

**Department of Social Services
Medical Care Administration**

Memorandum

Date: August 16, 2010

To: Medicaid Medical Directors

From: Robert Zavoski, MD, MPH

Re: New Medical Necessity Definition

The Department of Social Services is required to report data on the impact of the new definition of medical necessity to both the Medicaid Care Management Council and the Medical Inefficiency Committee of the General Assembly. It is therefore necessary to define standards to enable consistent reporting by the Medicaid managed care plans.

The new legislation defines medical necessity services as those health services required to “prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning.” To be medical necessary, health services must meet five criteria (below), which will serve as the basis for reporting of coverage decisions. Although more than one criterion will apply to many denials¹, for simplicity and clarity of reporting, the primary or most compelling basis for the denial should be reported.

In addition, the legislation which established the new definition of medical necessity requires that “Clinical policies, medical policies, clinical criteria or any other generally accepted clinical practice guidelines used to assist in evaluating the medical necessity of a requested health service shall be used solely as guidelines and shall not be the basis for a final determination of medical necessity.” This requirement is consistent with the Department’s long-standing policy and guidance to the MCOs.

To be considered medically necessary, services requested must be:

- 1) Within generally accepted standards of medical practice based on credible scientific evidence published in peer-reviewed medical literature, recommendations of specialty or clinical experts, and “any other relevant factors.”

¹ The same requirements and standards apply to decisions **to terminate, reduce or suspend** a previously authorized service.

Most requests for services will be initially reviewed using established clinical guidelines, such as Milliman, or opinions of panels of experts or specialty societies, such as the American College of Obstetrics and Gynecology guidelines for genetic screening for breast cancer (BRCA) or the American Academy of Pediatrics' recommendations for prophylaxis against Respiratory Syncytial Virus (RSV). When a request is denied because the service is not indicated according to established clinical criteria, guidelines, or expert opinions, standard #1 should be cited as the basis for denial. Examples would include a request for palivizumab for a 12 month old asthmatic born at term, or a request for BRCA testing of a 35 year old woman with breast cancer whose family history is limited to her mother who was diagnosed at age 60.

- 2) Clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease.

This standard is to be cited when treatment for a condition is determined to be medically necessary per the first standard, but the frequency, duration, site, level of care or type of therapy requested is inappropriate. Examples would be a 4 month old with lung disease of prematurity whose provider wishes to administer 6 doses of palivizumab or to administer it through the summer months because the child attends a large day care center. Other examples include "partial denials" of physical therapy, where the need for the service is not questioned, but the duration of therapy prior to reassessment of need, frequency of visits, or types of therapeutic modalities used are not appropriate.

- 3) Not primarily for the convenience of the individual, the individual's health care provider or other health care providers.

This criterion should be cited when a service requested is denied because the service, the timing or frequency of the service, or other factors leading to the request, are for reasons other than medical need. Examples include requests for home nursing services only on weekends for a child of a parent who wishes to work only weekends, or NEMT services to transport a patient for a consultation to a facility which is not the closest appropriate facility to the client's home, but is the facility preferred by their provider.

- 4) Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease.

This standard is to be cited when a decision to deny a service is made, all other factors being equal, because there is an equivalent service of lesser cost available, such as a brand name drug with an equivalent generic available. Other common scenarios are new

products marketed as “gold standards” among equivalent therapies due to small but unproven alterations of established products, such as certain vacuum powered wound drainage systems, ceiling mounted patient lifts, replacement joints, etc.

5) Based on an assessment of the individual and his or her medical condition.

The original intent of this standard was to ensure that individual needs of each patient be taken into account when reviewing requests for services, and the needs of the individual patient must be considered in authorization decisions. However, this standard may also be cited if a patient has not received a timely re-evaluation of their needs by the provider ordering the services. For example, this standard could be applied to renewed requests for ongoing home care for a wound which is not responding to therapy, when the ordering provider has neither reassessed the care plan nor re-evaluated the patient.

It is important to note that not all authorization decisions must be reported on this form. In particular, requests for excluded or non-covered services are not medically necessary services under Connecticut Medicaid and, therefore, should not be reflected on this form. For example, cosmetic surgeries for adults when there is no medical basis for the surgery, or administrative denials, such as payment denials, should not be reported on this form.

Other medical necessity scenarios will likely arise which will not easily fit into these criteria as discussed above, therefore this topic will remain a standing agenda item on the Medicaid Medical Director’s monthly meetings. There will likely be ongoing feedback from the Medical Inefficiency Committee to be taken into consideration as well.

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