Medical Necessity: Can You Please Define That?

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INTRODUCTION

One of Medicare=s most elusive concepts is the term medical necessity. Yet, lack thereof is the reason most often cited for denials of various services ranging from office visits/consultations to diagnostic tests to surgical procedures.

The Medicare Carriers Manual states that Aall services must be medically necessary and medically reasonable@ and no more. So - the conundrum: how is one to always provide a medically necessary service if there is no precise definition?

DEFINITION

One of the best explanations I have read was written by Michael K. Rosenberg, MD, Carrier Medical Director, Michigan, in his Medical Director=s Column for the February 2002 issue of the Medicare Bulletin for Michigan and Illinois. It is a classic and still rings true.

Dr. Rosenberg writes:

> The words Anot 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 Anot medically necessary@ for any reason, then Medicare will not pay the provider.

Dr. Rosenberg also has provided one of the clearest explanations of this. He 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.

Medical necessity is defined as the need for an item(s) or service(s) to be reasonable and necessary for the diagnosis or treatment of disease, injury or defect. The need for the item or service must be clearly documented in the patient's medical record. Medically necessary services or items are:

- Appropriate for the symptoms and diagnosis or treatment of the patient=s condition, illness, disease or injury; and
- Provided for the diagnosis or the direct care of the patient=s condition, illness, disease or injury; and
- In accordance with current standards of good medical practice; and
- Not primarily for the convenience of the patient or provider; and
- The most appropriate supply or level of service that can be safely provided to the patient@

RULES AND REGULATIONS

Dr. Rosenberg further states:

> *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 LMRPs (RLA: now LCDs).

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), LCD (Local Coverage Decisions), NCCI (National Correct Coding Initiative). In addition, 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 to Federal laws and state laws is valid. 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 Coverage Decisions as described above.

NCD. First, there are National Coverage Decisions. They are national decisions and cannot be overruled by local Medicare Contractor 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 as well as online.

LCD. A LCD (Local Coverage Determination) addresses issues not covered in national policies that may need clarification.

LCDs generally specify conditions under which a given service may be allowed. They correlate CPT codes with ICD-10 codes in accompanying coding Articles. 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 given diagnoses
- Allowing payment for services that do not have a CPT code by using an unlisted code and further enumerating which ICD-10 codes would render the service payable

Remember that LCDs vary from MAC to MAC and you must be up-to-date with your MACs policies. Your area also may be subject to a change in MAC. Be diligent in reviewing your carrier=s LCDs and the draft LCDs. When your MAC changes you can expect changes in the LCDs.

Let’s take a look at some specific applications.

DIAGNOSTIC TESTS

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

Unilateral verus Bilateral. In Medicare terminology (defined by the

Medical Physician Fee Schedule Data Base - MPFSDB) a test is unilateral when each side is eligible for payment (100 per cent of the allowable) by virtue of medical necessity for the test and correlating diagnosis. This does not necessarily correspond to good medicine. In recent years there has been a consolidation of most diagnostic tests wherein the single payment covers both sides.

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

Diagnosis. Lastly, there must be an appropriate diagnostic reason (and diagnosis) for which a test is ordered.

THE EYE CODES

Many carriers no longer have LCDs for the eye codes (CPT 92004, 92014, 92002, 92012). By CPT definition, the comprehensive eye codes require the following four elements: confrontation visual fields; basic sensorimotor evaluation; ophthalmoscopy 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 this can result in a serious audit encounter.

For serious conditions that warrant frequent follow-ups you should use level for E&M (99214 Evaluation and Management Code) rather than 92014 (comprehensive eye code). In the absence of new symptoms what would be the medical necessity for repeating basic sensorimotor examination in a patient being followed for Stevens-Johnson syndrome or endophthalmitis?

SURGICAL PROCEDURES

Cataract and After-cataract Surgery. Medical necessity for both of these procedures currently is determined by Medicare by described problems with ADL (Activities of Daily Living) rather than merely the surgeon's judgment. It is advisable to have patients fill out a brief form that lists their agreement/disagreements with problems in their daily activities. Frequently, this is missing in the history and causes denials of claims and subsequent audits.

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

Lesions. Be sure to check under dermatology LCDs for those pertaining to lesion removal. Many lesions (ie, seborrheic keratoses) are considered cosmetic and only reimbursed under certain conditions - the absence of which would render the service non-reimbursed due to lack of medical necessity.

Cosmetic Procedures. Blepharoplasty surgery always warrants having the patient sign and 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 communications with your patients. They should be told and understand that a service may be denied and will become their financial responsibility.

CONCLUSION

Medical necessity is multi-faceted. 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.

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EyeWorld May 2004 Original Publication
Current Update May 2021
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