White Paper on Determination and Documentation of Medical Necessity in Long Term Care Facilities

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SECTION I:

Determination of "medical necessity" in nursing facility care

Although a final definition and determination of "medical necessity" still is an unrealized goal of the medical, insurance, regulatory and legislative community, the American Medical Directors Association believes that the attending physician's decision and documentation should be held paramount. A working definition of "medical necessity" that could be accepted is:

Evaluation and management services, diagnostic tests and procedures, treatments, medical/surgical procedures, equipment or supplies that in the judgment of the attending physician (or physician extender [NP or PA] when permitted by federal and state statute) are required to professionally assess, plan, manage and monitor the health care of a resident or patient in the facility within the parameters of generally accepted principles of medical practice.

The physician must be prepared to justify that the service or intervention is sound clinical practice and that it reflects reasonable and realistic goals and expected outcomes. The physician also must be willing to address and defend a rationale in relation to pre-morbid function, excess disability, and the expected positive outcome of any prescribed intervention. However, explanations of the above need not be explicitly documented in detail prospectively in the clinical record.

SECTION II:

Dispute resolution:

Since the attending physician and medical director bears the ultimate responsibility of the care plan and medication or therapeutic device he or she has prescribed, that treatment should be considered "medically necessary" unless and until an insurer, a regulatory agency or another physician actually assumes the responsibility and liability for superseding the physician's care. In addition, "an insurer may be able to set aside the decision of the treating physician only if the insurer can show that the proposed treatment conflicts with clinical standards of care or that there is substantial scientific evidence, regardless of clinical practices, that the proposed care would be unsafe or ineffective or that an alternative course care of treatment would lead to an equally good outcome. By substantial evidence, we mean a sizable number of studies published in peer-reviewed journals that meet professionally recognized standards of validity and replicability and that are free of conflicts of interest. "Given the enormous power of the payor to influence appropriate medical care by the denial of services", such criteria would prompt insurers to act reasonably and responsibly. AMDA also supports patient and physician access to a speedy, external review process when "medical necessity" is challenged--to ensure impartiality and nondiscrimination based on coverage criteria.

SECTION III:

Determination and documentation of medical necessity for primary care services:

Medical necessity for a visit by a primary care provider may be, but is not limited to, the following:

- one physician visit to a nursing facility in a calendar month on the presumption that such a visit is "medically necessary" for a person whose condition requires him or her to reside in a facility providing round the clock nursing care--(Non-skilled);
- one physician visit/week on the presumption that such a visit is medically necessary for a person whose condition requires him or her to be receiving sub-acute care--(Skilled);
- the initial nursing facility admission evaluation;
- patient instability or change in condition that the physician documents is significant enough to require a timely medical or mental status evaluation and/or physical examination to establish the appropriate treatment intervention and/or change in care plan--(Skilled or Non-skilled);
- therapeutic issues that the physician documents require a timely follow-up evaluation to assess effectiveness of
therapy or treatment—including recent surgical or invasive diagnostic procedures, pressure ulcer evaluation, psychotropic medication regimens, or (for the terminally ill) comfort measures;

- regulatory requirements, including, when warranted, the need for more frequent evaluations and examinations to assist in time-delineated assessments associated with the Prospective Payment System or other regulatory or payor requirements;
- medical conditions—including delirium, dementia, or changes in mental status—manifesting with behavioral symptoms that are primarily organic in nature and that require timely evaluation. (Physician documentation of these conditions and symptoms precludes down-coding to a psychiatric visit.); and
- nursing, rehabilitation, managed care, patient, or family request to address a documented medical issue of concern that requires a physical (or mental status) examination to the concern.

Note: The above list is not exclusive and there may be other times when a medically necessary visit is required. The physician still bears the burden of documenting the need for any and all visits and that documentation needs to support the intensity of coding.

SECTION IV:

Consultation and specialist services

Consultations or specialist services should be considered "medically necessary" when they address a documented diagnostic or therapeutic question for which the attending physician determines he or she needs the assistance or second opinion of a specialist (by a record review and a physical and/or cognitive examination) to address the concern.

When ordering consultation services, the following elements need to be considered:

- A consultant should possess and additional knowledge base and/or skills clearly outside the skill/knowledge base of that primary care attending physician unless the consultation is for a second opinion.
- The service requested must be appropriate for the specific individual.
- The service will affect the resident/patient assessment, diagnosis or care planning or treatment.

Diagnostic services

Diagnostic studies are medically necessary if they are procedures (including clinical laboratory studies) that would be considered commonly accepted medical mechanisms to assess a medical condition, determine therapeutic intervention, establish the effectiveness of a treatment, or monitor a therapeutic range.

When ordering diagnostic services, the following elements need to be considered:

- Will the assessment, management, or monitoring of the individual's health care be affected by the service?
- Is the service appropriate? That is, does the individual wish to receive the service? Will the individual quality of life be affected by the service and its anticipated consequences?
- Can the individual tolerate the service and its consequences safely?

Therapeutic modalities:

Medications & Therapeutics are medically necessary if they are:
...treatments that are commonly accepted to be medically appropriate interventions for health problems identified and documented by the physician. If the medication or therapy is unusual or substantially more costly than the most commonly accepted intervention, the physician must document the rationale for the deviation from the community norm.

Factors the physician or other (ordering licensed practitioner) may consider regarding the “medical necessity” of an intervention, include:

- The physician believes there is potential for significant improvement in the level of function of the patient;
- The physician can document the goals and objectives of the therapy to the patient or surrogate decision maker, i.e. the potential benefits of therapy;
- The physician can document risks that may be avoided by skilled therapy intervention;
Factors that may make the use of skilled therapy services (e.g. physical therapy, occupational therapy, speech therapy) more appropriate than unlicensed rehabilitative services (e.g. rehab aides/technicians or nursing staff), include:

- The presence of comorbidities which require a skilled/licensed professional to adequately plan therapy and monitor the ongoing response to the intervention.
- If the physician determines that a therapy is unusual or more costly than the most commonly accepted intervention, the physician must be willing to document the rationale for the deviation from the norm. Alternatively, more costly therapeutic services may be justified if they improve the quality of life or functional status of the patient in a significant, otherwise unobtainable way.

Note: In all of the following, the regulatory requirement regarding “highest practicable level of function” must be taken into consideration when ordering evaluations and treatments. It will be in the physician’s purview to balance this mandate with the clinical status of the patient when determining medical necessity.

Rehabilitation evaluations and treatments can be considered medically necessary if there is:
...medical provider affirms the documentation stating the rationale of how the intervention will provide the patient with an added quality to their life, a higher level of independence, or will prevent unnecessary debility or decline.

Hearing and vision evaluations and treatments can be considered medically necessary if there is:
...a regulatory requirement for the evaluation and the medical provider and/or the evaluator can document a justification that the evaluation and treatment that has a reasonable potential to provide the patient with an added quality to their life or, a higher level of independence or has reasonable potential to prevent unnecessary debility or decline.

Dental services can be considered medically necessary if:
...the care assists patients maintain their health through optimal nutrition, hygiene, or comfort.

Supplies/DME can be considered medically justified if there is:
...a medical provider affirms the documented therapeutic advantage (super ceding any intermediary decision) to the use of supplies or equipment in the care regimen that will assist the patient heal or regain function more quickly, safely, or cost effectively.

References