Notes From Kevin Lembo: State Healthcare Advocate

Medical Inefficiency Committee
Human Services Committee
Panel Discussion and Public Hearing
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- MIC's definition of medical necessity combines critical elements in the current Medicaid MN definition with MN definition adopted in the class action settlements of physicians against all of the largest HMOs.

- Medical necessity and medical appropriateness always have been treated as separate and equally important concepts in the Medicaid program. Related, but not of equal weight.

    - Adopting the committee's recommended definition recognizes that medical appropriateness is a component of medical necessity and not of equal weight in a decision to approve or deny services.
    - This is important because healthcare providers recognize the concept of medical necessity already encompasses the concept of medical appropriateness.
    - In Medicaid under the current definitions, if a requested service is medically necessary, it could still be denied because it isn't medically appropriate.
    - Under the new definition and the statutory definition for private insurance in CT, the concept of medical appropriateness in the current Medicaid definition is a factor, but it is not determinative.

- OHA has handled many Medicaid cases under the current MN definition. Our client's experience has been positive, possibly with the exception of the area of Durable Medical Equipment, for which additional guidance by DSS had to be issued back in 2003.

- OHA has opened approximately 2,000 a year each year for the last four years--1,600 each year related to medical necessity. Majority of cases in mental health concern the issue of therapeutic equivalence or failure to consider co-morbidities in medical necessity determination.

- Most of the individuals we help are children with serious and co-morbid mental health conditions who require a higher level of care than the one in which they are currently receiving treatment.

    - For instance, we may have a child who has a serious eating disorder and severe PTSD. The child needs to be in a residential treatment eating disorder program that can also address her PTSD. It is more frequent than not that the insurer denies the eating disorder program by concluding one or both of the following: 1) she could be treated as well at a lower level of care with adequate supervision at home, or 2) her eating disorder isn't severe enough to meet these criteria. So both therapeutic equivalence and failure to address all medical conditions come into play if the MCOs are not adequately directed and supervised.

<u>Recommendations</u>

1. The committee should ensure that the language on generally accepted standards of clinical practice in subparagraph 1, "any other relevant factors" remain in the final definition. This is important because there will be times, just like there are with our cases, that a procedure or services hasn't risen to the level of a generally accepted standard.

- In fact, it might be experimental or investigational, but the patient's circumstances preclude any other option. For instance -- patient has developed malignant tumors in her liver ten years after having her right breast and five lymph nodes removed. During treatment for her original cancer, the patient had numerous radiation treatments and chemotherapy trials that left her lungs weakened. She and her doctor made a decision to remove the liver tumors by radioactive ablation therapy, a non-invasive procedure considered "experimental and investigational" by the insurer. The insurer denied the claim on that basis, and we argued that the carrier had to consider any relevant factors, including the evidence of success of the procedure in many cases with similarly situated individuals, and that in the particular case, where the patient had no other alternative--traditional surgery was not an option because of her lung damage--the procedure was medically necessary. The carrier upheld its denial and approved the

ablation treatment. On an expedited external appeal, we won the case and got this patient's care covered.

2. The committees should ensure that its language on individualized assessments remains in the definition. Although it is generally understood that individualized assessments are supposed to be performed in each case, this does not happen. The failure to consider co-morbidities in the behavioral health is especially egregious:

- Generally accepted standards are written for treatment of only one condition at a time. We see this most often, but not solely, in behavioral health cases. Insurers tend to use criteria for varying levels of care, but for certain conditions, there are specialized criteria like, Adult/Adolescent/Child Eating Disorder-Residential Treatment. These ultra-specific criteria are especially problematic when one has not only the specified condition, but also has major depression. Example: 16 yr. old with severe eating disorder, severe PTSD from sexual abuse two years earlier, and medical complications from eating disorder. She was hospitalized because of medical complications. Request was made for residential eating disorder program that can address the PTSD and monitor her medical situation. Carrier denied coverage stating that the patient did not meet criteria. Only after three tries did the carrier reveal the actual criteria that it claimed the consumer did not meet. Even on second level appeal, despite our argument that the co-morbidities made this case more complicated than a traditional eating disorder case and the criteria were written only for a traditional case, and in no way were controlling, we lost. On an expedited external appeal, we won the case and got this patient's care covered.

The pattern, the use of criteria only-- is repeated over and over again in the cases that we bring to appeal.

3. The committee should include a sentence in its definition that clearly states, ‘clinical policies, medical policies, clinical criteria, or any other generally accepted standards of clinical practice used by a contractor to assist in evaluating the medical necessity of a requested service shall be used *solely* as guidelines and shall not be the basis for a final determination of medical necessity’. Further: ‘Upon a denial of a request for services, the contractor shall provide the consumer, consumer's representative and the

healthcare providers who made the request for services with a copy of any guidelines used by the contractor in its decision-making.'

4. The committee should insist that the medical necessity definition become statutory. Medical necessity is pervasive--and too important not to be in statute. Regulations can be more detailed on proper application.

5. The Committee should issue a guidance document, similar to a Provider Bulletin, which lays out interpretive issues. This document could include instructions for medical necessity determinations that require the MCO to factor in a client's co-morbid condition when determining medical necessity or in making a decision to find the requested service medically necessary despite its status otherwise as experimental or investigational.

6. The Committee should ensure that HUSKY B recipients maintain the right to an external appeal for a denial of medical necessity. Recipients could be directed to our office for assistance with the preparation of such appeals.

Last part: Cautionary Tale

- Thank you work it put in to develop a definition. The critical part is the application of that definition. Our data shows that BH consumers suffer disproportionately despite an identical medical necessity definition to the medical/surgical side of the benefit, and despite the arguably more individualized and subjective treatment needs. Why? We believe that the criteria are ill-suited to behavioral health conditions.

- The definition the committee drafted is very good. We suggest a few edits, but this does not guarantee a perfect system. The definition is appropriately broad enough to ensure that services are not unfairly restricted. On the other hand, the definition is specific in its direction to contractors about what must, and must not be taken into consideration.

    - It will be necessary, however, to closely monitor the implementation of the definition for patterns such as the one described. This will require more detailed data collection from

DSS and/or the MCOs/ASOs beginning on day 1 of the definition's implementation.

- In the commercial market, in the small subset of denials called "Utilization Review Requests and Denials" – an appeal of medical necessity determinations, after losing on their appeal to their insurer, the reversal rate is over 40%. This means that the MCOs are only applying the MN definition correctly half of the time. There must be strict oversight of the application of the medical necessity definition, and clear direction to insurers/MCOs on expectations and consequences of noncompliance.