What Is Psychiatric "Medical Necessity"?

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The terms "medical necessity" and "medically necessary" are assuming increasing importance in American medicine for several reasons. Among these reasons are the essentiality of medical necessity as a basis for third-party payments, recent legislation enacting civil monetary penalties associated with allegations of fraud or abuse, and recent legislation pertaining to the clarification of knowledge required for the imposition of civil monetary penalties.

This column discusses these critical areas and proposes a definition of medical necessity that addresses issues important in psychiatry.

Third-party payments

When the Medicare program was first offered to the public in 1965, the intent was to pay only for those goods and services that were considered to be "medically necessary." Title 18 of the Social Security Act, Section 1862 (a)(1)(A), prohibits compensation for services that are not "reasonable and necessary for the diagnosis and treatment of an injury or illness or to improve the functioning of a malformed body member."

Medicare carriers have generally used four criteria to determine the medical necessity of health care items and services. First, the treatment should be consistent with the symptoms or diagnosis of the illness or injury in question. Second, the treatment should be necessary and consistent with generally accepted professional medical standards—that is, not experimental or investigational. Third, the treatment should not be furnished primarily for the convenience of the patient, the attending physician, or another physician or supplier. Fourth, the treatment should be furnished at the most appropriate level that can be provided safely and effectively to the patient.

Some factions within organized medicine have attempted to formulate definitions that incorporate these criteria. One definition was offered by the Oklahoma delegation to the 1998 annual meeting of the American Medical Association's (AMA) house of delegates (1). It reads as follows: "The term 'medically necessary' or 'medical necessity' when used in reference to the evaluation and/or treatment of a medical doctor or doctor of osteopathy shall mean any evaluation provided by or at the direction of an MD or DO, or treatment, which in the professional opinion of the MD or DO in consultation with and concurrence of the patient or his/her legal representative will provide functional, psychological, or health benefits to the patient."

The AMA definition is noteworthy because it was endorsed by the managed care committee of the American Psychiatric Association at its meeting in February 1999 (2). However, this definition is less than ideal for psychiatric purposes, because it ignores the standard of care in the community and it mandates the concurrence of the patient or his or her legal representative. In fact, a patient may not agree to treatment because of incompetence, irrational hostility, lack of insight, or other reasons. Also, the patient may or may not have a legal representative. Even if a legal representative exists, he or she may have a diminished appreciation of the appropriateness of psychiatric intervention.

Psychiatrists may argue with some merit that the question of medical necessity be considered independent of legal restraint and that the judgment of medical necessity be allowed as a medical concept even when treatment is disallowed for legal reasons. The problem of attempting to tie medical necessity to the "concurrence of the patient or his/her legal representative" is not restricted to psychiatry; it is exemplified by the inability to administer a medically necessary blood transfusion because of a patient's religious objections. It is important to acknowledge that a procedure may be legitimately medically necessary even though its administration may not be legally permissible.

The AMA definition was then referred to the AMA council on medical service, which presented an expanded definition of medical necessity that appears to be more specifically focused on the four criteria and to be more user-friendly to psychiatrists (3). The council defined medically necessary treatment as "health care products or services that a prudent physician would provide to a patient for the purpose of diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: 1) in accordance with generally accepted standards of medical practice; 2) clinically appropriate in type, frequency, level, site, and duration; and 3) not primarily for the convenience of the patient, physician, or other health care provider."

This definition is more acceptable to psychiatry because it eliminates the condition requiring concurrence of the patient, although the phrase "not primarily for the convenience of the patient" is troublesome. One cannot help but be concerned about a possible adversarial implementation of the phrase—for example, with regard to the duration or frequency of psychotherapy sessions. What may appear to be for the convenience of a

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patient may actually be necessary. Also, this definition of medical necessity is less than optimal because it ignores the possible importance of external sources of information in psychiatry and how they may be related to the concept of medical necessity. Psychiatry may be more dependent on such sources than other medical specialties for the determination of appropriate treatment.

An example from my clinical practice illustrates some of the problems that may arise from the ascription of convenience and the disregard of external sources of information. I treated a Chinese patient who had a very poor command of English with brief medication management sessions every two weeks. Even though our communication during the sessions was poor, a reasonably good stabilization of symptoms was achieved. Therefore, I decided to decrease the frequency of visits to once a month. A Cantonese-speaking social worker later contacted me to inform me that the patient had become very depressed after the frequency of visits had been decreased. He explained that the patient was isolated and had looked forward to these visits even though it had appeared to me that they were unnecessary. I resumed the two-week visitation routine, and the patient subsequently improved.

In this instance, the social worker's evaluation was crucial in the determination of medical necessity. However, in an adversarial audit it could be argued that the biweekly scheduling was done for the convenience of the patient. Also, it would be difficult to defend the medical necessity of biweekly sessions conducted in less than basic English without the social worker's support. Although the external source of information in this instance was a social worker, he or she could easily have been a visiting nurse, or relative, or anyone in a caretaking capacity.

As noted, in determining the medical necessity of services, psychiatry may be more dependent on external information sources than other medical specialties. Psychiatry deals with many patients who are, for one reason or another, poor communicators and poor historians.

Civil monetary penalties

In a report to Congress dated August 13, 1997, in which health care fraud was described as "the crime of the nineties," the Department of Justice alleged that health care fraud consumed more than $100 billion annually (4). The report stated that between 1992 and 1996 the Department of Justice had increased civil prosecutions approximately 1,000 percent and criminal prosecutions 400 percent and that each of the 94 U.S. Attorneys Offices had appointed a special health care coordinator to combat fraud.

In line with these warnings about fraud and abuse, Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) of 1996, which made it easier to prosecute health care providers, including hospital administrators, other administrators, hospitals, physicians, laboratories, billing employees, suppliers, and other health care workers. Under section 231 of the act is a section entitled "Social security act civil monetary penalties." Paragraph (c) states: "Modification of amounts of penalties and assessments—Section 1128A (a) (42 U.S.C. 1320a-7a(a)) as amended by subsection (b), is amended in the matter following paragraph 4—1) by striking '$2000' and inserting '$10,000.' "

The sum of $2,000 refers to a former penalty that is not alluded to elsewhere in HIPAA but that is described in the civil monetary section of the Social Security Act. The penalty is specifically related to the violations described as "upcoding" and rendering unnecessary medical services. Upcoding is defined as "presenting . . . a claim for an item or service that is based on a code that the person knows or should know will result in a greater payment to the person than the code the person knows or should know is applicable to the item or service actually provided."

With respect to the rendering of unnecessary medical services, this section of the Social Security Act states that the fines should be imposed in cases in which the provision of services reflects "a pattern of medical or other services that a person knows or should know are not medically necessary." In contrast to upcoding, no attempt is made to define what constitutes medically unnecessary services, perhaps because of the inherent fuzziness of the concept.

Clarification of level of knowledge required

A clarification of the level of knowledge required for the imposition of civil monetary penalties appears in paragraph (d) of section 1128A and describes what a person "should know" before these penalties can be assessed. A penalty can be assessed when a person acts in "deliberate ignorance" of information or "reckless disregard" of information." Morever, "no proof of specific intent to defraud is necessary."

In considering these concepts, in Medicare audits, unlike criminal law, it is guilt that is presumed and innocence that must be proved. In such proceedings, physicians might find that it is much easier to prove knowledge than ignorance, and once having proved ignorance, if it can be proved, one would have to prove that the ignorance was not deliberate. Since ignorance is lack of knowledge, a person may be faced with the task of proving that he or she was not deliberately unaware of something that he or she was unaware of; however, it is difficult to see how this can be accomplished.

Also, one should not underestimate the import of the phrase "no proof of specific intent to defraud is necessary." Good intentions and good character may be legally irrelevant. It is equally important to keep in mind that the $10,000 fine previously referred to is levied for each individual service violation.

Psychiatric "medical necessity"

In light of the above discussion, it may be advisable for psychiatry to develop its own definition of medical necessity, possibly incorporating the definition of the AMA council on medical services but expanding it. I propose the following definition.

In psychiatry, medical necessity pertains to health care services that a prudent physician would provide to a patient for the purpose of diagnosing and treating a psychiatric illness in a man

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ner that is in accordance with generally accepted community standards of psychiatric practice and is clinically appropriate in terms of type, frequency, level, site, and duration. The medical necessity of any individual service is a complex decision reached primarily by the psychiatrist while taking into consideration the needs of the patient. The decision may involve obtaining additional information from the patient's family, the patient's legal representatives, other professionals involved in the care of the patient, and nonprofessionals involved in a caretaking capacity. ♦

References

1. House of Delegates: Resolution 719, 1998 Annual Meeting. Chicago, American Medical Association, 1998
2. Model statutory provision on burden and standard of proof in decisions about medical necessity. Psychiatric Practice and Managed Care 5(2):6–7, 1999
3. Hanley KK: Definitions of "Screening" and "Medical Necessity: Preliminary Report to the AMA House of Delegates, 1998 Interim Meeting. Council on medical service, report 13-1-98. Chicago, American Medical Association, 1998
4. Vaughn DM: Fraud and Abuse Handbook for Psychiatrists. Fort Worth, Tex, Compliance Center, 1998