Medical Necessity—The Foundation of Medicare Physician Payments

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How is one to provide a medically necessary service if there is no precise definition?

One of Medicare's most elusive concepts is that of medical necessity—and yet it remains the reason most often cited for denials of various services ranging from office visits through diagnostic tests to surgical procedures. The Medicare Carriers Manual states that all services must be medically necessary and medically reasonable and no more. So, the conundrum: How is one to provide a medically necessary service if there is no precise definition?

Definition

One of the best explanations of medical necessity I have read was written by Michael K. Rosenberg, MD, in his Medical Director's Column for the February 2002 issue of the *Medicare Bulletin* for Michigan and Illinois:

The words "not medically necessary" are frequently used in Medicare provider and beneficiary messages and communications. It is a very unfortunate term. It evokes a lot of emotion. ... The implication inherent in a medical necessity denial is that the diagnostic or therapeutic service, provided by the physician, was unnecessary, and, therefore, in some way bad or at the very least superfluous. This has the effect of confusing patients and angering physicians. Medical necessity thus becomes the reason a given service is covered and payable by Medicare. If the service is deemed "not medically necessary" for any reason, then Medicare will not pay the provider.

Dr. Rosenberg further clarifies:

What is not appreciated is the fact that Medicare has evolved, over the years, into a very defined benefit program. In Medicare terms, "not medically necessary" simply means that the service is not a benefit under this defined benefit, for this diagnosis, at this time. Time and diagnosis are the key words, in that neither is immutable. A given procedure may become medically necessary, for a given diagnosis, at future time, and vice versa.

As the old movie says, "Things Change"; and so does "medical necessity," along with Medicare rules and regulations. It is important to remember that the phrase is not a value judgment regarding the provider's diagnostic acumen, therapeutic decisions, and/or services.

Rules and regulations

Dr. Rosenberg further stated that the criteria for and limitations of any given service are the basic subjects addressed in Local Medical Review Policies—now called Local Coverage Determinations (LCDs)—in which the conditions (ICD-9-CM codes) under which a service (CPT code[s]) is covered, i.e., medically necessary, are defined.

Clinical applications for diagnostic tests

There are many intertwining issues involving medical necessity and diagnostic tests.

Unilateral versus bilateral. In Medicare terminology (as defined by

the Medical Physician Fee Schedule Data Base—MPFSDB) a test is unilateral when each side is eligible for payment (100% of the allowable) by virtue of medical necessity for the test and correlating diagnosis. This does not necessarily correspond to good medicine. An example: If a patient presents with symptoms of flashes and floaters in the right eye, there is only medical necessity for performing extended ophthalmoscopy in the right eye, even though prudence and good medicine would dictate bilateral testing.

Medical necessity. There must be medical necessity for the test itself. In the absence of appropriate indications the test becomes a screening test and is not eligible for payment, an example being the performance of routine visual fields on all patients.

Diagnosis. Lastly, there must be an appropriate diagnostic reason (and diagnosis) for which a test is ordered. For example, advanced glaucoma is not considered a valid diagnosis for SCODI (scanning computerized ophthalmic diagnostic imaging) testing by most LCDs.

The eye codes and E/M codes

Many MACs (Medicare Administra- tive Contractors) have LCDs for the eye codes (CPT 92004, 92014, 92002, 92012). Although most policies are now retired, you are still responsible for adhering to the requirements. Most incorporate the CPT definitions into the policy.

By CPT definition, the comprehensive eye codes require the following four elements: confrontation visual fields; basic sensorimotor evaluation; ophthalmoscopy (dilation requirements vary with each policy); and adnexal and external examination. You must have medical necessity for the examination, the level of the examination, and each component of the examination. Some providers erroneously believe they can perform a comprehensive examination (CPT 92014) twice a year, regardless of the reason for the encounter. Without medical necessity these services will be disallowed or down-coded under audit. In the absence of new symptoms, what would be the medical necessity for repeating a basic sensorimotor examination in a patient being followed for Stevens-Johnson syndrome or endophthalmitis?

The 1997 E/M guidelines specifically state, "Because the level of E/M service is dependent on two or three key components, performance and documentation of one component (e.g., examination) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service." You must have medical necessity for each element as well as the service itself. This also applies to the eye codes.

Surgical procedures

Cataract and after-cataract surgery. Medicare determines the medical necessity for both of these procedures based on problems described by the patient with ADL (activities of daily living) rather than merely the surgeon's opinion. It is advisable to have patients fill out a brief form that lists their agreement or disagreement with stated problems in their daily activities. Frequently, this is missing in the chief complaint and causes denials of claims and subsequent audits.

The attorneys have long made a major point of having the surgeon ascertain there are ADL problems attributable to the second eye when surgery for that eye is scheduled, especially when the surgery is performed within the global period of the first operation.

Lesions. Be sure to check under dermatology LCDs for guidelines pertaining to billing for lesion removal. Many lesions (i.e., seborrheic keratoses) are considered cosmetic and are only reimbursed under certain conditions—the absence of which would render the service not reimbursable due to lack of medical necessity.

Cosmetic procedures. Blepharoplasty surgery always warrants having the patient sign an ABN (Advanced Beneficiary Notice). Medicare does not preauthorize surgery and, if denied, Medicare will adjudicate in favor of the patient. This is also applicable to other surgeries such as certain refractive procedures and many newer operations. Another important safeguard is having good communication with your patients. They should be told and understand that a service may be denied and will become their financial responsibility. For cosmetic procedures the patient must also pay for that portion of the anesthesia fee and the ASC fee.

Takeaway

Medical necessity is multifaceted. It changes from circumstance to circumstance. It pervades all aspects of your practice and can wreak havoc in your billing department. Brief but diligent study of Medicare's policies certainly will help you avoid unnecessary denials, requests for refunds, patient complaints, and undeserved audits.

Note

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