COMPLIANCE TIP

TO: Compliance Alert Distribution List

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SUBJECT: Medical Necessity

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The issue of medical necessity for services is becoming more and more prevalent in government settlement agreements. Medicare will only cover services which are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Clearly no such provision may interfere with a health care provider’s discretion to furnish necessary care. The payer, however, must be sure that it can manage the delivery of care to all of its enrollees and therefore has an interest in the determination of what is considered to be “medically necessary.”

The AMA’s Model Managed Care Contract, a sample contract to help physicians negotiate with health plans, suggests this definition of medically necessary services:

Health care services or procedures that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician or other health care provider.

Whether a particular health care service is “medically necessary,” and therefore warranted, requires a balance between diagnosis, medical documentation and the likelihood that medical community peers accept that the treatment is necessary for the patient.

To provide guidance on whether a particular medical service is medically reasonable and necessary, the Centers for Medicare and Medicaid Services (“CMS”) may publicize a National Coverage Determination (“NCD”) which will grant, limit or exclude Medicare coverage for a specific medical service. If CMS elects to issue a NCD, the NCD is binding on all Medicare contractors processing Medicare claims. In the absence of an NCD, medical necessity decisions
are made at the discretion of local Medicare Administrative Contractors ("MACs"). MACs may also publish Local Coverage Determinations ("LCDs") to provide guidance to the public and the medical community within a specified area and explain when an item or service will be considered "reasonable and necessary" and thus eligible for coverage under the Medicare statute.

If a biller or coder conveys that a service is not medically necessary, they certainly are not telling the provider how to practice medicine or that his or her care is suboptimal, but rather that the documentation does not appear to support the need for the volume of services, the level of service, or the frequency of services according to the payer’s coverage policies.

It is critical that Medicare LCDs or NCDs are checked to ensure the documentation supports the coverage requirements. Coverage determinations are more than just a list of covered diagnoses. Some provide detail on what must be documented in order for a service to be covered or what must occur before a service will be covered. For example, one MAC’s LCD for cataract extractions requires the documentation to support not only a diagnosis of cataract but the following:

- Visual acuity (best corrected Snellen chart);
- Visual acuity during glare or contrast sensitivity testing when the best corrected Snellen chart visual acuity is 20/40 or better;
- Symptomatology directly related to the presence of the cataract;
- Physical evidence of the existence of a cataract (e.g., slit lamp examination) and no evidence of other ocular disease (e.g., retinal disease) that would prevent an improvement of vision when the cataract is removed;
- There is a reasonable expectation that removal of the cataract will improve the patient’s visual acuity;
- The use of conservative treatment including current refraction is no longer satisfactory;
- Degree of functional impairment (This can be in any form; e.g., narrative or assessment tool as long as it supports how the cataract affects the patient’s ADLs.); and
- Risk and benefit of the procedure.

As you can see, the documentation would not support all of the above requirements simply by way of a diagnosis code. This is why from a compliance perspective I would advise you to avoid using "diagnosis cheat sheets" or relying only on diagnosis “favorites lists.” These sheets and lists only provide covered diagnosis codes but leave out other, pertinent information necessary for coverage. Keeping up with LCDs and NCDs is difficult to do in a large, multi-specialty practice so this responsibility needs to be shared with billing managers, office managers,
managed care department representatives, or even physician leaders. These individuals should all know how to access the coverage database or locate payer policies.

To mitigate compliance risk, I suggest starting with your top 25-50 procedure codes by volume. Check for Medicare coverage policies on these procedures and convey this information to appropriate faculty, staff, and nonphysician practitioners.

These policies change periodically so it is recommended that, at a minimum, they be checked quarterly and that superseded versions be archived.

Here is a link to the Medicare Coverage Database:


A search may be performed on a keyword or a procedure code. Searches may be made for NCDs as well as Florida or Georgia MAC LCDs. In addition, NCDs may be found in the Medicare National Coverage Determinations Manual which is available on the CMS website at:


Lastly, on the Compliance website, you will find a detailed educational pamphlet entitled “How to Use the Medicare Coverage Database.” Here is a link to the page:

http://www.hscj.ufl.edu/college-of-medicine/compliance/edu.aspx

The pamphlet is under the Medicare Specific section.

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