries ABNs when Medicare is likely to deny the charges.

How to use ABNs

Providers give Medicare beneficiaries ABNs to inform them that Medicare may not pay for a covered item or service. ABNs allow beneficiaries to decide whether to receive the service, even though they may have to pay for it themselves or through another insurance. ABNs list the tests or services for which the beneficiary would be held liable. You do not have to give a patient an ABN for a noncovered service.

Beneficiaries must select one of the following options on the ABN:

- Receive the service and assume responsibility for payment
- Decline to receive the service

Obtaining a valid ABN

Obtain an ABN before rendering an item or service, but only when you believe Medicare will deny payment for the test or service. The following are the two most common reasons for obtaining ABNs:

1. You expect Medicare to deny payment (entirely or in part) for the item or service because it is not reasonable and necessary based on NCDs or LMRPs.

2. The patient has exceeded the frequency limit for payment of certain screening tests (e.g., mammography, pap smear, pelvic exam, glaucoma, prostate cancer, colorectal cancer).

EMTALA

Hospitals must meet all requirements under the Emergency Medical Treatment and Labor Act (EMTALA) before obtaining an ABN when a patient presents with an emergency medical condition. Screen and stabilize patients with emergency conditions before obtaining an ABN or explaining Medicare coverage rules.

What to do when patients won't sign the ABN

Under LOL, beneficiaries who refuse to sign the ABN but demand the service can be billed as long as you properly con-

duct and document the benefits-determination process and provide the patient with an ABN.

To document such a situation, you and a second witness should sign and annotate the unsigned space on the ABN to state that the patient refused to sign the document.

However, Medicare's RR clause protects patients who refuse to sign the ABN. Medical suppliers and physicians who do not participate in Medicare must obtain the patient's signature or Medicare will not pay for the items or services.

Note: Providers can deny a service to a beneficiary who has refused to sign an ABN unless the consequences (e.g., health and safety of the patient, civil liability in the case of harm) rule out this option.

Coding guidelines

A complete and accurate understanding of the coding guidelines for diagnostic tests is critical to the medical-necessity process. Chapter 23 of the *MCPM* provides the following rules for reporting ICD-9-CM diagnosis codes:

- Use the ICD-9-CM code that describes the patient's diagnosis, symptom, complaint, condition, or problem. Do not code a suspected diagnosis.

- Use the ICD-9-CM code that is chiefly responsible for the item or service provided.
- Assign codes to the highest level of specificity. Use fourth and fifth digits where applicable.
- Code chronic conditions when they apply to the patient's treatment.
- Code all documented conditions at the time of the visit that require or affect treatment.
- Do not code conditions that no longer exist.

How to choose ICD-9-CM codes

Medicare bases its medical-necessity determination on the primary ICD-9-CM code assigned for a test or service. Use the following guidelines when assigning the primary diagnosis code:

- **Confirmed diagnosis**—Code the diagnosis confirmed by the diagnostic tests. You can also report the signs or symptoms that prompted you to order the test as additional diagnoses if they are not explained by or related to the confirmed diagnosis.
- **Normal findings**—If the diagnostic test did not provide a diagnosis or was normal, code the signs or symptoms that prompted the study.

- **Uncertain findings**—If the results of the diagnostic test are normal or nondiagnostic and/or the referring physician records a diagnosis preceded by words that indicate uncertainty (probable, suspected, questionable, rule out), the interpreting physician should not code that diagnosis. The interpreting physicians should instead report the signs or symptoms that prompted the study.

- **Screening (no signs or symptoms given)**—Facilities use physician documentation to determine whether a test is considered a screening or diagnostic. They perform screening tests without any signs or symptoms of the disease. For tests ordered without signs or symptoms, report the screening code as the primary diagnosis code. Report any condition discovered during the screening as a secondary diagnosis.

- **Incidental findings**—Never list incidental findings as the primary diagnosis. However, you may report incidental findings as secondary diagnoses.

- **Unrelated or coexisting conditions**—The interpreting physician may report unrelated and coexisting conditions or diagnoses as additional diagnoses.

Proper ICD-9 code assignment must be based solely on documentation, not on the arbitrary assignment of an ICD-9 code that will be reimbursed by the insurance company.

Code the ICD-9-CM code to the highest degree of accuracy and completeness based on the results of the test, or use the signs/symptoms that prompted you to order the test. Use Chapter 23 of the *MCPM* for more guidance in determining the appropriate primary ICD-9-CM code to assign.

Final exam

1. **True or false: Medicare considers medical necessity to be a determination of whether a service is reasonable and necessary to diagnose or treat an illness or injury or to improve the functioning of a malformed body member.**

2. **Which of the following is a financial-liability provision that does not require a beneficiary signature on the ABN?**

   a. NCD
   b. RR
   c. LMRP
   d. LOL

3. **True or false: Third parties may reimburse a service designated as noncovered under certain circumstances.**

4. **Which of the following are referring physicians required to do?**

   a. Include actual ICD-9-CM codes on a test order
   b. List actual CPT codes on a test order
   c. Provide a narrative description of signs/symptoms or diagnosis
   d. Both a and c

5. **Which of the following does CMS consider to be a test order?**

   a. A written document signed by the treating physician that may be hand delivered, mailed, or faxed to the testing facility
   b. A telephone call by the treating physician or his or her office to the testing facility
   c. Electronic mail by the treating physician or his or her office to the testing facility
   d. All of the above

6. What is an LMRP?

a. Low medical reimbursement payment
b. Local medical review policy
c. Last minute refusal to pay
d. Local medical reimbursement policy

7. Which of the following will Medicare contractors begin issuing by October 2005?

a. NCDs
b. ABNs
c. LCDs
d. LMRPs

8. True or false: Providers can submit requests for reconsideration to have LMRP content modified.

9. True or false: Facilities can obtain ABNs after a patient has received a diagnostic test.

10. In the absence of signs or symptoms, how does Medicare describe a diagnostic exam?

a. Preventive
b. Screening
c. Diagnostic
d. None of the above

Answer key

1. True
2. d
3. False
4. c
5. d
6. b
7. c
8. True
9. False
10. b

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Suzanne Perney
Vice President/Publisher