Medical-necessity determinations begin in the lab

Q What role should the laboratory play in the determination of medical necessity?

A Because all test orders eventually pass through it, the laboratory is in a unique position to contribute to the discussion of medical necessity, both from a test-volume standpoint and from the scientific aspects of test design and applicability. Because the determination of medical necessity also relies on medical history and clinical follow-up, however, laboratory data must be integrated in some meaningful way with information from physicians and from allied healthcare personnel if it is to be practical. Thus, any discussion of “medical necessity” must begin with a formal definition, in the clinical setting, of just what the term means. The definition will often include not only the utility of a specific test in a particular clinical setting, but also how often it should be used and when follow-up is needed.

The laboratory can provide a starting point for medical-necessity determinations by providing the medical staff with an analysis of the ordering patterns of physicians and of overall test volumes. Increases in test volumes for a particular test, for example, may indicate an increased staff awareness of new and useful testing procedures, may be purely defensive medicine, or may be the result of a misunderstanding of the utility of the test in question. The laboratory can start the discussion by bringing to the attention of the appropriate medical staff committee a change in ordering patterns or a discrepancy among physicians in the way tests are being used.

Once the discussion is initiated, the laboratory can provide valuable assistance to the medical staff members by educating them about the limits and utility of the tests under consideration so that a reasonable analysis of necessity and propriety of ordering patterns can be made. The presence of a well-informed pathologist or technologist at the table when discussions of tests are underway can facilitate the process by eliciting questions, uncovering problems, and providing answers.

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Once a determination of a general standard of medical necessity has been made, the laboratory is in the best position to monitor compliance with that standard on an individual-patient or ordering-physician basis. Such monitoring should only be performed under the direction of the medical staff itself and should be conducted with the intent of education rather than punishment. The laboratory should never be put in the position of “policeman” regulating the ordering patterns of physicians, but rather that of colleague assisting physicians in the best and most efficient management of patient care.

Remember that even well-implemented programs can take time to produce results, because they invariably involve refining practice patterns that have been established over many years. One laboratory struggled with daily ordering of international normalized ratios (INRs) on patients whose anticoagulant had been so recently re-adjusted that no change in INR could reasonably be expected, leading to a cycle of multiple adjustments of medication on the heels of too many tests. In this situation, the pharmacy actually identified the problem, the lab collected the data, and the two jointly presented information to the medical staff regarding optimum timing of INR testing and dose adjustment. After several months of discussion with the medical staff and several different presentations, an “anticoagulant team” eventually was established to assist physicians. Dosage adjustments decreased, patients had fewer venipunctures, and INR management improved dramatically with fewer patients over- and under-coagulated: a near-perfect example of how the laboratory can coordinate with its other partners in healthcare to improve patient care under the banner of “medical necessity.”

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