Medical Necessity

LMHS Medical Staff Education

Presented by: Lee Memorial Health System
Corporate Compliance Department
Medical Necessity

Is it Reasonable and Necessary?

Medicare 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.”
Is it Reasonable & Necessary?

• Sounds straight forward….but…many definitions for “reasonable and necessary.”
• Leaves much room for misinterpretation.
• Long-winded debate regarding what “necessary” means as it relates to health care services.

NOTE: All Medicare auditors have medical necessity on their radar screens
Provide Optimum Care & Get Appropriate Reimbursement

• National Coverage Determinations (NCDs)
• Local Coverage Determinations (LCDs)
• Advanced Beneficiary Notice (ABN)
• Documentation of medical necessity
• Documentation of medical decision making
CMS Coverage Policies

**National Coverage Determinations (NCDs)**
- To ensure that services paid for by Medicare are medically necessary.

**Local Coverage Determinations (LCDs)**
- CMS directs the Medicare Administrative Contractors (MACs) to establish LCD policies.
- LCDs are aligned with NCDs, and also address how contractors review claims.
Clinical Judgment

- Physicians provide services and order tests based on **clinical judgment** for treating illness / injury.
- But...even if treatment falls within scope of accepted medical practice, it does not necessarily mean the service will be covered.

**Coverage may be limited by:**
- Frequency
- Specific diagnoses

**Coverage may be denied as not reasonable & necessary if:**
- Investigational, experimental, or without proven efficacy.
Medical Decision Making

Denial of Claims

• Services deemed not reasonable and necessary can result in denial of claims.
  • Frustrating and costly.

Abuse

• Important to prevent what Medicare defines as “abuse”:
  • Repeatedly submitting claims in violation of Medical Necessity rules is considered “abuse”.

DENIED
Advanced Beneficiary Notice (ABN)

• Hospitals and physicians can issue an ABN when a service is presumed necessary, but does not meet medical necessity criteria (i.e. NCDs or LCDs).

• **Purpose:** To inform a beneficiary before receiving specified items or services, that Medicare probably will not pay.

• Allows beneficiary to make an informed decision re: accepting items or services that he/she may need to pay for.

• **Without a valid ABN the patient should never be billed.**
ABN Criteria

• Notice provided in writing prior to the service.
• Must include pt. name, date and description of test/procedure, projected fees, and reason service may not be deemed medically reasonable or necessary by Medicare.
• Pt. must sign & date the ABN indicating acceptance of financial responsibility for the services should Medicare deny payment.
Documentation is key!

- From coding and auditing perspective, **nothing** can be assumed.
- The best way to support medical necessity and billing for higher levels of service is through **documentation of medical decision-making** (complete documentation of physician **thought process** including issues being R/O).
- Documentation for each encounter must stand alone.
- Proper sequencing of diagnoses.
- Avoid **copy/paste** features which create “**cloned documentation**” (**NOTE**: Cloned documentation does not meet medical necessity per OIG).
Medical Decision Making Process

Documenting the medical decision making process rather than just the medical decision is the easiest way to determine and support medical necessity within the medical record.
Documenting Medical Necessity

Case Example:

Medical Decision Making Process

- Mr. Cool is a 68-yr. old male with multiple comorbidities.
- Moderate sized aneurysm which does not currently require treatment but will in the future.
- Major problem is bilateral lower extremity claudication which will require surgery.
- Endovascular intervention is not a good plan because of his aneurysm and total occlusion on the left.
- Open surgery would treat both of these problems.

VS.

Medical Decision

- Bilateral claudication.
- Surgery to be scheduled for next week.
Documenting Medical Necessity

Medicare contractors use the following criteria to assess medical necessity

- Consistent with symptoms or diagnoses of illness / injury.
- Necessary and consistent with generally accepted professional medical standards (i.e. not investigational or experimental).
- Not provided primarily for convenience of the patient / family, physician(s) or supplier.
- Furnished at the most appropriate level for patient safety and efficacy of care.
Medical Necessity

Steps to ensure appropriate care of the patient and reduce claims denials:

**Step 1 ~** Let medical necessity guide the care provided.

**Step 2 ~** Document the care accurately.

**Step 3 ~** Code based on the documentation.
Medical Necessity & Inpatient Admission

Physician decision: Hospital vs. Home

• “Decision for inpatient status is a complex medical decision based on many factors:”
  • Risk of an adverse event during the period considered for hospitalization
  • Assessment of services needed during hospital stay”

The crux of the decision is the choice to keep the beneficiary in hospital for services or to reduce risk, or discharge home because may be safely treated through outpatient services.

(IPPS Final Rule CMS – 1599-Federal Register, p. 50945)
Medical Necessity & Inpatient Admission

Medical Necessity **Must be Documented**!

- Physician’s order for inpatient admission should be based on a clinical expectation that care will surpass 2 midnights *(CMS Two-Midnight Rule)*.

- Significant clinical considerations must be clearly and completely documented in the medical record.
Physician Documentation Supporting Inpatient Admission

Complex Medical Factors:

- Medical reasons for inpatient hospitalization
- Failed outpatient treatment (*What was tried and did not work?*)
- History and co-morbidities
- Severity of signs and symptoms
- Current medical needs (i.e. diagnostic evaluation)
- Risk of an adverse event
Medical Necessity Documentation Needed for Other Areas too!!

**Some clinical examples:**
- Observation status
- Surgery
- Minor procedures
- Diagnostic tests
- Therapeutic services
- Prescriptions
- Evaluation and management services
Medically Unnecessary Care

- The Office of Inspector General (OIG)
- The Department of Justice (DOJ)
- State Attorneys General
- Health Care Regulatory Agencies (RACs, MACs, AHCA, CERT, etc.)

Working collaboratively to address the provision of substandard or medically unnecessary care
Five Fraud and Abuse Laws

One or more may be implicated when medically unnecessary care is rendered:

- False Claims Act
- Anti-Kickback Statute
- Physician Self-Referral Statute
- Exclusion Authorities
- Civil Monetary Penalties Law
False Claims Act

Claims for medically unnecessary care:
• False / fraudulent claim when medical record does not support medical necessity.
• Medicare will deny payment (or request repayment).

Consequences
• Exposes the patient to unnecessary services or items and creates risk for harm.
• Creates needless Federal health care costs.

False Claims Act Violations
• Fines up to 3x program’s loss.
• Plus up to $11,000 per claim, therefore fines add up quickly.
• Each claim has a separate ground for liability.
Texas Doctor & Four Others Charged with Defrauding Medicare of Nearly $3 Million

- Leonard Kibert, M.D., 63 of Houston charged in 47-count indictment alleging conspiracy to defraud Medicare of $2.9 million.

- Fraudulent Medicare billing for diagnostic tests at New Life Sleeping & Allergy Disorder Center *(owned by Kibert).*

- All five (Kibert, O’Brien, Brown, Manning, & Gevorgyan) charged with health care fraud for filing false claims with Medicare for procedures which either were not performed or were not medically necessary.

- Gevorgyan and Manning also charged with paying & receiving kickbacks.
True Claims Act 06/03/2014

Texas Doctor & Four Others... (continued)

• Dr. Kibert also charged with money laundering.
• Kibert was the only doctor working at New Life and O’Brien and Brown worked as PAs (although O’Brien had no such license).

• Manning, paid by Gevorgyan, was a recruiter who brought patients to the clinic and was paid more than $229,000 in kickbacks.

• If convicted, each of the 37 fraud counts, the conspiracy charge and money laundering = max. penalty of 10 yrs. in Federal prison.

• Conspiracy to pay and receive kickbacks, and paying and receiving kickbacks = possible 5 yrs. in prison.
• Also, charges carry a max. possible fine of $250,000.
Anti-Kickback Statute

**Asking** for, **or receiving** any remuneration in exchange for referrals of Federal health care program business is a **crime** under the Anti-Kickback Statute.

**Applies to:**
Both payers **and** recipients of kickbacks.

Just asking **or** offering can violate the law.
Anti-Kickback Statute

Kickbacks can lead to medically unnecessary care

- Corrupts medical decision-making process.
  - *i.e. Physician may place more value on kickback rather than what is best for patient*
- Patient may end up with item or service not medically necessary and possibly harmful.

Anti-Kickback Violations

- Monetary penalties up to 3x amt. of remuneration.
- Fines up to $50,000 per violation.
- Federal prison time.
- Exclusion from Federal Health Care Programs.
Board-Certified New Jersey Pediatrician and Internist Sentenced to 20 Months in Prison for Taking Kickbacks

• Chikezie Onyenso, 55, convicted Oct. 15, 2013 after a three week trial, of conspiracy to solicit and receive kickbacks from a diagnostic testing facility (<i>Orange Community MRI LLC</i>), and of soliciting and taking such kickbacks.

• Including Onyenso there were 18 defendants, involving 16 doctors convicted for this ongoing investigation.
Anti-Kickback Statute

Board-Certified New Jersey Pediatrician and Internist Sentenced to 20 Months (continued)

- **Summer of 2010 thru December 2011** - Onyenso conspired to take illegal kickbacks for sending his patients to Orange MRI.

- Onyenso sought & accepted thousands of dollars of cash in envelopes for referring his Medicare & Medicaid patients for MRIs and CAT scans (medical necessity of high cost diagnostic testing questioned).

- Onyenso received more than $25,000 for ultrasound referrals disguised as rental payments and documented by a bogus $1,000-per-sq-ft lease.
Board-Certified New Jersey Pediatrician and Internist Sentenced to 20 Months (continued)

- Onyenso also sentenced to 2 yrs. supervised release following 20 month prison term, fined $40,000, and ordered to forfeit $42,176.

Outcome of Some Other Individuals Involved:

- Ashokkumar Babaria, 64, Orange MRI’s former medical director ordered to forfeit $2 million for corrupt referrals.
- Chirag Patel, 38, Orange MRI’s former executive director awaiting sentencing and will forfeit $89,180 in corrupt gains.
- In addition health care providers, including Onyenso agreed to forfeit a total of $429,666 in illegal kickbacks.
Exclusion from Medicare and Medicaid

Two categories:

**Mandatory Exclusion**
- Imposed on basis of certain criminal convictions

**Permissive Exclusion**
- Based on sanctions by other agencies (i.e. state medical board suspending/revoking a medical license), **or**
- Other types of misconduct *(with medically unnecessary care at top of list!)*
Exclusion from Medicare and Medicaid

- May not bill **directly** for treating Medicare & Medicaid patients.

- Also may not bill **indirectly** (i.e. through employer or group practice).

- Some refer to exclusion as a “**financial death sentence**”

- Currently, more than 5,200 physicians are excluded from Federal health care programs.
Civil Monetary Penalties Law

Penalties = $10,000 - $50,000 per violation

OIG may seek civil monetary penalties for a wide variety of abusive conduct.

Examples:

• Medically unnecessary items / services.
• Overcharging or double billing Medicare beneficiaries.
• Violating Anti-Kickback Statute.
Thank you for viewing!

If you have questions or comments please contact the Corporate Compliance Department at 343-3212

We are Caring People, Caring for People.
References


References


• Office of Inspector General (n.d.). For physicians who may be unable to attend a live, didactic presentation of the material contained in the *Roadmap*, the OIG has also provided a narration of the speaker notes to accompany the PowerPoint slides. The narration is available on OIG’s website at [http://oig.hhs.gov/compliance/physician-education/index.asp](http://oig.hhs.gov/compliance/physician-education/index.asp).
