The Role and Importance of Medical Necessity in Healthcare Today

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MEDICAL NECESSITY

- While Always IMPORTANT, THE IMPORTANCE OF MEDICAL NECESSITY HAS GROWN MORE IN THE PAST 25 YEARS
- NOT AS HIGHLY SOPHISTICATED BEFORE; MAINLY DOCTOR-PATIENT
- ICD CODES MUCH LESS SOPHISTICATED
- IN MID-1900'S EMPLOYER & GOVERNMENTAL HEALTHCARE PLANS BEGAN DEVELOPING
- BEGINNING OF NEW PATIENT MINDSET FOR QUICK CURES; MORE VISITS
- MEDICAL NECESSITY IS THE NEW DRIVER IN HEALTHCARE

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OVERSIGHT

- OVERSIGHT NOT AS NECESSARY BEFORE
- WITH GROWTH OF INSURANCE AND GOVERNMENT HEALTHCARE PLANS, OPPORTUNITIES FOR FRAUD AND ABUSE GREW
- WITH GROWTH ALSO CAME NEED FOR MORE ADMINISTRATIVE & GOVERNMENTAL OVERSIGHT
- OVERSIGHT CREATED NEED FOR MEDICAL NECESSITY AS PROOF & TO SET STANDARDS

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PATIENTS' RIGHTS

- ENSURING PATIENTS' RIGHTS ONE OF THE MAJOR IMPETUS FOR MEDICAL NECESSITY STANDARDS
- PATIENTS' RIGHTS INCLUDE
  - INFORMATION SO CAN MAKE INFORMED CHOICES
  - PRIVACY & CONFIDENTIALITY
  - RIGHT TO REVIEW AND OBTAIN INFORMATION
  - RESPECT
  - QUALITY & CONTINUITY OF CARE

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REGULATORY AGENCIES

- Federal Government
- Regulatory
- State agencies
  - State health department
  - State health boards
  - State medical examiner
  - Licensing boards
- Local agencies
  - County health departments
  - County medical examiner
  - Coroner

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REGULATORY AGENCIES

- NCQA (National Committee for Quality Assurance)
- CARF (Commission on Accreditation of Rehabilitation Facilities)
- CHAP (Community Health Accreditation Program)
- ACP (College of American Pathologists)
- AMA (American Medical Association)
- AHIMA (American Health Information Management Association)
- ACS (American College of Surgeons)
- CMS (Centers for Medicaid & Medicare Services)
- DHSS (Department of Health and Social Services)
- CDC (Centers for Disease Control)
- NIH (National Institutes of Health)
- VA (Department of Veterans Affairs)
- Many more

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REGULATORY AGENCIES

- DEEMING AUTHORITY
  - GOVERNMENT HAS DETERMINED THAT COMPLIANCE WITH STANDARDS OF A VOLUNTARY AGENCY CAN SUBSTITUTE FOR COMPLIANCE WITH GOVERNMENT REGULATIONS
  - MOST HEALTHCARE STANDARDS SET BY ACCREDITING & PROFESSIONAL AGENCIES
  - ARE VOLUNTARY
  - ARE USED BY GOVERNMENT/LEGAL ENTITIES TO JUDGE LIABILITY & RESPONSIBILITY
  - PROVIDE CERTIFICATIONS & LICENSURE

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LEGAL/GOVERNMENTAL

- FRAUD
- ABUSE
- OMISSIONS/ERRORS
- NEGLIGENCE
- MALPRACTICE (INTENTIONAL/NONINTENTIONAL)
- FALSE CLAIMS ACT
- STARK LAWS
- ANTI-KICKBACK
- DEFICIT REDUCTION ACT
- HIPAA
- PATIENT PROTECTION & AFFORDABLE CARE ACT

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LEGAL/GOVERNMENTAL

- DENIAL OF PAYMENT
- RETURN OF PAYMENTS
- $10,000 FINE PER INCIDENT, PLUS 3 TIMES THE ERROR TIMES ALL OF THE FILES
- JAIL TIME
- LOSS OF PRIVILEGES TO SERVE PATIENTS

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HIPAA

- INSURANCE PORTABILITY
- MEDICAL SAVINGS ACCOUNTS
- DECREASE IN HEALTHCARE COSTS, PROMOTING EMR
- PRIVACY RULE
- RELEASE OF INFORMATION STANDARDS
- SECURITY RULE
- COMBAT WASTE AND FRAUD
  - FRAUD & ABUSE CONTROL PROGRAM
  - MEDICARE INTEGRITY PROGRAM
  - BENEFICIARY INCENTIVE PROGRAM
  - MEDICAID & ABUSE INITIATIVE
  - FRAUD & ABUSE DATA COLLECTION PROGRAM

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PATIENT AFFORDABLE CARE ACT 2010

- QUALITY HEALTHCARE FOR ALL
- PUBLIC PROGRAMS
- IMPROVING QUALITY & EFFICIENCY
- PREVENTION OF CHRONIC DISEASES
- TRAINING HEALTHCARE WORKFORCE
- TRANSPARENCY & INTEGRITY
- IMPROVING ACCESs
- COMMUNITY LIVING ASSISTANCE
- REVENUE PROVISIONS

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DEFINITIONS

- DIFFICULT TO DEFINE MEDICAL NECESSITY
  - TENS OF THOUSANDS OF AGENCIES/PRACTICES INVOLVED WITH INCONSISTENCIES
  - WHO'S IN CHARGE?
  - HIGHLY COMPLEX FIELD & BIG BUCKS
  - BASIC DEFINITION: JUSTIFICATION SUPPORTING THE PROVISION OF HEALTHCARE
  - SIMILIARITIES & DIFFERENCES AMONGST DEFINITIONS
  - CONSTANTLY CHANGING DEFINITION JUST AS HEALTHCARE IS & JUST AS EACH PATIENT IS UNIQUE
  - MEDICARE ACT DEFINITION: REASONABLE & NECESSARY FOR DIAGNOSIS OR TREATMENT OF ILLNESS OR INJURY OR TO IMPROVE FUNCTIONING OF A MALFORMED BODY MEMBER
  - AMA DEFINITION: IN ACCORDANCE WITH STANDARDS, CLINICALLY APPROPRIATE, NOT FOR ECONOMIC BENEFIT BUT FOR PATIENT BENEFIT

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IMPLEMENTATION OF MEDICAL NECESSITY

- NOT DOCUMENTED NOT DONE
- REPORTING PROCESS (TEMPLATES & SUPERBILLS)
- OVERSIGHT
- CONSISTENT APPLICATION OF SOUND HEALTHCARE PRACTICES INCLUDING ADMINISTRATION
  - STANDARD REPORTING
  - SOURCE ORIENTED REPORT
  - INTEGRATED HEALTH RECORD
  - PROBLEM ORIENTED RECORD (POMR)
  - COMBINATION RECORD
  - PROGRESS NOTES: SOAP/SNOCAMP
  - HOSPITAL REPORTS STANDARD FORMAT

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HEALTH RECORDS

- HEALTH RECORDS: "backbone of virtually every professional liability action and to establish standards."
  - PHI/PHR/EMR (Electronic medical records)/paper forms
  - Reasons for record content regulations
    - Standardization
    - Completeness (not documented, not done)
    - Compliance
    - Consistency
    - Transferability
    - Legal defense
    - Ensure proper patient care
    - Ensure proper payment for healthcare provider

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DATA SETS

- Regulations/standards for health records
  - UHDDS (Uniform Hospital Discharge Data Set)
    - Contains patient name, address, DOB, race, record #, admission date and type, discharge date, physician info, diagnoses, procedures, disposition of patient, payment, charges)
  - UACDS (Uniform Ambulatory Care Data Set)
  - MDS (Minimum Data Set for Long-term Care)
  - OASIS (Outcome and Assessment Information Set – home health)
  - DEEDS (Data Elements for Emergency Department Systems – ER visits)
  - EMDS (Essential Medical Data Set – EHR)
  - HEDIS (Health Plan Employer Data & Information Set – compare health plans)

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STANDARD REPORT SAMPLE

HISTORY AND PHYSICAL REPORT
PATIENT'S NAME: REBECCA MILLER

PATIENT'S DOB: 10/02/89

ADMIT DIAGNOSES: Abdominal pain.

DETAILED HISTORY: This is an elderly 78-year-old female who has a history of atrial fibrillation, coronary artery disease and chronic A-Fib also. She was admitted with some abdominal pain, left upper quadrant radiating to the back, associated with some sharp pain. During admission she was found to have a drop in her blood counts and with her having a history of peptic ulcer disease and staying on anticoagulation she has been consulted for risk assessment and the presence of any ulcer disease, which may limit the use of anticoagulation on her. She at the moment is not having gross hematemesis or any hemotochezia.

PAST MEDICAL HISTORY: Coronary artery disease, A-Fib, hypertension, history of ulcer disease.

PAST SURGICAL HISTORY: Bypass grafting. She also has chronic hyponatremia and is being worked up at the moment.

FAMILY HISTORY: Noncontributory. SOCIAL HISTORY: No alcohol. No tobacco abuse. REVIEW OF SYSTEMS: All systems reviewed and negative and detailed on chart.

PHYSICAL EXAM: GENERAL: She was seen in the medical ward. Alert and oriented. HEENT: Atraumatic, normocephalic. CARDIOVASCULAR: S1, S2 irregular. RESPIRATORY: Clear bilaterally. ABDOMEN: Soft and nontender. NEUROLOGICAL: Nonfocal.
ASSESSMENT: This elderly 78-year-old female with chronic anticoagulation with slight drop in her blood counts with having a history of peptic ulcer disease and also presented initially with abdominal pain. Would want to do an upper endoscopy and I would do it diagnostically to see if there is any ulcers present. If they are then we will have to discuss with the physician regarding whether Coumadin is safe to continue in the immediate settings. For the moment continue on PPIs.

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HIGHEST SPECIFICITY

- HIGHEST SPECIFICITY
  - PROPER INFORMATION INCLUDED IN REPORT
  - CRITICAL ELEMENT OF MEDICAL NECESSITY: SELECTING PROPER CODES ON BILLING FORM
  - GREATEST DETAIL INCLUDING PROPER DIGITS
  - NOS/NEC

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BILLING FORM

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MEDICAL NECESSITY CONCERNS

– PROPER UPDATING PATIENT RECORDS

– PAYMENT DENIED FOR OTHER REASONS, NOT FAILURE TO PROVE MEDICAL NECESSITY

– CODING CAN BE GRAY SO DIFFICULT SOMETIMES TO PROVE MEDICAL NECESSITY

– TRAINING/EDUCATION CRITICAL

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IMPLEMENTATION PROCESS

• SUBJECTIVE INFORMATION
• ASSESSMENT
• PLAN
• REPORTING
• REIMBURSEMENT
  – COVERED BENEFIT?
  – WHO DEFINES MEDICAL NECESSITY?
  – CLINICALLY APPROPRIATE VS MEDICAL NECESSITY
  – IF COVERED, WHAT ARE RESTRICTIONS?

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IMPLEMENTATION PLAN

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COVERAGE

- DEFINITION OF GLOBAL
- GLOBAL PERIODS
- CODING EXTRAS
- NCCI PHYSICIAN EDITS
- NCD/LCD (NATIONAL & LOCAL COVERAGE DETERMINATIONS)
- www.cms.gov/Medicare/Coding
- Link between ICD codes & CPT

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MEDICAL NECESSITY ERRORS

- Altering claims fraudulently after they have already been submitted in order to increase payment.
- Billings for services not rendered.
- Billing for office visits when only surgical procedures were performed.
- Unbundling of global services.
- Overutilization and billing of laboratory or radiological services.
- Billing for consultations when an office visit was provided.
- Improper billing for physician services when services are provided by other staff who are not qualified to provide the service for billing purposes.

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MEDICAL NECESSITY ERRORS

- Billing for services by two physicians for a surgical procedure that is not billable as a team procedure.
- Changing of dates of service to ensure additional payments.
- Duplicate billing.
- Billing and/or performing a more costly procedure, lab, or test when not justified as medically necessary.
- Misidentifying the person receiving the services for billing purposes.
- Kickbacks, bribes, rebates or other remuneration in exchange for services and referrals.
- Routine waivers of copays and deductibles which can be construed to be an inducement to gain referrals and patients.

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POSITIVES/NEGATIVES

- POSITIVES
  - ENSURING QUALITY AFFORDABLE HEALTHCARE
- NEGATIVES
  - PROVIDERS NOT DETERMINERS OF PATIENT CARE
  - PROVIDERS DENIED PAYMENTS
  - PROVIDERS PENALIZED/PUNISHED
  - FRAUD & ABUSE
  - PATIENTS DENIED NEEDED SERVICES
    - RATIONING

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