

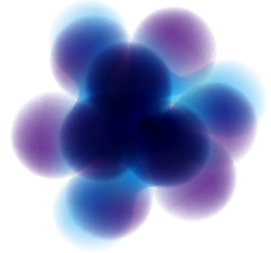
**Documenting to Support  
Medical Necessity**  
for the Pediatric Dental Professional



AMERICA'S PEDIATRIC DENTISTS  
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# Documenting to Support Medical Necessity

## for the Pediatric Dental Professional



## What is Medically Necessary Care (MNC) and How Do I Correctly Document it?

### 2014 AAPD Definition of Medically Necessary Care

Medically necessary care (MNC) is the reasonable and essential diagnostic, preventive, and treatment services (including supplies, appliances, and devices) and follow-up care as determined by qualified health care providers, in treating any condition, disease, injury, or congenital or developmental malformation. MNC includes all supportive health care services that, in the judgment of the attending dentist, are necessary for the provision of optimal quality therapeutic and preventive oral care. These services include, but are not limited to, sedation, general anesthesia, and utilization of surgical facilities. MNC must take into account the patient's age, developmental status, and psychosocial well-being, in addition to the setting appropriate to meet the needs of the patient and family.

Dental care is medically necessary to prevent and eliminate orofacial disease, infection, and pain, to restore the form and function of the dentition, and to correct facial disfiguration or dysfunction.

The term clinical medical necessity is also often used. Health insurance companies provide coverage only for health-related services that they define or determine to be medically necessary. Medicare, for example, defines medically necessary as: "Services or supplies that are needed for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice." MNC is also the benchmark for coverage of dental services under Medicaid.

## **AMA Definition**

Services or procedures that a prudent physician would provide to a patient in order to prevent, diagnose or treat an illness, injury or disease or the associated symptoms in a manner that is:

- in accordance with the generally accepted standard of medical practice.
- clinically appropriate in terms of frequency, type, extent, site and duration.
- not intended for the economic benefit of the health plan or purchaser or the convenience of the patient, physician or other health care provider.

## **CMS Definition 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...

In essence, the diagnosis drives medical necessity. Providers must document the diagnosis as well as what services or treatment options are available.

## **Third-party Payers**

Medical necessity can also be confusing when it comes to who is going to pay for the procedure or services. Many third-party payers have specific coverage rules regarding what they consider medically necessary or have riders and exclusions for specific procedures. Third-party payers may have a specific exclusion for procedures that they consider experimental, unproven for a specific diagnosis, or cosmetic.

One example is when a dentist using a laser device to perform a frenectomy. Upon pre-authorization for the surgery, the insurance payer states it will not pay for the surgery if the laser is used. The insurer's policy includes a rider that deems the laser as an experimental device. However, if the dentist uses a traditional blade, the third-party payer would reimburse. In this case, the insurance carrier is not stating that the surgery is not medically necessary, just that it will not reimburse for this surgery if the laser is used to complete the procedure.



Even if a particular procedure or service is considered medically necessary, some payers impose limits on how many times a provider may render a specific service within a specified time frame. For Medicare and Medicaid, these limitations are known as National Coverage Determinations (NCD) and Local Coverage Determination (LCD). Private payers may simply refer to this type of limitation as a policy guideline or policy exclusion or rider.

Within these guidelines, payers may define where or when they will cover a specific service, but may limit coverage to a specific diagnosis. For example, insurance policies may have a wellness or preventive care benefit, but may only cover one such visit per year.

For example, if patient had a fluoride treatment on Jan. 1, 2013, her insurance may not pay for another until 180 days have elapsed. However, if the patient has high risk for caries, the clinician may decide more frequent fluoride applications are necessary. The coder must submit that claim with the appropriate diagnosis for a sign, symptom, or abnormality to justify more frequent applications.

Providers must sign a claim form that legally assigns responsibility to the user for entries he or she creates, modifies, or views.

## **Claim Form Language**

### **ADA Claim Form – Box 53 - Provider signature**

“I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed”

### **CMS 1500 Claim form – Box 31 - Provider signature**

“I certify that the statements made on the reverse apply to this bill and are made a part thereof.

“Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

“I certify that the services shown on this form were medically indicated and necessary for the health of the patient”

### **How to Document Medical Necessity**

Pediatric dentists should be able to explain the rationale for their treatment, demonstrating that dental necessity equals medical necessity.

Consistent use of correct/appropriate/specific diagnosis coding is critical. Many diagnosis codes are not specific enough in themselves.

Understanding and determining medical necessity can be very complex for coders and billers.

- Tell a story
- Don't assume level of knowledge at claim review level
- Don't rely on diagnosis documentation alone
- Review any payer policies – and document in their terms  
For example, for equilibration: “Patient reports 60 percent decrease in pain after previous equilibration”

A dentist may have a completely different understanding, interpretation, and definition of medical necessity than the patient or a patient's family member. A third-party insurance payer may also have another completely different understanding and application of the term.

Medical necessity continues to be open for interpretation by all parties involved. Many third-party payers have created lists of criteria they use to interpret medical necessity. These lists do not necessarily reflect all options, but payers include this reference in their policy guidelines.

Most providers have not developed a comprehensive listing of medically necessary qualifiers, so coders and clinicians must focus on good documentation and coding accuracy to communicate the medical necessity of services accurately to payers. If third-party payers deny reimbursement for dental services; dentists, and coders need to rely on the formal appeal process.

Medical necessity documentation from a provider should include the following: reason for any services ordered – labs, radiographs, other diagnostic studies.

### **CMS Documentation Guidelines**

- “If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.” If not documented, it didn’t happen.
- Severity of the “signs and symptoms” or direct diagnosis exhibited by the patient. Diagnosis is the driver, and multiple diagnoses may be involved.
- Probability of an adverse or a positive outcome for the patient, and how that risk equates to the diagnosis currently being evaluated. This is the medical risk vs. gain.
- Need and/or availability of diagnostic studies and/or therapeutic intervention(s) to evaluate and investigate the patient’s presenting problem or current acute or chronic medical condition. In other words, does the facility, office, or hospital have what the provider or clinician needs to render care?

Third-party payers employ a wide spectrum of policies defining what medical necessity is and should encompass. Clinical providers and coders should review what these payers have established within their guidelines. Someone within the provider’s office, hospital, or medical facility should thoroughly scrutinize these guidelines before establishing a contractual relationship with a particular third party payer. This up-front communication will help avoid claim denials in the future.

Here are some examples of what some third party payers are currently including in their medically necessary verbiage:

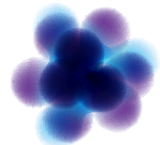
- Treatment is consistent with the symptoms or diagnosis of the illness, injury, or symptoms under review by the provider of care.
- Treatment is necessary and consistent with generally accepted professional medical standards (i.e., not experimental or investigational).
- Treatment is not furnished primarily for the convenience of the patient, the attending provider, or other provider or supplier.
- Treatment is furnished at the most appropriate level that can be provided safely and effectively to the patient, and is neither more or less than what the patient is requiring at that specific point in time.
- The disbursement of medical care and/or treatment must not be related to the patient's or the third party payer's monetary status or benefit.
- Documentation of all medical care should accurately reflect the need for and outcome of the treatment.
- Treatment or medical services deemed to be medically necessary by the provider of those services,(e.g., dentist, therapist, clinician, etc.) does not imply or infer that the service(s) provided will be covered by or deemed a medically necessary service payable by a third-party insurance payer.

Providers must understand the complex relationships between the patient, the medical record documentation, the coder, the biller, the insurance payer, and the communication between all of these entities to successfully guide the interpretation of medical necessity.

Finally, always remember what are the auditors are looking for:

- Authentication – do signatures, dates and times all add up?
- Contradictions between review of systems and history of present illness.
- Wording or grammatical errors.
- Medical/dental questionable documentation.

For further information, please contact AAPD Dental Benefits Manager Mary Essling at (312) 337-2169 or [messling@aapd.org](mailto:messling@aapd.org)





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