Utah Medical Home Newsletter

Medical Necessity, part 1

Volume No. 1 Issue No. 1 http://medhome.med.utah.edu Date: September, 2002

Welcome

The purpose of this publication is to support health care providers in the establishment and maintenance of Medical Homes for their pediatric patients by providing tools and information for use in their practices.

In each issue, we will highlight one of the seven components of the Medical Home, present a related, practical topic, and provide a resource for obtaining more information. **To offer comments, ideas for future newsletters, or to sign up for email delivery contact the Project Coordinator, Russ Labrum, R.N., at medhome@utah.gov.**

Copies of newsletters may be found on the Utah Medical Home web portal: http://medhome.med.utah.edu/

Obtaining authorization for an assistive technology (AT) device or special treatments, services, or supplies will be the subject of the first 2 newsletters:

- This issue- Defining medical necessity and writing the letter.
- Next issue- Sample letters and the appeal process.

Medical Home Components:

- **Accessible**
- **Family-centered**
- **Continuous**
- **Comprehensive**
- **Coordinated**
- **Compassionate**
- **Culturally competent**

Medical Home Concept: Care Coordination

Care coordination in a Medical Home may be identified by the following:

- Families are linked to appropriate support, educational, and community-based services.
- Information from other service providers is centralized.
- The primary care provider (PCP) communicates effectively and collaborates with other service providers and payers on plans for child's care.

PCPs are often called upon to support and assist patients and families in obtaining needed devices and other medical services. To do so effectively requires understanding insurance benefits and requirements. The following addresses some of these issues. For future editions, let us know of helpful tools or approaches you've developed.

What do you do?

Your 9 year old patient with spastic quadriplegia comes in with a note from the school physical therapist indicating that she has developed sufficient head control to benefit from a switch-controlled electric wheelchair. She needs a letter from you to support a request for Medicaid funding for the chair and associated equipment.

It's October and your healthy 8 month old, former 27-week premie, patient has been told by their insurance company that they don't qualify for Synagis (palivizumab).

A Letter of Medical Necessity is often required to enable patients to access their contracted or statutory insurance benefits.

Defining Medical Necessity

For the purposes of obtaining insurance coverage for a device, treatment, supplies, or other special service, the insurer defines Medical Necessity. Coverage for a specific device, treatment, etc. is based on the "covered benefits" as stipulated in the insurance contract. Covered benefits may vary widely between insurance companies and between contracts within the same company. Medicaid plans for children do not stipulate "covered benefits". Rather, Medicaid is mandated to cover all services that are deemed medically necessary.

Utah Medicaid Definition of Medical Necessity

A service is medically necessary if:

1) It is reasonably calculated to prevent, diagnose, or cure conditions that endanger life, cause suffering or pain, physical deformity or malfunctions, or threaten to cause a handicap, and;

2) There is no equally effective course of treatment available for the recipient that is more conservative or less costly. Utah Administrative Code 1996

Private Insurance Definition of Medical Necessity

Each insurer may have its own definition of medical necessity and some no longer require meeting such a definition as long as the requested device/service is a covered benefit. It is very helpful to confirm availability of coverage from the insurance contract or from a company representative early in the evaluation of the patient's needs.

If, based on your evaluation, and that of any relevant specialists, you deem the device/service to be appropriate and medically necessary, then providing a letter supporting a request for the device/service will often be required before coverage is authorized.

The Letter of Medical Necessity

Such a letter should document your careful evaluation of the patient and consideration of the requested device or service and potential alternatives. Your letter with accompanying documentation from specialists or vendors) should provide specific information that addresses the insurer's criteria for preauthorization. If these criteria are not known, a direct query may save considerable time (see sample query in the next issue).

The letter should focus on the patient's needs, not those of the school, family, or institution. Important components of a letter of medical necessity include:

- **Diagnoses** (list all)
- **Medical History** Be brief but specific and include relevant details. Mention current devices or services and why the device/service or change is now needed.
- **Describe** the patient's condition and/or disability(ies) and how health, speech, hearing, mobility, activities of daily living (ADLs), pain, etc. are affected. Including results of developmental screening or evaluation, growth charts, etc. may be helpful.
- **Prognosis** Explain the expected duration of the illness/disability or need for the device/service. How will it diagnose, cure, treat, or ameliorate the disability or problem? How will it impact functional activities?
- **Documentation** Explain why the device or service (and relevant components) is medically necessary. Explain why available alternatives are not appropriate. Briefly describe any prior success or failure with similar devices or services. (E.g. power vs. manual wheelchair). Photos may help clarify device description or disability.
- **Summary** Summarize the request.
- **Attach** any relevant reports, letters, or descriptions from specialists, therapists, etc. Supporting evidence in the form of journal articles or practice guidelines may help to educate reviewers.

A convincing letter may be necessary to assure coverage and avoid time-consuming appeals.

Related Billing Issues

Billing for your expertise and your time with the patient/family in evaluating relevant information and discussing alternatives is appropriate as long as that effort has not been billed as part of another service.

If an office visit is extended by discussion of the need for the device/service and the process of supporting that need, charges may be submitted for the expanded service in one of two ways. It may be appropriate to increase the level of service billed for that visit based on the time. Documentation in the medical record should reflect the service, who was present, the total length of the visit, and the proportion (must be >50%) spent in counseling/discussion. For details on time-based coding, see the Coding section of the MedHome Portal (http://medhome.med.utah.edu).

Alternatively, you could use a Prolonged Service code (**99354** – 1st additional 30-74 minutes or **99355** – each additional 30 minutes) in addition to the appropriate office visit. Again, documentation should accurately reflect the face-to-face service provided and time involved. Always be sure to consider and document the complexity of your medical decision making.

Other applicable CPT codes may include:

99080 - "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

99371, 99372, 99373 - under "Case Management Services", these codes reflect increasing levels of "telephone calls by a physician…for coordinating medical management with other health care professionals…"

99361 - Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient not present); approximately 30 minutes and **99362** - same; approximately 60 minutes

The latter two codes do not necessarily apply to a formal conference – they could subsume multiple conferences with such individuals.

Some insurers will not reimburse for these codes (e.g., Utah Medicaid does not currently reimburse for these other codes). Communicating with those insurers about their failure to reimburse for valuable services may help over the long run. A full list of Medicaid reimbursement by CPT code can be found at http://www.health.state.ut.us/medicaid/st_plan/bcrp.htm.

For details and clarification, please consult Current Procedural Terminology, published by the American Medical Association (http://www.amapress.org) and available through the AAP Bookstore (http://www.aap.org) and others.

For More Information

Future issues of this newsletter will provide sample letters and additional guidance.

"Accessing AT Through the Health Care System in Utah". Obtain free copies from Utah Assistive Tech Program 435-797-3824 or http://www.uatpat.org/advocacy/

Utah Collaborative Medical Home Project