Pain Management Coding Alert

Reader Question: Use These Definitions of 'Medically Necessary'

Question: Recently, our practice has had a couple of claims denied. The payers said the services rendered by our practice's physician were not "medically necessary." I'm sure the physician thought the services were medically necessary - otherwise he wouldn't have ordered or performed them. What definitions are payers working from?

Michigan Subscriber

Answer: According to the American Medical Association's (AMA's) 2011 report to the Institute of Medicine's Committee on Determination of Essential Health Benefits, the AMA defines medical necessity as "Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider."

The Centers for Medicare and Medicaid Services (CMS) relies on the Social Security Act (Title XVIII of the Social Security Act, Section 1862 [a] [1] [a]) for its understanding of "medical necessity." That part of the law states "no payment may be made under [Medicare] part A or part B for any expenses incurred for items or services which … are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." Other payers may take a similar approach.

In the end, the definition of "medical necessity" and its application by a payer tends to be a subjective matter. Thus, a payer may conclude that services rendered were not "medically necessary," even though your practice's physician concluded otherwise.