



## Checklist: Medical Necessity

Medical necessity according to insurance carriers:

- Patient services are determined by the treating physician and based on their preferred practice patterns, training, peer review journals and experience. Ophthalmologists use their best judgment to determine the appropriate diagnosis and treatment for each patient. Generally, these services are considered medically necessary by the medical community and peers.
- Insurance carriers, however, may consider some services not medically necessary, even when the physician considers it the best treatment for their patient. Examples may include:
  - Treatment not approved by the FDA
  - New and emerging technology (Category III codes)
  - Experimental services
  - Excessive frequency based on administrative policy
  - Screenings
  - Routine examinations

**Use insurance policies as a reference to determine medical necessity.**

Review the Medicare Administrative Contractors (MAC) Local Coverage Determination (LCD) and National Coverage Determination (NCD) or other commercial insurance policies, as applicable. These policies provide guidance for insurance coverage and documentation requirements.

Practices should be signed up for payer listservs and bulletins, as once this information has been disseminated they feel you should be informed.

If policies are unable to be found online, consider reaching out to provider or contract representatives for assistance.

**Record chart notes supporting medical necessity per insurance policies.**

A review of the patient's medical records reveals documentation of the medical necessity for the services provided and reflects the context of a changing clinical picture.

**Complete preauthorization and predetermination appropriate.**

Preauthorization (PA) is a process to determine the medical necessity for treatment as required by insurance carriers for certain covered services. If the PA is required and not completed, the claim will be denied. Many insurance carriers will not allow retroactive requests for PAs. Even when obtained, a PA is not a guarantee of payment.

Predetermination is a voluntary request to review a service, prior to treatment, to determine the medical necessity and possible approval based on policies. This process would not replace the PA process if required.

**Use Advance Beneficiary Notice of Noncoverage (ABN) appropriately.**

For Medicare Part B beneficiaries only, an ABN is used when:

- You believe Medicare will not pay for an item or service;
- Medicare usually covers a service but is expected to deny because in this case it may not be medically necessary for this beneficiary;
- Experimental and investigational as determined by Medicare;
- Not indicated for the diagnosis and/or treatment per policy;

- Services are always denied for medical necessity;
- When a service exceeds the frequency limits based on Medicare policy.

ABN should NOT be used when:

- The liability shifts to the beneficiary for exclusions under Medically Unlikely Edits (MUEs);
- The patient is charged for a component of a service when Medicare pays for the full service through a bundled payment;
- Payment transfers to the beneficiary for a Medicare-covered service;
- Patients have insurance coverage under a Medicare Advantage Plan (MA), commercial plan or Medicaid. These insurance carriers may have their own waiver of liability form. If not, an internal practice waiver of liability may be used to disclose non-covered services under these plans.

**Frequency**

- Bill the frequency of the medically necessary test based on the insurance policies guidelines.

**File insurance claim.**

Complete CMS-1500 paper claim or Electronic Data Interface (EDI) transaction 837P electronic claim with:

- Appropriate CPT code that is billed,
- ICD-10 codes accurately linked to the appropriate service, and
- Any necessary modifiers that are used.
- If an ABN is completed, append the -GA modifier to CPT code. When Medicare should deny the services billed, use a -GY modifier.

**Obtain physician signature.**

- Ensure the physician signature is legible on paper chart records.
- Create a signature log to provide during an audit. The log should include initials and signature and credentials of all who may document in the chart.
- For EHR, the electronic physician signature is secure. Ensure the practice has an electronic signature policy to provide it in the event of an audit.

**Chart notes have the correct beneficiary name and date of birth.**

**Prepare abbreviation list.**

The practice has an approved abbreviation list readily available for all audits.