Medical Necessity for Outpatient Services

Audio Seminar/ Webinar
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Practical Tools for Seminar Learning

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Introduction to Medical Necessity

When Did This All Happen?

- Around since 1965
- Medicare Carriers Manual 3/1/96 required documentation of medical necessity for chemistry profiles/panels
  - ABNs (Advance Beneficiary Notices)
- Heightened with the Balance Budget Act of 1997 (effective 1/1/98) (Section 4317 andSubtitle D-Anti-fraud and Abuse Provisions)
- We should be obtaining ABNs for testing/services that are not deemed Medically Necessary by Medicare
What are We Experiencing?

- Medicare’s complex claims editing system
  - Increased ancillary service denial management
- HIPAA enforcement
- Medicare’s Recovery Audit Contractors (RACs)

Overpayments by Error Type
(Self-Reported by RACs)

[Bar chart showing overpayments by error type:
- Incorrectly Coded
- Medically Unnecessary
- Inadequate Documentation
- Other]

2007
So if it’s not deemed Medically Necessary by Medicare - What do we do?

- Issue an ABN
  - Advance Beneficiary Notice of Non-coverage
    - Giving a notice in advance to beneficiary
    - Allows beneficiary to consider options and to make a decision

When Do We Use ABNs?

- Whenever we believe a service may be medically unnecessary and denied by Medicare (Part A & B)
  - Inpatient stays (Hospital Issued Notices of Non-coverage)
  - Testing
  - Observation services
  - SNF services (Notice of Exclusion from Medicare Benefits and SNF-ABNs)
  - Etc.

What We’re Experiencing?

- Physician complaints/complacency
- Patient complaints
- Labor impact
- Medicare Administrative Contractor
  - Access to all providers
  - New emphasis on Local Coverage Determinations
  - A MAC is not a MAC

Why Us?

- Physicians refer patient care services to the hospital
- Labs and hospitals are the 3rd parties to physician’s orders
- Administrator resistance
**WHO Should Get the ABN?**

- Chicken-Egg dilemma
- The laboratory has the financial risk
- The physician can explain why he/she is ordering the test to the patient and discuss alternatives
  - Has a better opportunity to give “informed” notice

**How do we determine what is Medically Unnecessary?**

- Outpatient Tests
  - Medicare Coverage Database (MCD)
  - Use the LCDs and NCDs
    - Local Coverage Determinations
      - [http://www.cms.hhs.gov/mcd/index_lmrp_bycontractor_criteria.asp?error=A+Contractor+must+be+selected%2E](http://www.cms.hhs.gov/mcd/index_lmrp_bycontractor_criteria.asp?error=A+Contractor+must+be+selected%2E)
    - National Coverage Determinations
**LCD Website**

![LCD Website Image](image-url)

**Database**

Select a contractor to view list of LCDs.

The table below lists all LCD contractors and the state(s) they service. An asterisk (*) indicates that the contractor has secondary jurisdiction in that state.

- **View jurisdiction definitions**
- **View state abbreviations**

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![Database Image](image-url)
Medical Necessity for Outpatient Services

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Indications and Limitations of Coverage and/or Medical Necessity

I. Allergy Testing
A. Allergy sensitivity tests:
The performance and evaluation of selective cutaneous and mucous membrane tests in correlation with history, physical examination, and other observations of the patient. These tests are performed to determine body sensitivity and reaction to the antigen for the purpose of diagnosing the presence of allergic reaction to antigenic stimuli. The number of tests performed should be judicious and dependent upon the history, physical finding and clinical judgment. All patients should not necessarily receive the same tests or the same number of sensitivity tests. Intradermal tests are injections of small amounts of antigen into the superficial layers of the skin.

B. Patch testing:
Patch testing is the gold standard method of identifying the cause of allergic contact dermatitis, a delayed cell-mediated type IV hypersensitivity reaction. It is a diagnostic test reserved for patients with skin eruptions for which a contact allergy source is likely.

The patch test procedure can induce an eczematous reaction in miniature by applying suspect allergens to normal skin, allowing the physician to determine a specific patient allergy. Patch tests are applied to the skin on the patient's
Medical Necessity for Outpatient Services

1. The following tests are considered not medically necessary:
   - Provocative Testing
   - Blood, Urine or Stool Micro-nutrient Assessments
   - Qualification of Nutritional Assessments
   - Elisa (ELISA) Tests - 86001
   - Environmental Cultures and Chemicals
   - Live Cell Analysis
   - Passive Transfer
   - Rebuff Skin Window
   - Leukocyte Histamine Release - 86343
   - Metabolic Assessments
   - General Immune System Assessments
   - Secretary IgA (Saliva)
   - Qualitative multi-allergen screen - 86005
   - Food Allergen Extract Immunotherapy
   - Cytotoxic Food Testing

2. Allergy Immunotherapy
   Indications for immunotherapy are determined by diagnostic testing appropriate to the individual needs of each patient and his/her clinical history of allergic diseases. Allergen immunotherapy should be differentiated from the process of desensitization, which usually involves the gradual increase...
General Information

Documentation Requirements
1. Documentation must be available to Medicare upon request.
2. Documentation supporting the medical necessity, such as ICD-9-CM diagnosis codes, must be submitted with each claim. Claims submitted without such evidence will be denied as not medically necessary.

Allergy Testing
1. Prior to performance of allergy testing, there must be evidence on the patient’s record that a history has been obtained, indicating the possible presence of allergy. This history should attempt to narrow the area of investigation so that the minimal number of necessary skin tests might deliver a diagnosis.
2. The selection of antigens should be individualized based on the history and physical examination. The number of tests performed should be judicious. All patients should not necessarily be tested for the same antigens or receive the same number of tests. Claims with excessive numbers of tests (2 standard deviations above the national mean) will be reviewed for medical necessity.

NCD Website

There are 23 items in this list.

NCDs

- Alpha-fetoprotein (AFP) (190.25)
- Blood Counts (190.15)
- Blood Glucose Testing (190.20)
- Carcinoembryonic Antigen (CEA) (190.26)
WHEN Should the ABN be Obtained?

- Another dimension
- Must be given sufficiently in advance of the service to permit an “informed” refusal
- Must be given with enough information to permit “informed” agreement
What Services Trigger the Need for an ABN?

- Services that can be “covered” services under Medicare but qualify for denial based on an LCD rules
  - Statutory screen exams of limited frequency when the prior test date is not known
  - Conditions disassociated with the test
  - Homecare to a non-homebound patient
  - There are more....

- More info on ABNs or the Beneficiary Notice Initiative
  - http://www.cms.hhs.gov/ BNI/

ABN Sections

(A)Notified(s):
(B) Patient Name: (C) Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D)__________ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your healthcare provider have good reason to think you need. We expect Medicare may not pay for the (D)__________ below.

(D)__________ (E) Reason Medicare May Not Pay: ____________________________
(F) Estimated Cost: ____________________________

WHAT YOU NEED TO DO NOW:
- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose one option below about whether to receive the (D)__________ listed above.
  - Note: If you choose Options 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.
### ABN Sections

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<th>Check only one box. We cannot choose a box for you.</th>
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<tr>
<td>☐ OPTION 1.</td>
<td>I want the (D)___________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn’t pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.</td>
</tr>
<tr>
<td>☐ OPTION 2.</td>
<td>I want the (D)___________ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.</td>
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<tr>
<td>☐ OPTION 3.</td>
<td>I don’t want the (D)___________ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.</td>
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(If) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call 1-800-MEDICARE (1-800-633-4227) TTY: 1-877-486-2048.

Signing below means that you have received and understand this notice. You also receive a copy.

| (I) Signature: | (J) Date: |

According to the Payment for Textbook Act of 1990, the patient is required to respond in writing to a request to return a signed ABN form. The valid CMS control number for this information collection is 0991-0531. The time required to complete this information collection is estimated to vary between 10 minutes per response, including the time to review instructions, search existing data sources, gather the data needed, complete and submit the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Room H3220, Baltimore, MD 21244-3388.

Form CMS-1501 (03/08) Form Approved OMB No. 0991-0531

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### What to Do?

- **Patient choices**
  - Agree and Sign
  - Disagree and Not Sign
  - Decide to have the services but refuse to sign the form
    - 2 witnesses that patient refuses
    - Proves that notice was provided to the patient
- **It’s the “Notice” that makes the patient liable—not the signature!**
Examples of When is an ABN NOT Necessary?

- Whenever you’re in an EMTALA period
  - Completion of the medical screening examination
  - Only until the emergency condition has been stabilized
- For repetitive treatment IF:
  - Original ABN identifies all the items and services for which the doctor believes Medicare won’t pay (series tests)
  - Valid for 1 year

Examples of When is an ABN NOT Necessary?

- If an item or services does not meet the definitional requirements for Medicare, then the item or service will NEVER be covered by Medicare...hence patient (beneficiary) will always be liable for the cost of the item or service (ex. Routine Physical Exams)
- When the order has sufficient information to comply with the LCD/ NCD!

Valid Order-Revisited

- Medicare definition: an "order" = a communication from the treating physician/practitioner requesting that a diagnostic test be performed for a beneficiary.
- Forms of communication:
  - A written document signed by the treating physician/practitioner
  - A telephone call by the treating physician/practitioner or his/her office to the testing facility; or
  - An electronic mail by the treating physician/practitioner or his/her office to the testing facility.

Valid Order-Revisited - a Proviso

- NOTE: If the order is communicated via telephone,
  - both the treating physician/practitioner or his/her office and
  - the testing facility must document the telephone call in their respective copies of the beneficiary’s medical records.
Valid Order-Revisited

- On the rare occasion when the interpreting physician does not have diagnostic information as to the reason for the test.....
- obtain the information directly from the patient
- or the patient's medical record if it is available.
- [Medicare Transmittal 1891 dated 6/27/03]

Valid Orders - Updated Effective 9/30/08

- MLN Matters Number: MM6100 (CR6100)
  - If service is paid under Physician Fee Schedule
  - or Clinical Laboratory Fee Schedule
  - or Pathology Physician Services
  - PHYSICIAN SIGNATURE NOT REQUIRED BUT...
  - Physician must clearly document in the medical record his or her intent that the test be performed
- Check
  - State Regulations
  - Conditions of Participation
  - Your Bylaws
  - Joint Commission Requirements
The Coder's Role

- Understand the difference between medical necessity and coverage
  - Medical necessity
  - Coverage policies
    - National determination (NCD)
    - Local determination (LCD)
Reimbursement Decisions

- A medical-necessity decision is a clinical decision about the appropriateness of a specific treatment for a specific patient.
- A coverage decision is a policy decision about categories of health interventions provided as part of the contract between plan and purchaser.

The Coder’s Role

- Medical necessity [coverage & payment purposes]
  - The health care service is required for the prevention, identification, treatment, or management of a condition
  - And is in accordance with the following six qualifications...
**The Coder’s Role**

1. Consistent with the signs, symptoms, diagnosis, and treatment of the insured’s condition
2. Widely accepted by professional peers as efficacious and reasonably safe based upon scientific evidence
3. Not experimental or investigational

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**The Coder’s Role**

4. Universally accepted in clinical use such that omission of the service or supply in these circumstances raises questions regarding medical accuracy and appropriateness
5. Not for cosmetic purposes
6. Not primarily for the convenience of patient, family, or provider
The Coder’s Role - Case Study

The results of an ultrasound showed several thrombi in the right leg of this 83-year-old patient. Due to other conditions, the patient cannot be put on blood thinners. The physician wants to insert an inferior vena cava (IVC) filter to prevent any clots from going to the patient’s lungs.

CMS National Coverage Policy

- Title XVIII of the Social Security Act (SSA) section 1862 (a)(1)(A).
  This section allows coverage and payment of those services that are considered to be medically reasonable and necessary.
- Title XVIII of the SSA section 1862 (a)(7).
  This section excludes routine physical examinations and services.
- Title XVIII of the SSA section 1833 (e).
  This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Medicare National Coverage Determinations Manual, Chapter 1, Part 4, 270.5, CMM 45-12
The Coder’s Role

♦ Third-party payer coverage policy
  • Those diagnoses and/or procedures, services, treatments meeting the terms of the insured’s policy as covered and payable.
  • Covered diagnoses and/or procedures are not universal; they may differ for each patient
  • Uncovered services commonly known as policy exclusions

The Coder’s Role - Case Study

The 73-year-old patient has become hard-of-hearing. The audiologist has recommended digital hearing aids to improve the patient’s quality of life.

Hearing aids are not covered by Medicare.
Medicare Coverage Policies

- National Coverage Determinations (NCD)
- Describes whether specific medical items, services, treatment procedures, or technologies can be paid for under Medicare in accordance with title XVIII of the Social Security Act, and in Medicare regulations and rulings.

The Coder’s Role

- Local Coverage Determinations (LCD)
- Developed to specify under what clinical circumstances a service is reasonable and necessary. They serve as an administrative and educational tool to assist providers in submitting claims correctly for payment.
Example from an LCD (excerpt)

- These are the only ICD-9-CM codes that support medical necessity for the application of a skin substitute:
- Consistent with FDA labeling, the use of skin substitute products (J7340 or J7342) are limited to lower limb ulcers caused by varicose veins or diabetes. When performing wound care or debridement of a wound for varicose veins the following ICD-9-CM codes may be used alone:
  - 454.0 VARI COSE VEINS OF LOWER EXTREMITIES WITH ULCER
  - 454.2 VARI COSE VEINS OF LOWER EXTREMITIES WITH ULCER AND INFLAMMATION
  - 459.81 VENOUS (PERIPHERAL) INSUFFICIENCY UNSPECIFIED

Definition of Medical Necessity

Medicare's definition of medical necessity:

"Services or supplies that are proper and needed for the diagnosis or treatment of a medical condition, are provided for the diagnosis, direct care, and treatment of a medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of the patient or doctor."

Source:
Definition of Medical Necessity

Stanford University researchers have developed a model definition of medical necessity:

"An intervention is medically necessary if, as recommended by the treating physician and determined by the health plan's medical director or physician designee, it is (all of the following)...

- Purpose of the intervention: A health intervention for the purpose of treating a medical condition.
- Scope of the intervention: The most appropriate supply or level of service, considering potential benefits and harms to the patient.
**Definition of Medical Necessity**

- Available evidence: Known to be effective in improving health outcomes.
- Value: Cost-effective for this condition compared with alternative interventions, including no intervention.”

Linda Bergthold, Ph.D., Adjunct Fellow and Grant Project Director, Stanford University, Center for Health Policy, Palo Alto, CA.  

**Reimbursement Decisions**

- A *medical-necessity decision* is a clinical decision about the appropriateness of a specific treatment for a specific patient.
- A *coverage decision* is a policy decision about categories of health interventions provided as part of the contract between plan and purchaser.
Educating Clinicians

- It is not assumed that just because a treating clinician
  - Orders,
  - Prescribes,
  - Approves, and/or
  - Directs

That a health care service is a medical necessity.

Educating Clinicians - Case Study

The physician admits the 77-year-old patient into observation after carpal tunnel release surgery so his daughter can come pick him up after work. The patient does not require extended care, the physician is just accommodating the daughter’s schedule.
**Educating Clinicians**

- Without a documented **diagnosis** that supports this patient requiring observation, this service will not be reimbursed
- Providers must be certain to cover their decisions with documentation

**Educating Clinicians**

Explain documentation requirements

- If it’s not documented, it didn’t happen
- Signs, symptoms, and explanation of medical decision making... *evidence of the provider’s rationale* for ordering, prescribing and providing
**Educating Clinicians**

**Do NOT ...**

- Tell providers that Medicare will not pay if you diagnose this for this procedure
- Direct their medical decisions in any manner
- This is fraud...coding for coverage!

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**Example from an LCD (excerpt)**

- If you inform the provider that codes 454.0, 454.2, and 459.81 are the only ICD-9-CM codes that support medical necessity for the application of a skin substitute, you may be accused of colluding with the provider to code for coverage.
- This is fraud!
Observation Stays

- Recovery Audit Contractor target
- Hot spot for most hospitals
- What is necessary to support the medical necessity of Observation Stays?
Observations - What to Avoid

- Is the order written prior to ambulatory surgery?
- Is observation used for patient and/or family convenience?
- Is there only an admit and discharge note from the physician?
- Is the claim for the time from registered to the time discharged?

Observations

- The Rules:
  - Orders specifically for Observation
    - Diagnosis, treatment, stabilization and discharge expected within 24 hours
    - Complications from surgery - written 4-6 hours post-op
    - Explains why the patient needs to be in observation
    - Defines services and goals and when orders are met
Observations

• The Rules:
  • Orders specifically for Observation
    • Dated, Timed and Signed
    • Indicate the clinical reason for placement in observation
  • Use of Risk Stratification Criteria
    • If this, do this and when this, then what
  • Critical Access guidance: CMS
    4/4/08 Letter to State Survey Agency Directors Ref# S&C 08-16

Observations

• The Rules:
  • Progress Notes
    • Throughout the observation period
    • Regular physician interaction
  • Once sufficient information is available to render a clinical decision, the patient should be expeditiously admitted, appropriately transferred, or discharged

Day Egusquiza-A/R Systems
Observations

The Rules:

- Time in Observation
  - Observation starts with time appearing in the nurse’s observation note
  - Observation ends at time documented in physician’s discharge order
    - And treatment ordered is completed by nurses

Day Egusquiza-A/R Systems

Observations

The Rules:

- Not appropriate:
  - As a substitute for an inpatient admission
  - For continuous monitoring
  - For medically stable patients who need diagnostic testing
  - For patients awaiting nursing home placement
  - For the convenience of the patient or family
  - For routine prep or recovery
  - As a “stop” between the ED and Inpatient bed
  - Standing orders for Observation
  - Ordered prior to admission to an ED

CMS notice to State Surveyors
Establish Criteria:
- Have same criteria for a Medicare patient using Observation as for a non-Medicare patient

 Fixes
- Dedicated Observation Beds
- Nurses trained on documentation requirements
- Nursing and Case Manager = Gatekeeper

Observations
- Nursing plays a major role in demonstrating
  - Physician intervention
  - Active treatment
  - Documenting whether goals achieved and outcomes
- If achieved in middle of night...rest of time not covered
HIM’s Role in Observations

- Calculating the observation hours for billing purposes
- Identifying documentation deficiencies and/or non-qualifying observation services
- Capturing compliance statistics
- Designing forms/templates to capture supporting documentation

Courtesy: Knoxville Hospital & Clinics, IA
Documentation Improvement Ideas

Documentation Improvement

- Explain what information is needed to code - this can be different than what information is needed for continuity of care
- Develop an internal query process to keep communication between provider and coder open
- Reimbursement $$$ can *not* be a consideration!
**Documentation Improvement**

- Create an internal policy that promotes quality coding processes and avoid unspecified codes.
  - Query provider
  - Check ancillary reports (imaging and pathology documentation for test results)
  - Review patient history/charts

*Always get provider to update documentation*

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**Documentation Improvement**

- Coders should learn more about the diagnoses and procedures most often applicable to their facility or area
- Review NCD and LCD policies regarding those diagnoses and procedures so you know what details are needed for reimbursement
- ...in advance!
Example from an LCD

- Diagnoses that **DO NOT** Support Medical Necessity
- All ICD-9-CM codes not listed in the LCD under “ICD-9-CM Codes that Support Medical Necessity”

Example from an LCD

- After reading the LCD, you would know that certain diagnoses do not support reimbursement in this case.
- This may generate a query to the physician to see if another diagnosis was inadvertently omitted – one that would support this.
Documentation Improvement

- Educate providers on
  - Specificities,  
  - Manifestations, and  
  - Co-morbidities

within a diagnosis, procedure or service that - with accurate documentation - may affect the resulting codes and reimbursement

Case Study #1

- Cardiologists gain better insights for patients when they know if patient’s arterial plaque is lipid-rich or not
- A new 2009 ICD-9-CM code now reports this positive finding
  - 414.3 Coronary atherosclerosis due to lipid rich plaque

This provider may not be in the habit of including this detail because it never mattered before.
Case Study #2

- Myeloma and leukemia diagnoses have previously only been coded
  - Without mention of remission
  - In remission
- A new 2009 ICD-9-CM fifth digit for these codes also reports
  - In relapse

*This provider may not be in the habit of including this detail because it never mattered before.*

Educate Clinicians

- As we move forward toward the implementation of ICD-10-CM and ICD-10-PCS, coders must position themselves to educate the providers and help them understand the need for MORE specificity in order to gain accurate reimbursement
ICD-9-CM Outpatient Coding Guidelines

- Supporting diagnosis codes for signs, symptoms, or confirmed conditions must be shown on order
  - Code **ONLY** what is known for a fact
  - Do **NOT** code probable, rule out, possible, etc.
  - Code differential diagnoses as if both were confirmed

Outpatient Coding Case Study

Physician orders stress test for patient to rule out Dressler’s syndrome.

*This is not sufficient documentation for medical necessity for the test. Signs and symptoms that brought the physician to decide to order the test must be documented and coded.*
ICD-9-CM Outpatient Coding Guidelines

- Physician forgot Dx on order?
  - Query
  - Do not “fill in” code that confirms medical necessity
  - Have ordering physician document Dx in patient chart
  - Make certain documentation meets LCD/ NCD requirements

Outpatient Coding Case Study

Physician plans endoscopic sinus surgery for patient with chronic sinusitis.

This is not sufficient documentation for medical necessity for the procedure. The LCD states the physician must document previously tried and failed therapeutics.
ICD-9-CM Outpatient Coding Guidelines

- Screening test turns into diagnostic test
  - Sometimes 1 code; sometimes 2
  - Check guidelines in CPT
- Place-of-service codes matter!
  - Check LCD and/or NCD for POS restrictions

Others Involved in the Process
Registration’s Role in Avoiding Medical Necessity Denials?

- Ensure valid physician orders
  - Patient’s full name
  - Service ordered
  - Diagnosis or signs and symptoms
    - avoid code numbers
    - NO RULE-OUTS
  - Date
- Obtaining ABNs when appropriate
- Entering occurrence codes
- Scanning the order or ABN for ease of access

Patient Financial Services (PFS) Role in ensuring Medical Necessity

- Figure out how much you’re losing
  - Establish separate denial code in billing system
  - Report it monthly to Compliance Committee
- Categorize the losses by Department
- Categorize by ordering physician
  - Target education
  - Provide resources
PFS’s Role in Medical Necessity

- Store the ABNs to support billing the patient
- Providing updated transmittals on LCD or NCD changes
  - To Registration
  - To Physician Offices
  - To HIM
  - To Case Management

What can our facilities do to avoid Medical Necessity denials?

- Set policies (Put them in writing)
  - Encourage orders to be received 24-48 hours in advance or test is scheduled
    - Allows for pre-screening of orders
    - Hire a coder or nurse to review the orders received in advance for medical necessity
  - Require the physicians to attach the ABN to the order
  - Require provision of “back office” number
What can our facilities do to avoid Medical Necessity denials?

Tell medical staff what you will be saying to patients
- "Incomplete order"
- "You'll [We'll] need to call your physician"
  - "Here's a telephone"
- "Sorry, you'll need to wait until we receive the complete information from your physician."
- "Would you like to get something in the cafeteria while you wait? Here's a coupon for $1"

Enforce policies
Educate Physician Offices
What can our facilities do to avoid Medical Necessity denials?

- **Invalid order**
  - Obtain a valid order from the physician’s office
  - What are the consequences of doing tests without a valid order?
    - Incentive/Kickback
  - Don’t alter/change the diagnosis or code=altering the physician’s documentation
- **Bill the patient when the payment is denied**
  - Why?

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What can our facilities do to avoid Medical Necessity denials?

- Ensure you have the LCDs and NCDs available (either electronically or on paper)
- Buy software that is easy to use
  - Install it on a network accessible by your physicians
What can HIM do to avoid medical necessity denials

- Educate staff in Registration
  - HIM should provide Registration guidance
    - Medical terminology education
    - Basic coding training
    - Assist in selection of easy to use ABN software

In Summary...
Resource/Reference List

Revised ABN Form
www.cms.hhs.gov/BNI/02_ABNGABNL.asp

AHRQ

CMS Internet-Only Manuals
www.cms.hhs.gov/manuals


Resource/Reference List

“Effective Claims Denial Management Enhances Revenue.” Jackie Hodges J HFMA August 2002

CMS

MedLearn
http://cms.hhs.gov/medlearn

Compliance Guidance
www.oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf
Resource/Reference List

Physician Education

Appeal Guidance:
www.medicare.gov/Basics/ClaimsOverview.asp

ABNs—Always Been Neglected. Rose Dunn JAHIMA 11/14/2003 AHI MA BOK

Guide to Medicare Preventive Services

Local Coverage Determinations
http://www.cms.hhs.gov/mcd/index_lmrp_bycontractor_criteria.asp?error=A+Contractor+must+be+selected

National Coverage Determinations

Strategies for Medicare Medical Necessity. Darren Carter, MD AHI MA Proceedings 2002 AHI MA BOK

Start to Finish—Medical Necessity Review. Kathy Arner AHI MA Proceedings 2001 AHI MA BOK

Examine Medical Necessity to Avoid Unnecessary Follow Up. Glenn Krauss Medical Records Briefing 1/08
Audio Seminar Discussion

Following today’s live seminar
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for information on the 2008 seminar schedule.
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Upcoming Seminars/Webinars

Facility Specific ICD-9-CM Coding Guidelines
October 30, 2008

New - Hot Topic:
Understanding RAC Audit Trends
November 4, 2008

Facility Coding for ED Services
November 6, 2008

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sign-in form and evaluation in order to view and
print their CE certificate

Certificates will be awarded for
AHIMA Continuing Education Credit
Appendix

Resource/Reference List ....................................................................................... 52
CE Certificate Instructions
Resource/ Reference List

www.cms.hhs.gov/BNI/02_ABNGABNL.asp
www.cms.hhs.gov/manuals
http://cms.hhs.gov/medlearn
www.oig.hhs.gov/fraud/docs/complianceguidance/thirdparty.pdf
www.medicare.gov/Basics/ClaimsOverview.asp
http://www.cms.hhs.gov/mcd/index_lmrp_bycontractor_criteria.asp?error=A+Contractor+must+be+selected
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the online evaluation and sign-in information after the seminar, in order to view
and print the CE certificate.*