Medical Necessity: Can You Please Define That?

Part II

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INTRODUCTION

Last month we reviewed the definitions of medically reasonable and necessary services. This month we will explore some of the legalities.

RULES AND REGULATIONS

Dr. Michael K. Rosenberg further states in the explanation of medical necessity from the editorial in the February 2002 column as Carrier Medical Director for Michigan:

> The criteria for, and limitations of any given service are the basic subjects which are addressed in Local Medical Review Policies (LMRP). The purpose of an LMRP is to define the conditions (ICD-9-CM codes) under which a service (CPT 4 codes) is covered, i.e., *medically necessary.*
>
> "*Medical necessity"* has become a ubiquitous term in a vast array of Medicare documents, such as national coverage decisions, guidelines, claim denials, and provider education materials, as well as in LMRP's.

Here is some alphabet soup. There are various regulations promulgated by CMS (Centers for Medicare and Medicaid Services). This is often confusing or unknown to providers. Among these are:

- NCD (National Coverage Decision)
- LMRP (Local Medical Review Policy which is transitioning to
- LCD (Local Coverage Determination)
- NCCI (National Correct Coding Initiative).

- CPT (Current Procedural Terminology) is recognized as the official coding system by the CMS, as well as most all other insurers, and many definitions are wholly or partially included in Medicare policies

A comparison between Federal and state laws is a good starting point. In the presence of a national regulation a state cannot come in and make its own; however, when no federal regulation exists, the state can make its own. The same is true for Medicare. In the absence of national policy, the local carrier can put forth local policies known as Local Medical Review Policies as described above.

NCD. First, there are National Coverage Determinations. They are national decisions and cannot be overruled by local Medicare Carrier policies, even though this sometimes does happen. National policies and regulations may be found in the Federal Register, Medicare Carriers Manual and Coverage Issues Manual. The policy on Visudyne, for example, is a National Coverage Decision.

LMRP. (Note: all LMRP's will be converted to LCD's – Local Coverage Determinations by December 2005). A LMRP addresses issues not covered in national policies that may need clarification. It is not supposed to conflict with national policy; however, on occasion this occurs. An example is the definition of consultation found in HGSA Administrator's (Pennsylvania Carrier) LMRP on General Ophthalmological Services.

LMRP's generally specify conditions under which a given service may be allowed. They correlate CPT codes with ICD-9 codes. This could be:

- Allowing payment for the service itself (ie, Medicare does not pay for various refractive surgeries)
- Allowing payment for a given service with only certain diagnoses (ie, corneal topography, pachymetry)
- Allowing payment for services that do not have a CPT code by using an unlisted code and further enumerating which ICD-9 codes would render the service payable (ie, IOL master before it received a CPT code, corneal topography)
- Coding Guidelines

Remember that LMRP's vary from carrier to carrier and you must be up-to-date with your carrier's policies. Be diligent in reviewing your carrier's LMRP's and the draft LMRP's. When your carrier changes you can expect changes in the LMRP's.

LCD. That being said, in January 2004 Medicare issued instructions that beginning December 7, 2003 contractors shall issue LCD's and all LMRP's will be converted to LCD's by December 2005.

LOCAL COVERAGE DETERMINATIONS

The main characteristic of LCD's is that they are prohibited from giving coding guidelines, unlike LMRP's.

LCD's specify under what clinical circumstances a service is considered to be reasonable and necessary. They are administrative and educational tools to assist providers in submitting correct claims for payment.

Codes describing what is covered and what is not covered can be part of the LCD. This includes, for example, lists of HCPCS codes that spell out which services the LCD applies to, lists of ICD-9-CM codes for which the service is covered, lists of ICD-9-CM codes for which the service is not considered reasonable and necessary, etc.

Coding guidelines are separate documents.

In next month's column we will take a look at some specific applications and how medical necessity affects your billing and coding patterns.

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All LMRP's have been converted to LCD's. Most Medicare carriers have been or are in the process of amalgamating into Medicare Administrative Contractors (MACs).