

# What Is Medical Necessity?

Written by Angela Buckley, CCS, CPC, CPMA, CPC-I, RMA

# Definition of Medical Necessity

- Medicare defines "**medical necessity**" as health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine. The services must be items reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
- CMS provides specific information under the Social Security Act:  
*... 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*
- Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.
- The diagnosis must provide the medical necessity for testing. In essence, the diagnosis drives medical necessity.

# Documentation

Per the CMS MLN Fact Sheet, the physician must clearly document in the medical records his or her intent that the lab be performed.

- The physician should clearly indicate all tests to be performed when completing the progress note.

Documentation in the patient's medical record must support the medical necessity for ordering the service(s) per Medicare regulations and applicable Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs).

# Advance Beneficiary Notice when Medical Necessity is not Met.

- Without a specific diagnosis code (Dx) that indicates medical necessity for a test(s) based upon the LCD or NCD policies, a claim submitted for payment to Medicare will be denied for these services.
- The Advance Beneficiary Notice (ABN) is a waiver of liability and is provided to the patient when Medicare payment is expected to be denied.
- Original Medicare is the only payer that uses ABNs. TriCore cannot bill the patient when medical necessity is not met and a valid ABN is not obtained.
- The Medicare program allows the laboratory to bill the patient for denied coverage only if an ABN is valid (completed, signed, and dated prior to the service being rendered), and provided to the laboratory with specimens prior to testing.
- ABNs cannot be signed after the fact. The diagnosis codes provided must be reflected in the patient's medical records.

# Medical Necessity Rules

- All Medicare Advantage plans follow original Medicare medical necessity rules.
  - ABN's are not applicable to Medicare Advantage plans.
  - Some Medicare Advantage plans require prior authorization in lieu of the ABN. Know plan requirements.
  - TriCore cannot bill the patient if the prior authorization is not obtained or medical necessity is not met.
- All payers require medical necessity to be clearly documented in the medical records and the diagnosis must provide medical necessity for tests ordered. Third-party payers have their own set of criteria they use to interpret medical necessity.
- The condition(s) and/or diseases should be coded in ICD-10 to the highest degree of certainty for that encounter/visit, such as signs, symptoms, abnormal test results, or other reasons for the visit. When a non-specific ICD-10 code is submitted, the underlying sign, symptom, or condition must be related to the indication for the test.
- All digits required by ICD-10 coding conventions must be used. A code is invalid if it has not been coded with all digits/characters required for that code.

# Denials

- Per CMS, tests for screening purposes that are performed in the absence of signs, symptoms, complaints, or personal history of disease or injury are not covered except as explicitly authorized by statute.
- Failure to provide documentation of the medical necessity of tests might result in denial of the claim.
- Tests that are not reasonable and necessary for the diagnosis or treatment of an illness or injury might result in the denial of the claim.
- Per the CMS MLN, the majority of improper payments for laboratory services identified by the Comprehensive Error Rate Testing (CERT) Program were due to insufficient documentation.
  - Insufficient documentation means something was missing from the medical records, such as documentation to support the medical necessity of ordered services.

# Resources

- MLN Fact Sheet  
<https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ProviderComplianceLabServices-Fact-Sheet-ICN909221.pdf>
- CMS  
<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/r178cp.pdf>
- Novitas  
<https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00099545>  
<https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00027224>  
<https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00161503>
- Social Security  
[https://www.ssa.gov/OP\\_Home/ssact/title18/1862.htm](https://www.ssa.gov/OP_Home/ssact/title18/1862.htm)