



Medical Necessity Denials: Prevention Pays Off



This project is a collaborative effort by
3M Health Information Systems and the
Healthcare Financial Management Association.

Hospitals are always looking for ways to improve operating margins. One reason for a drain in cash flow is due to payment denials because medical necessity is not met. Medical necessity denials are a significant challenge to hospitals not only because of lost revenue, but also because of the resources and time required to resolve denials. Organizations that have made strides in improving the management of medical necessity denials share one key characteristic: their priority is to *prevent* denials from occurring in the first place.

Hospitals have developed processes to avoid medical necessity denials in two general areas: at patient access (before providing the medical service) and in patient accounting (well after the patient has gone home, but before the bill is submitted for payment). These scenarios are typically referred to as preservice editing and postservice bill scrubbing, respectively.

Preservice steps involve:

- *Before* rendering service, checking to determine whether Medicare or the primary payer will pay for that item or service
- Ensuring there is proper documentation to support the order for the services
- Providing the patient an advance beneficiary notice (ABN) if the provider expects the claim to be denied by the payer for reasons of medical necessity, local standards of care, or similar denials. The ABN lets the patient know that the item or service is not covered by Medicare or the payer and that the patient may be financially responsible for that service.

Postservice steps involve:

- Processing UB92 and HCFA 1500 claims through a bill-scrubbing routine, either at the facility or at the claims clearinghouse

- Suspending the claim and returning it to the health information management (HIM) department to have the patient record checked for documentation that supports medical necessity, and adding new diagnosis codes, if applicable
- Writing off unbillable charges

Although these actions appear straightforward, they each present complexities providers must address.

Determining Medical Necessity

In the 1990s, the Office of Inspector General (OIG) and the Health Care Financing Administration (HCFA, now called CMS) began a series of investigations that dramatically altered the landscape of healthcare coding and billing. The goal was to determine the *appropriateness* of Medicare payments.

Medical necessity is required under Section 1862(a)(1)(A) of the Social Security Act. This section lays out Medicare’s regulatory structure for determining medical necessity by stating, “No payment shall be made for items or services that are not reasonable and necessary.”¹ In addition, the Medicare guidelines say, “A test may be considered medically appropriate, but nonetheless excluded from Medicare coverage.”²

Medical necessity involves both hospitals and physicians, and thus affects both Part A and Part B Medicare claims.

Medicare Coverage Database

The Medicare Coverage Database allows you to search for national or local coverage determinations, view an index of coverage information, and view new determinations. The database is usually updated weekly. Access the database at: www.cms.hhs.gov/mcd/search.asp?

Medical necessity is determined by looking at the combination of ICD-9-CM diagnosis codes with CPT-4 procedure codes. Although not every procedure code is currently covered by a medical necessity policy, for many CPT-4 procedure codes (the service provided), there is a corresponding list of ICD-9-CM diagnosis codes (the reasons for the tests or treatment). These are called “code pairs,” and it is the combination of these listed codes that identifies a service as meeting medical necessity and makes it eligible for payment by Medicare.

The “code pairs” that determine medical necessity are developed at both the national level by CMS and the local level by the contracted fiscal intermediary or carrier. At the national level, the medical necessity policies are called National Coverage Decisions (NCDs). At the local level, the policies are referred to as local medical review policies, or LMRPs.

To understand the scope of medical necessity, consider the following: NCDs cover 23 categories of lab tests. There are 66 HCPCS/CPT codes that fall under those 23 categories. When the total numbers of ICD-9 diagnosis codes are combined with the 66 HCPCS/CPT codes covered by the lab NCDs, the result is 176,000 “code pairs” that support medical necessity. To add further confusion to medical necessity, LMRPs and NCDs are written in two styles: inclusionary, which list all covered ICD-9s, and exclusionary, which list only those diagnosis codes that do not support medical necessity.

Only someone with superhuman speed-reading skills and memory could look through all the documents containing the various NCDs and LMRPs and identify modifications made on a monthly basis. The only way most hospitals can get a handle on this is to use medical necessity software designed specifically to track, compare, and display the appropriate code pairs that confirm medical necessity coverage.

Providing an ABN

When a service does not meet medical necessity, hospitals can issue an ABN to the patient, giving the patient an opportunity to pay for the amount of the service that Medicare or the payer will not cover. CMS defines an ABN as “a written notice which a physician or supplier gives to a Medicare beneficiary.” This may not be limited just to Medicare; some payers and insurance companies are considering following Medicare guidelines when setting their own medical necessity policies. Hospitals should check to see if other third-party payers require ABNs.

According to CMS, the purpose of an ABN is to inform a beneficiary *before* he or she receives specified items or services that Medicare probably will not pay for the services on this particular occasion. CMS says, “The ABN allows the beneficiary to make an informed consumer decision whether or not to receive the items or services for which they may have to pay out of pocket or through other insurance.”³

If the hospital does not produce an ABN for the patient to sign, but still provides the medical service, and receives a subsequent denial, it may not bill the patient. The hospital will not receive payment from Medicare, and furthermore, the monies lost in these cases cannot be listed as bad debt on cost reports. Providing an ABN is not a cut-and-dried action. Hospitals must consider how to handle patients on fixed incomes with sensitivity.

How ABNs are handled is critical from a patient and public relations standpoint. This is more problematic in small rural communities where there is only one hospital, or a mid-size community that may have several competing hospitals. In the final analysis, a hospital that complies with all coding regulations is the best defense: document what is provided, code accurately what is documented, and bill accurately each and every time.

Urban vs. Rural Hospitals: Measuring the Impact of Medical Necessity

The impact of medical necessity can be greater on rural facilities because what is lost as a result of medical necessity denials is more significant to the total bottom line. Outpatient services account for a greater percentage of total revenue in small hospitals, whether in the rural or urban setting, and Medicare revenue usually accounts for a higher percentage of their total income. Of greater importance might be the rural hospital’s sensitivity to “bad press” or negative public reaction if it appears as if a hospital is gouging patients, especially the elderly or those on a fixed income.

Issuing ABNs for patient signature is not the only requirement. There are specific codes that need to be added to the claim itself to identify which line item will be paid by the patient. If this is not done, the entire claim could be denied. In some cases, a separate claim has to be issued for the services that the hospital expects to be denied. So it is critical that the hospital’s billing systems can handle these details accurately.

Implementing a Program to Prevent Medical Necessity Denials

A program to prevent medical necessity denials requires an investment of time and resources to change processes and implement software, but it is an investment that definitely can pay off. Training physicians and their office staff to provide the required information on the initial request for services takes time. Managers who are willing to meet the challenges of developing the right process and instituting a comprehensive education program are finding significant improvements in their facility’s bottom line.

³ “What Doctors Need to Know about the Advance Beneficiary Notice (ABN),” CMS, 2003.

Those hospitals that are successful with their medical necessity programs have worked hand-in-hand with their physicians to ensure that they understand the advantages of following medical necessity procedures to the letter. Educating physicians and staff on the importance of compliance is one of the keys to success.

At Hammond-Henry Hospital in Geneseo, Ill., a town of approximately 6,000 residents, a team of department managers, physicians, financial administrators, medical records staff, and business office staff have all worked together to implement a medical necessity software solution at this 25-bed, critical-access hospital. Like Hammond-Henry, many hospitals

Reviewing Services to Avoid Denied Claims

Hospitals should ask the following questions about the services they provide to Medicare beneficiaries:

- Under what conditions is payment made for this service?
- How and to what degree will the service be covered?
- What type of staff certification is required to render the service?
- What ICD-9-CM and/or CPT/HCPCS codes are approved for use?
- What modifiers, if any, apply to the procedure codes?
- How is the billing unit defined for the service?
- Are there limits on how many units may be billed for a particular service?
- What revenue codes may be used to bill for this service?
- Are certain providers prohibited from providing the service?

Adapted from Jackie Hodges, "Effective Claims Denial Management Enhances Revenue," Healthcare Financial Management, August 2002.

have found that it's helpful to involve everyone from preservice to patient accounts to achieve success in managing medical necessity.

According to William Murdock, vice president of finance, medical necessity software has reduced the hospital's denials significantly. "I don't think we could manage medical necessity without the software," Murdock says. "It's a very good check. I don't know that I would want to chance running our medical necessity program without it."

Looking at the big picture is important when it comes to implementing a successful medical necessity verification program. For example, many medical necessity denials are related to laboratory procedures, which often are reimbursed at only \$3 or \$4 each. However, when the total number of lab tests that a typical hospital conducts each day is considered, the numbers really begin to add up. Also, as hospitals begin to market lab-outreach programs to local nursing homes and senior centers, managing Medicare lab denials can be the difference between profit and loss.

Where to Check for Medical Necessity

One important consideration in setting up a program to prevent medical necessity denials is *where* medical necessity should be assessed. Patient registration is presently the most common place where hospitals verify necessity and generate ABNs, when needed. According to one recent survey of 123 hospitals, 57 percent of hospitals stated that they check for medical necessity at registration, followed closely by 52 percent in the ancillary departments at the point of service. Only 17 percent reported checking medical necessity at the physician's office where the order or admit diagnosis is written.⁴

Hammond-Henry Hospital, for example, initiates ABNs at the department level before providing service, whereas Froedtert Hospital, a 440-bed academic hospital in

Milwaukee rolled out its program at the point of order, according to Jean Voight, coordinator of financial programs. “Our approach to ABNs is very different from the approach most hospitals have taken,” explains Voight. “We’ve found the majority of hospitals issue ABNs at the point of service in the ancillary department, or at registration. We’re doing it in the clinic at point of order. Even though this required significant physician and staff education, we felt that from a customer service standpoint it was the way to go.”

Many hospitals, including Central Texas Medical Center, a 113-bed hospital located in San Marcos and part of Adventist Health System, are initiating a medical necessity check through the scheduling department or at preregistration, says Frances Crunk, vice president and CFO. Wherever medical necessity is checked, staff should be trained to handle that function. Also, education and buy-in from the physician community is paramount for the program to be successful.

Educating Physicians and Others

Education has been a major component of the medical necessity program at Froedtert Hospital, says Voight. Because ABNs are initiated at the clinic level, the hospital has taken a two-tiered approach to education. They meet with clinic managers first, and then with the physicians. Says Voight, “So far it’s been enlightening for both sides—the finance side as well as the clinical side. As we rolled out ABNs, we realized our physicians are very willing to learn about reimbursement issues. In every physician group, we have found a champion who believes this is the right thing to do.”

At Central Texas Medical Center, physician education is an ongoing process, says Crunk. Medical necessity is handled at the time of registration, and if the procedure code does not indicate a medically necessary procedure for the diagnosis of record, then the hospital works with the physician to make sure the hospital has the appropriate diagnosis or another procedure that the doctor would prefer to order for the patient.

The real solution lies in educating physicians about medical necessity and getting their buy-in. Often this starts by using data to identify medical necessity issues by physician or department, and then explaining to physicians and staff the advantages of taking the time to ensure that the service is ordered correctly with sufficient diagnosis information to meet medical necessity requirements.

The staff actually performing the medical necessity check also needs training. Often the people who are checking for medical necessity are not professional coders. They are usually lab technicians, lab clerks, medical assistants, or registration personnel with limited coding knowledge. Because of personnel turnover, there needs to be a continuing education and training program. Some facilities have placed professional coders at registration or point of service (ancillary departments) because of their coding expertise and because they are used to interacting with physicians on documentation issues.

Technology Issues

Providers interviewed for this article all emphasized the importance of technology in preventing medical necessity denials. Just ask Frances Crunk. About five years ago, Central Texas Medical Center implemented two software programs to facilitate its compliance with CMS’s medical necessity guidelines. The software is integrated into the hospital’s registration process as well as in ancillary areas of the hospital.

According to Crunk, the software has led to a significant decrease in Medicare denials. “We’ve probably reduced our denials by 75 percent in the past three years,” says Crunk.

“These savings in time and reductions in lost reimbursement are due to our software and how we’ve been able to proactively manage the process based on the information we obtain through the software.”

Healthcare financial managers are finding that software reduces the time it takes to check for medical necessity and enhances patient throughput in the registration and admission process. “Initially, it took us a little while longer to get the patients through,” says Voight. “But now, with our software, we can screen for medical necessity, speak with the patient, and issue an ABN in less than five minutes.”

“For us,” says Crunk, “the biggest benefit is that our data are accurate and, if used properly and patients are scheduled in advance of treatment, you can identify potential cases that don’t meet medical necessity and hopefully come up with the right solution in advance of providing the procedure.”

Evaluating a Medical Necessity Software Solution

If you’re considering a medical necessity software solution for your hospital, here are some questions to ask:

- Does the software directly integrate with your healthcare information systems?
- Is it easy to use?
- Does it allow the user to add user descriptions or commonly used acronyms?
- How will it affect existing processes, workflows, rework, and A/R days?
- Are the policies and bulletins easily available?
- Does the system automatically update LMRPs and NCDs?
- Does it link to specific LMRPs that triggered the need for Medicare ABNs?
- Will it also transfer the appropriate occurrence and condition codes to the UB92 or 837I claim?
- What type of customized reporting is available?
- Is technical support available?

She adds, “It has the potential to save the patient wait time, save the hospital a potential write-off, and also save the patient from being personally responsible for the cost of the procedure or service.”

Evaluating a Software Solution

Most medical necessity software programs enable hospitals and physician groups to validate Medicare coverage according to LMRPs and NCDs *before* rendering service. When considering a software program, it’s important to ensure that it is specific to your fiscal intermediary and that it contains all the LMRPs for your service area. There are also software applications that provide a second medical necessity check later in the cycle—at the point of coding, when all related documentation and charges are present. This allows a professional coder to review the record and any medical necessity or outpatient code editor (OCE) edits that might be triggered before the claim is dropped. If there is a problem, the coder can notify the responsible department or physician that different or additional documentation is needed to pass medical necessity requirements.

A good medical necessity solution tracks all patient encounters on the front end—not just those that fail medical necessity requirements. It also generates ABNs before service is rendered so that, if Medicare does not cover the procedure, the patient has the opportunity to sign the ABN. A medical necessity software solution should automatically update LMRPs and NCDs on a monthly basis so that those using the software on the front end can be sure the software incorporates the most current updates. The software should automatically flag items that don’t have a diagnosis supporting medical necessity. It should also provide hospitals with reports so they can determine the highest rates or trends for medical necessity errors and coding failures. The facility may then use this information to follow up with physicians and staff and monitor compliance with the hospital’s medical necessity guidelines.

Ease of use is also an important factor. Some software allows the user to enter a diagnosis and test codes from a pull-down menu, and then the computer searches against a database that contains millions of code combinations that define Medicare coverage for all 50 states. The system alerts the user if the requested procedure is not covered and automatically prints out an ABN form to notify patients that they may have to pay for the noncovered service or lab work.

Others go so far as to offer a “smart encounter” form that allows the user to determine by color-coding and by medical nomenclature whether a procedure is covered by a policy. The software takes common verbiage used by physicians and maps it to the appropriate code sets. Some software will keep track of ABNs by physician or by ancillary department to be sure the process is working. This is useful for both auditing and compliance monitoring.

The Compliance Factor

Before the age of medical necessity, hospitals would simply register patients and send them on their way. Today, however, hospitals must spend additional time at the front end deciphering the physician’s requisition or gathering more information from the patient to determine if his or her scheduled treatment meets medical necessity guidelines.

Many hospitals are struggling with the impact of medical necessity on their bottom line. “Quite frankly,” says Voight, “I don’t think CMS understood how cumbersome this whole process was going to be. It sounds like a great idea, but it can be very people- and resource-intensive to stay in compliance with all of the regulations.”

Developing an effective medical necessity solution at your hospital should not only lead to a reduction in denials, but also help prevent exposure to what Medicare refers to as “abuse.” The repeated submission of the

same type of bills (with or without denials) that are consistently against CMS’s published medical necessity rules constitutes “abuse” as defined by the OIG.

Medicare expects hospitals to remain up to date on the changes to the bulletins. Only a comprehensive medical necessity program that includes medical necessity software integrated with effective process changes can help ensure compliance.

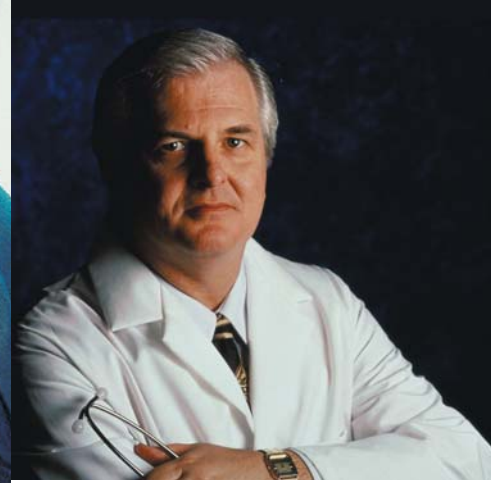
Hospitals that cannot prove compliance may be fined, under the civil monetary penalties law, \$10,000 for each item or service fraudulently claimed, assessed up to three times the amount of the claim, and risk exclusion from the Medicare program (a death sentence for the financial health of virtually any facility). If found guilty under the False Claims Act, the hospital faces up to three times the amount of the charge, as well as up to an \$11,000 fine for each false UB92 claim. Thus, the total penalties can easily add up to hundreds of thousands or even millions of dollars.

Preventing Medical Necessity Denials Pays Off

Complying with federal and local rules. Avoiding penalties. Ensuring optimal payment. Improving cash flow. These are important goals for hospitals today, and a well-designed program focused on preventing medical necessity denials can help fulfill those goals.

Tips on Medical Claims Denial Management

HFMA’s “Tip Sheet: Medical Claims Denial Management” suggests different ways to appeal denied claims and methods to prevent future denials. Access the Tip Sheet at: www.hfma.org/resource/focus_areas/patient_financial_svcs/tools/claims_denial_management.htm.



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