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### Practice Management Tips and Tools – Determining Medical Necessity

This Timely Topic is the second article in a series of “Practice Management Tips and Tools” focused on helping anesthesia and pain practices build and strengthen their toolkits to address billing, coding and other payer related issues. The purpose of this article is to explore the issue of “medical necessity”: what is it, how to demonstrate it and why is it required.

The Social Security Act (referred to as “the Act”) provides the regulatory framework and other requirements for the Medicare program. In Section 1862 (a) the Act states:

*“Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—*

*(1)(A) which, except for items and services described in a succeeding subparagraph, are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member...”*

While the Act requires services to be “reasonable and necessary”, no further definition has been provided via statute. The Centers for Medicare & Medicaid Services (CMS) has operationalized medical necessity to mean:

*“Adequate evidence to conclude the item or service improves clinically meaningful health outcomes for the Medicare population.” (Louis B. Jacques, M.D., Director, Coverage & Analysis Group, CMS)*

In addition, CMS and its local Medicare Administrative Contractors (MACs) provide national and local coverage documents that outline the national CMS and local contractor requirements for payment of services, treatments and equipment. These coverage documents typically outline the service/treatment and documentation requirements, including a listing of what conditions or symptoms indicate the service is warranted, any procedural requirements and if there are limitations to the coverage—for example any contraindications or limits in frequency or duration.

National Coverage Determinations (NCDs) are written by CMS and identify items and services that will be covered by Medicare Part A and Part B. The NCDs outline policy that is binding nationally. Local Coverage Determinations (LCDs) are developed by the individual MACs and are specific to the region(s) specified in the document, but they must be consistent with any CMS policy and written instruction. More detailed information regarding

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NCDs, LCDs and other Medicare policy is found in a previous Timely Topic [NCDs, LCDs and the MCD: How to Learn What CMS Does or Does Not Cover \(January 2017\)](#).

Most relevant to the topic of Medical Necessity, however, is that the LCDs often list specific diagnosis codes that the MAC has determined demonstrate medical necessity or specifically do not demonstrate medical necessity for coverage. We discussed in our last [Timely Topic](#) that the diagnosis codes or International Classification of Diseases, 10th Edition, Clinically Modified (ICD-10-CM) codes are used on the claim form to communicate why services are performed.

If there are NCDs and LCDs specific to the service you are providing, you can refer to them to determine if the ICD-10-CM code you are using is in the covered or non-covered listing of codes or other description information. These listings may not be comprehensive, but they do indicate how the listed codes will cause a claim to pay or not pay automatically—according to the likely edits in the MAC’s claims processing platform. If the diagnosis code you are using is not on the list of covered diagnoses, the claim may still be payable but will require further review for determination. If the code you are using is on the list of non-covered diagnoses, the claim is not payable. The non-covered diagnoses are considered either contraindicated, not medically necessary, or outside of the policy’s scope of coverage. An example of being outside the scope of coverage could be if the service is considered experimental or investigational for particular clinical conditions.

Ultimately the medical record documentation determines if the claim may be paid. For example, the NCD for Infusion Pumps (280.14) states, “This may not be an exhaustive list of all applicable Medicare benefit categories for this item or service.” LCD’s will also include a reference to CMS and medical necessity requirements such as the language found in the Noridian LCD for Lumbar Epidural Injections (L34980): “When the documentation does not meet the criteria for the service rendered, or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary under Section 1862(a)(1) of the Social Security Act.”

You may wish to request a redetermination of payment or appeal a claim denial if you receive a denial with the following Claim Adjustment Reason Codes (CARC):

- 40 Charges do not meet qualifications for emergent/urgent care.
- 50 These are non-covered services because the payer does not deem this a ‘medical necessity’.

These two CARCs are assigned based on the ICD-10-CM diagnosis codes as listed on the claim form. Assuming the services provided were medically necessary, a review of the medical record documentation to confirm it includes indications why the services were reasonable and necessary prior to submitting a redetermination or appeal request may be in order.

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Such indications might include:

1. an adequate description of the patient's condition necessitating the treatment
2. the patient's active diagnosis or symptoms match the ICD-10-CM reported on the claim
3. a clinically positive outcome is expected based on the service rendered
4. the services, including frequency and duration, were within the specific coverage policy coverage requirements

The information above, though specific to Medicare Part A and Part B claims, also applies generally to other payers. However, you should check with each specific payer for medical coverage policies and listed requirements and coding to confirm what they each consider "medically necessary" and within coverage to allow payment.

Medical necessity is not always clearly defined but general requirements are usually outlined in each payer's coverage documents. You can help demonstrate the medical necessity of the care you provide by making sure your clinical documentation tells a complete and accurate story of your patient's actual condition, shows why the services would improve that condition, and validates the ICD-10-CM code reported on your claims.

Establishing that the services were reasonable and necessary is a requirement for payment. Reviewing the coverage documents, your documentation and the coding on your claims to ensure the medical necessity guidelines are met will help reduce disruption in your revenue flow.

Watch for our next Timely Topic in this series – it will offer tips on analyzing and managing claim denials.