



Medical Necessity Management: Simple Solutions, Big Benefits

a Resource Guide



for Providers

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Introduction

Medical Necessity denials and related coding problems are familiar to most hospitals and specialty providers. But their importance in the overall financial picture is now greater than ever. Medical necessity denials cost hospitals hundreds of thousands to millions of dollars every year in write-offs, plus waste critical staff time researching denials and responding to patient questions about “medically unnecessary” services.

Effective implementation of a medical necessity compliance system will:

- Improve revenues
- Improve coding efficiency
- Maximize staff effectiveness
- Minimize compliance concerns
- Prevent medical necessity denials from occurring in the first place
- Provide tools to quickly and effectively research denials that do occur

Providers have many options for medical necessity management systems, but an evaluation and comparison of four critical aspects of any system will help to provide long-term performance satisfaction:

- Accurate, easy to understand information
- Ease of use for both staff and referring providers
- Cost-effectiveness
- Ease of deployment and updates

This resource will provide a brief overview of the regulatory environment, the process challenges, and key factors in implementation success, as well as provide a checklist to help you determine your needs.



Regulatory Environment

Background

Medicare provides medical insurance coverage for over 43 million beneficiaries. The Medicare program, by law, covers only items and services deemed to be medically reasonable and necessary [Social Security Act, Section 1862(a)(1)(A)]. However, medical necessity, as defined under Medicare coverage, does not encompass every procedure or service that is medically appropriate. As an example, many screening or preventive services are not covered because they are not necessary to treat a known injury, illness, or symptom. In some cases, such as with pap smears and prostate screenings, regulations have been enacted providing coverage for specific services or tests that would not otherwise meet the strict definition of medical necessity.

Medical Necessity Coverage Policies

Additionally, Medicare requires that medical necessity be documented adequately in the medical record, and reported appropriately via procedure and diagnosis codes. Medicare develops coverage policies when it has seen or suspects coding errors or lack of medical necessity, and also for many common tests, services, and items in order to clearly identify the documentation required to support medical necessity. Providers must review and synthesize information from numerous federal and regional sources to manage these requirements. These sources include:

- Medicare Program Transmittals
- Medicare Program Integrity and Claims Processing Manuals
- Medicare NCDs (national coverage decisions)
- Carrier LCDs (local coverage decisions)
- Fiscal Intermediary (FI) LCDs
- MAC (Medicare Administrative Contractors, replacing Carriers and FIs) LCDs

Medical necessity encompasses multiple requirements, including:

- Procedures covered only for specific diagnoses
- Procedures that will be denied coverage for specific diagnoses
- Procedures that are never covered
- Diagnoses that are never covered
- Procedures that have frequency limitations
- Procedures that have patient age and/or gender limitations
- Procedures that have treatment, provider, and/or patient history limitations
- Procedures that require more than one diagnosis for coverage
- Procedures that are covered only in inpatient settings

Advance Beneficiary Notices (ABNs)

When a service is not expected to meet published medical necessity guidelines, an ABN must be prepared and delivered to the patient *before* the service is rendered, verbally reviewed with the



Regulatory Environment (continued)

patient, and the patient must have time to ask questions, consider the options, and make an informed decision as to whether or not to receive the service. ABNs should never be provided in emergency situations. However, once the possible emergency has been triaged and stabilized by medical personnel, then an ABN may be presented if necessary for further treatments and/or testing.

The newest ABN form, CMS-R-131, is to be used by all providers in all cases where Medicare coverage for a procedure, lab or other service is expected to be denied. The new form was mandatory as of March 1, 2009, and replaced the set of forms that were previously used (CMS-R-131G, CMS-R-131L, and NEMB). Detailed instructions for the current form and its use can be found at http://www.cms.hhs.gov/BNI/02_ABN.asp#TopOfPage. To be upheld as valid, the ABN form must meet specific Medicare requirements, including wording, font, page layout, and completion.

An estimated cost for the non-covered services must also be provided to patients on the form. Although it is acceptable for final billed charges to be different than the estimated cost, they should not be more than \$100 or 125% of the estimated cost. Providers may insert a single charge, a range, or a “not-to-exceed” amount. It is at the provider’s discretion whether to bill such services at the provider’s “list price,” at the Medicare fee schedule amount, or at another rate.

The patient must check the option (receive service or not) they are selecting, and must also complete both the signature and the date with their own hand. If a patient refuses to sign the ABN, a facility may opt to refuse to provide the service, but whether the service is provided or not, a staff member should note on the form that the information was explained to the patient, that they refused to sign it, and the staff member should sign and date the note.

A copy of the ABN form should be provided to the patient, and the original signed copy retained by the provider. If an ABN was required but not provided to the patient prior to the service, and Medicare denies the service, the provider may not bill the patient, but must write off the entire item or service. For hospitals, losses from these services may also not be reported as bad debt on cost reports.

Frequency Issues

In cases where a service has a frequency restriction (such as pap smears), providers may obtain an ABN that states the frequency restriction, and that the patient understands if he/she has received the service within the timeframe, that the service will be denied and they will be personally responsible for the service. If Medicare determines the patient did have the service performed within the timeframe, the service will become patient responsibility; otherwise, Medicare will pay as usual.

Modifiers

There are several modifiers appropriate for use with an ABN process. These are:

- GA Waiver of liability statement on file [ABN obtained from patient]
- GZ Item or service expected to be denied as not reasonable or necessary [ABN **not** obtained]
- GY Item or service statutorily excluded or does not meet the definition of any Medicare benefit [ABN optional]



Regulatory Environment (continued)

Compliance

To improve financial performance and improve patient understanding, it is clearly important to implement an effective ABN process that staff can perform consistently. However, it is also important to maintain overall compliance with Medicare regulations. Routinely billing for non-covered services without signed ABNs and subsequent billing to patients could put your facility at risk for fraud and abuse charges under federal and state anti-kickback statutes (ie, providing inappropriate free services in order to encourage continued or expanded visits or referrals) or the False Claims Act (presenting a claim that a provider knows or should know is not medically necessary).

Financial Impact

The impact of medical necessity regulations are significant within the Medicare environment and often extend to the private payer market as well, as commercial markets adopt the commonly accepted national guidelines and policies.

Medical necessity impact benchmarks to keep in mind (Medicare only) include:

- Average medical necessity denial rate: 1.5% - 18% depending on type of service
- Average staff cost to gather information related to a denied claim after the fact: \$53-117
- Average staff cost to gather information for a clean claim prior to service: \$0.83-\$19
- Average outpatient facility per-claim denial write-off: \$696-\$1590, varies with service**
- Average physician per-claim denial write-off: \$237**
- Average annual hospital revenue lost due to medical necessity without an ABN program: \$960,000

Summary

Medical necessity requirements no longer allow facilities to admit patients and have coding and billing staff provide outpatient encounter information later. Basic procedural and diagnostic information must now be evaluated at the time of patient arrival in order to determine medical necessity. Failure to comply by writing off patient balances for denied claims may be considered an anti-kickback violation. Failure to comply by consistently billing non-covered procedures to the CMS program without an ABN may be considered abuse according to OIG guidelines and even subject to fines and penalties. A properly managed medical necessity program helps to ensure legal and program compliance, and also improves facility financial and operational performance.

**Based on expected Medicare reimbursement had the service been covered. Collections via ABN process are typically higher than Medicare reimbursement, so real revenue losses would be higher.



Process Challenges

Overview

Medical necessity policies are developed at multiple levels and through multiple program divisions, making it nearly impossible for facility staff to stay current with medical necessity changes without one or more dedicated staff positions for this role alone. Although CMS offers a medical policy look-up tool, most facility staff have limited understanding of how to use the tool, do not have the resources to monitor daily changes, and are not aware of additional policy databases that must also be reviewed for a complete program.

Quick Facts and Problem Areas

- Nationally, there over 2.8 million unique procedure-diagnosis edits.
- For any given provider, there are approximately 1/2 million procedure-diagnosis edits alone, not including frequency and other coding requirements.
- Multiple sources for edits include LCDs from MACs/FIs/Carriers, CMS Lab Edits, CMS NCDs, program transmittals and memorandums, Correct Coding Initiative, and annual payment policy addendums.
- Medical necessity policies may be lengthy and difficult to understand, with no simple summary.
- Changes are not made on a regular basis. They are released continually, and there is no synchronized one-stop method to be alerted to the daily changes.
- Change footnotes are often incomplete, requiring full review of the policy to identify changes.
- Policies may be published with coding errors, requiring coder review and correction prior to implementation.
- ABN forms, formats, and instructions change periodically.
- Policy coverage is date-specific down to the diagnosis level, requiring not only lists of covered diagnoses for each procedure, but also dates of changes and effective dates for each of the linked diagnosis codes.
- All policy procedure and diagnosis codes must be reviewed and partially updated at least twice per year for new releases of ICD-9 and CPT.
- All policies will need to be updated in their entirety for ICD-10 in 2013.
- When a transition occurs from one Medicare MAC/FI/Carrier to another, hundreds of new and/or updated policies can be effective with as few as 45 days' notice.

Implementation

In addition to gathering and understanding all applicable medical necessity policies and rules, facilities must also manage:



Process Challenges (continued)

- Encapsulating pertinent information in an easy-to-use format
- Updating the information on an ongoing basis
- Answering questions from admissions staff, clinical staff, and referring providers; many facilities have designated HIM/coding staff who serve as primary contacts for these questions
- Assisting admissions and clerical staff with little to no coding background in identifying procedure and diagnosis codes at the time of patient registration
- Creating, maintaining and storing CMS-compliant ABN forms

Monitoring Performance

To ensure an effective process after initial implementation, facilities must also consider how they will monitor their ABN process, identify services with high ABN rates that can be targeted for physician education, and generate reports on standard and custom ABN measures. Because medical necessity requirements change over time, facilities must be able to dynamically review their ABN process and activities, and compare those to financial measures and actual denials received.

Facilities should also be able to easily generate profiles and detailed reports for specific physicians, including reports requested at physician request, requested by a specific department, or reports needed for specific procedures and/or diagnoses for coding and audit purposes.

Changes in Requirements

Facilities must also find ways to quickly adapt to new medical necessity requirements, such as new policies requiring secondary and/or tertiary diagnosis codes.



Key Implementation Factors

Effective and Efficient

Any successful ABN program must provide fast, accessible, easy to understand information, with minimal user inputs. Many laboratory tests reimburse at low levels, and the cost to appeal denials exceeds the value of the reimbursement. However, if coding and ABN compliance happens at the time of service, the cumulative value of even those low-paid tests is highly significant in improving hospital revenues. And for many facilities, the revenues recovered from only one high-dollar imaging study or service per month will fully offset both the ABN system costs and the associated staff time to implement and maintain the program.***

Deployment Flexibility

Facilities must decide where medical necessity verification will be most appropriately performed. For many facilities, the answer is that there will be multiple points of service entry, and therefore multiple points of possible medical necessity verification. A survey of hospital usage finds the following common deployment options, often utilized together:

- Centralized registration (77%)
- Ancillary department registration (especially lab, radiology, and rehab) (41%)
- Scheduling (26%)
- Referring physician/clinic (15% non-owned, 41% owned practices)
- Integrated with order entry (31% overall, 82% where HIS supports the option)

Information Dissemination

A successful ABN program also should allow hospital staff to easily email, fax, or print coverage information for use by referring providers who do not have access to an ABN program. An ABN system should have features that allow quick copy/paste as well as printing of coverage information, including procedure codes along with all covered or non-covered diagnoses and frequency limitations, to any referring provider who needs the information to correct a current order or use as reference for ongoing orders. Having convenient distribution options minimizes interruption to facility staff, optimizes turnaround times for order correction, minimizes unnecessary ABNs, and reduces final billing delays due to inaccurate or incomplete information.

Referring Physician and Clinic Access

It is also helpful to ensure easy access for referring physicians and off-site clinics. This allows those sites to review and research coverage requirements themselves, and even generate ABN forms for the patient. Although physician adoption of ABN requirements can be slow, many facilities find that even when a small number of offices start with the process, the benefit to the hospital is worth the effort to help them get started. Not only does it ease the medical necessity checking burden on the hospital if the ABN forms are already completed, but the overall coding accuracy for that physician is improved significantly over only a few-month period, which helps in all aspects of the physician-hospital relationship. Many physicians also find that access to the coding and medical necessity tools helps them in their office workloads and billing processes, resulting in a strong benefit to both parties.



Key Implementation Factors (continued)

Facility Staff Training

Staff members need to have an understanding of medical necessity and ABN requirements, so that they may answer patient questions and be comfortable with the process. Staff should understand that it is a Medicare requirement, the protections it provides to the patient, the information the patient must be given, and what the patient's options are for accepting or declining the services. Staff should also understand the facility policy in terms of obtaining ABNs, entering ABN information into information systems, storage of ABNs (either on paper or electronically) and communication with ordering physicians.

Many facilities routinely fax a copy of completed ABNs to the ordering physician so that he/she may provide corrected coverage/coding information if available. Others fax only copies of ABNs where the patient has refused the service, so that the provider may follow-up with the patient regarding other options in their treatment/diagnostic services.

Billing staff must also be made aware of the facility medical necessity process, and a process might be considered where ABN-documented services are held for a defined period (24-72 hours) to allow physicians to update diagnostic information if appropriate.

Physician and Physician Staff Education

Physicians and their clinical and administrative staff should be aware of medical necessity requirements, but it is usually helpful to give them a brief overview of the requirements that CMS has put forth and how the facility is implementing the process. They need to know whether they will receive notification of ABNs given to their patients, and their timeframe for updating the diagnostic information if appropriate. They also should know if they can have access to the ABN program software to use for referred tests and/or their own office use or, if no access is available, how they can request coverage policies to help them document the service better. It can be very helpful to have a patient-oriented brochure about ABNs available for them to distribute to patients.

Patient Education

Patients should receive simple yet accurate information that Medicare does not cover every test and/or service that their doctor may order, and that the facility is required to check coverage ahead of time so that there are no billing or cost surprises after the fact. If an ABN is determined to be necessary, the patient should know their options for receiving the service and paying for it, or refusing the service at this time and discussing other options with their physician. They should also be told how much the test will cost. It is often very helpful to have patient-oriented brochures available about the ABN process.

***Cost analysis based on YEI program and software costs; other vendor's systems may result in lower ROI.



Needs Evaluation Checklist

Things to Consider in Implementing or Upgrading a Medical Necessity Program and Associated ABN Software:

Usability

- Are the system responses simple enough for admitting clerks and non-coders to understand?
- Is the system streamlined to allow rapid answers without slowing down patient registration?
- Does the results window display a clear description of any action necessary?
- Does the results window display gender, age, frequency, and inpatient-only warnings clearly?
- Are simple coding tips and natural language search tools available to help non-coders?
- Can aliases and acronyms be set up to ensure fast retrieval without CPT and ICD-9 codes?
- Can multiple procedures and diagnoses be checked at the same time?

ABN Forms

- Does the system generate ready-to-sign ABN forms for patients?
- Have the ABN forms been reviewed by CMS and certified to be compliant?
- When changes are made to the ABN form, how will you receive those? Is there a charge?
- Can you customize ABN forms with logo, name, and other information?
- Does the ABN form support automatic inclusion of the service cost?
- Can you upload cost information from your chargemaster?
- Is electronic signature capture available?
- Can ABN forms be electronically stored and retrieved?

Medical Policy Depth and Updating

- Is there access to edits for local MAC/FI/Carrier/DME in addition to NCD (national edits)?
- How often are edit changes provided? What needs to be done to load them?
- Will you get notifications and a summary of what edits have changed with each update?
- What will happen when your local FI/Carrier is transitioned to a new MAC? Is there a charge?
- What if your MAC is changed and you will need a different set of policies? Is there a charge?
- Does the system support retroactive and future dates of service in addition to current edits?
- Can users easily view key policy details including diagnosis restrictions?
- Can users click on a link to go directly to the Medicare page with the policy?
- Can users easily cut and paste or print the policy details to share with others?
- Can private payer policies be added if necessary? What is the cost?

Reporting

- What kind of pre-loaded reports are available?
- Can physician-specific reports be prepared for physician review?
- Can procedure-specific reports be prepared for audit and training?
- Can diagnosis-specific reports be prepared for audit and training?
- Can comparative physician reports be prepared for targeted education?
- Are reports available for searches and medical necessity checks that do not result in an ABN?



Needs Evaluation Checklist (continued)

- Are patient-specific searches and reports available?
- Do reports include estimated billed charge values?
- Can reports be broken down by user and department as needed?
- Will reports identify commonly used codes that do not have aliases for faster reference?

Supporting Data

- Will you be warned about procedures that are only covered in the inpatient setting?
- Will your billers/coders have access to bundling/coding/CCI edits and a CCI checker?
- Will your billers/coders have access to coding guidelines?
- Will your billers/coders have access to modifiers and place of service codes?
- Will your billers/coders have access to a fee schedule calculator and RVU data?
- Will CPT/HCPCS and ICD-9 updates be included? How frequently? Is there a charge?
- How will the ICD-10 transition be implemented? Will there be a charge?
- Has the software been tested for ICD-10 compatibility?

Coding Tools

- Can the facility or individual users enter custom notes and instructions?
- Can users or departments maintain favorite/commonly used codes for quick retrieval?
- Can the facility customize the search results for local abbreviations or usage?
- Can aliases be established for commonly used or hard to find codes?
- Are the search features easy to use for non-coders?
- Can searches be done by acronyms, descriptions and lay terms?
- Do the search tools include AI modules to assist non-coders?
- Can medical necessity policies be reviewed post-service to aid in denials resolution?

Deployment?

- Is a server-PC version available?
- Is a web-based version available?
- Can both server and web-based versions be simultaneously supported? What is the cost?
- How much training time is typically scheduled for new users?
- What is the typical timeline for full implementation from the date of contract signing?
- Are data files available to use within functionality provided by the facility HIS system?

Support

- Is unlimited toll-free and email support included in the purchase price?
- Is support for physician and clinic users provided directly through the vendor to avoid IT burden?
- Is on-site training available? What is the cost?
- Is live web-based training available? Is there a cost?
- Are training materials available? Is there a cost?
- What kind of manuals are provided? Is there a cost?
- Is there any limit to the amount of training provided at no cost?



About Yost Engineering Inc



Yost Engineering Inc, founded in 1999, is located in Portsmouth, Ohio. YEI's Healthcare Division offers both off-the-shelf and custom medical necessity, coding, and compliance products, as well as a wide variety of data files and claim scrubbing services. Products can be accessed through software, web services, data subscriptions, back-end web interfaces and hosted solutions.

YEI provides software, services, and data to clients from providers to suppliers to clearinghouses to payers to software vendors and web service vendors. From multi-state hospital facilities to solo physicians, from laboratory systems to medical device manufacturers, from payers to claims processors, we provide comprehensive support and the most accurate data in the industry.

YEI Medical Necessity Products

ABN Assistant PC/Server—Verify medical necessity quickly and easily before services are provided. Correct coding problems or issue CMS-compliant ABN forms as needed, including cost estimates and specific reasons for non-coverage. Print reference materials for ordering physicians, generate comprehensive reports by procedure, patient, physician, and for audit and training purposes. Includes encoder and full suite of coding tools. Electronic signature capture option. Available in packages for enterprise-level deployment, laboratory, radiology, cardiac services, and physician office. Installation options for server, thin-client (including Citrix), networked, and PC.

ABN Assistant WEB—Verify medical necessity quickly and easily before services are provided. Correct coding problems or issue CMS-compliant ABN forms as needed, including cost estimates and specific reasons for non-coverage. Print reference materials for ordering physicians, generate comprehensive reports by procedure, patient, physician, and for audit and training purposes. Includes encoder and full suite of coding tools. Electronic signature capture option. Available in packages for enterprise-level deployment, laboratory, radiology, cardiac services, and physician office. Completely hosted web application, can be accessed by users at any time from any location.

Medical Necessity Tables—Comprehensive medical necessity files for NCDs, LCDs, and MACs, as well as commercial payers. Single-facility or redistribution licenses. Standard or custom formats, including CPSI, Epic Systems, Fletcher-Flora (FFlex eSuite, LabPak), Iatricis (MNO, LAB e-Laborate), MediTech & other systems. Compiled entirely from original sources by our in-house staff of professional coders and proprietary AI systems, updated daily. The most accurate data in the industry.

Medical Necessity Claims Validation—For medical necessity data files and dictionaries for use in other systems, see Medical Necessity Tables, above. However, to validate a broad range of medical necessity and correct coding rules through single claim submission or batch submission process, we also offer medical necessity modules through YEI ClaimScrub. Web-based solutions for small providers and vendors, and web and fully managed network-appliance solutions for large claim volumes.