Featured Tom's Take

We occasionally have a topic that's particularly popular among our regular readers; when that happens, we like to share it more widely. We hope you enjoy the following piece.

Why is medical necessity a factor when reviewing health claims?

Tom's Take: As employers work to get more control of the health plan dollars they're spending, closer claim review has become a key strategy. Medical necessity factors into this as it's one area where excess spending is occurring on a regular basis.

Unfortunately, in today's society, there's a trend toward overutilization in care: ordering tests that aren't necessary, performing procedures that don't fit the symptoms and even prescribing medications that aren't warranted in treating the conditions they're written for.

Cypress's claims review experts know it's important to evaluate incoming health claims to ensure medical necessity. What does that mean? We're looking at claims to be sure that the medical care members receive in the process of diagnosing, treating or preventing a medical condition follows medical necessity protocols. This is done by taking a thorough look at the codes used for billing in combination with other medical documentation and ensuring that everything in the care process adds up.

For example, if a patient presents heart-related symptoms, there are multiple ways to complete a stress test, including an exercise EKG, an echocardiogram and a more advanced SPECT scan. The SPECT test is a form of nuclear imaging, making it a costlier option – and one that is needed only in specific situations. So, in most instances, medical necessity protocols would call for the less-specialized tests to be done first, progressing to more specialized (and costlier) ones if results are inconclusive or point to the need for a different test. If a provider skips the protocols and orders a high-level, non-medically necessary test first, the claim would be red-flagged, potentially resulting in a difficult situation for all parties involved.

Just like with testing, we're seeing a lot of instances where high-cost procedures are being performed before other, often more suitable options are explored. It's not only the hefty price tags attached to medically unnecessary care that can be problematic in these cases, but also the recovery process – more intense or invasive procedures can lead to greater risks for the patient as well as longer, more complicated recoveries.

Medical necessity can be tricky as patients are often prone to trust their providers' guidance without seeking a second opinion or inquiring about other available diagnostic or treatment methods. This is yet another reason why educating members to be informed consumers of care (including steps like obtaining pre-qualification of any procedures before they are performed) is so essential.

Careful claim review is a smart way for employers to control overspending with health plans, but it's not just things like duplicate entries or miscoded services to be watching for. Taking the time to review claim charges for medical necessity and appropriate care can be well worth the effort.

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