Medical Necessity and Coding

NEW MEXICO HEALTH INFORMATION MANAGEMENT
ASSOCIATION
FALL CODING WORKSHOP

September 14, 2012
Hyatt Downtown
Albuquerque, NM
Presented by:
Andrea Busby, RHIA
ADHIMA, INC
Goals

- Define Medical Necessity
- Review the history of Medical Necessity
- Define ABN
- Identify key process variables Medical Necessity
- Review the Coder’s Role with a successful Medical Necessity Process
- Discuss Medical Necessity Denials and Financial Impact
- Steps to Optimize the Medical Necessity Opportunity
What is Medical Necessity???

Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, treating or rehabilitating an illness, injury, disease or its associated symptoms, impairments or functional limitations in a manner that is:

1. in accordance with generally accepted standards of medical practice;
2. clinically appropriate in terms of type, frequency, extent, site and duration; and
3. not primarily for the convenience of the patient, physician, or other health care provider.
What is Medical Necessity???

Medicare’s Definition:

“No Medicare payment shall be made for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”
Historical Background

- Medicare Carriers Manual requires medical necessity documentation for chemistry profiles/panels
- National Coverage Policies published in the Federal Register
- Implementation of ABNs
Key Process Variables

- Education
- Physician’s order
- ABNs
- Patient Access
- Coder’s
Education

- Gather data; really the facts about Medical Necessity Denials and process concerns
- Provide in-service training for Patient Access, HIM, and Patient Financial Services
- Provide in-service training for physician’s and the office staff
- Make sure your efforts are continuous
- Address problem and/or high volume areas
Physician’s Order

- A written document signed by the treating physician.
  - Must have a reason (Diagnosis/Symptoms)
  - Must request a service/test
  - Must identify the patient with name, date of birth, and date for services/test
  - Must provide contact information for the requesting physician (i.e. Name, Telephone, and fax)
  - Must include any special instructions for processing the service/test
  - Must be sign, date and time by the requesting physician
ABN Defined

- Advance Beneficiary Notice of Non-Coverage
  - To provide notice of the possibility of non-coverage
  - To list reason of possible non-coverage
  - To provide a cost estimates not be more than $100 or 125% of the estimated cost
  - To allow beneficiary to have input
ABN is a must do!

- Must tell why the claim maybe denied
- Must be a specific message relating the requested services for the patient
- Cannot be given to every Medicare patient
- Must CMS form standards
- Must contain hospital logo, name, address, and telephone number
- Must be hand delivered to the patient or an authorized representative
ABN is a must do!

- Can be a telephone call if it is immediately mailed or delivered to the patient
- Must be presented in a way for patient understanding
- Must provide a timely, accurate, and complete response to questions from the patient
- Must be signed by patient or representative
- If patient refuse to sign, document refusal.
- If patient refuse to sign but want to receive services, the hospital can have ABN witnessed by another staffer. Patient’s failure to sign ABN does no release them from liability, if the hospital executes
Patient Access Role

- Provide user-friendly tools
- Create HIM coder contact for coding questions, etc
- Provider continuous training
- Review physician order for completeness
- Establish a contact with the physician office for prompt response when you need clarification
Coders Role

- Review and assign ICD-9-CM codes to fully capture the reason
- Code ALL Applicable diagnosis to support all test ordered
- Review posted charges for CPT/HCPCS codes
- Compare ICD-9-CM, CPT and HCPCS to NCD/LCD
Denials, and the Impact!

- Medical Necessity Denials cost healthcare providers millions of dollars in write-off
- Wasted time for staff
- Average Medical Necessity denials are 1.5% - 18% for Medicare only
- Average outpatient per facility write-off $696 - $1590
- Average annual lost revenue is $960,000

What Can You Do?

- Create a Medical Necessity Taskforce
- Gather and Review Data
- Know the Hot Spots
- Be Flexible
- Think Out of the Box
- Implement Education plans for Facility Staff, Physician and Office Staff, and Patients
- Do not underestimate the importance of being proactive
Reference