

ANNOTATED PROPOSED REWRITE OF “MEDICALLY NECESSARY”
DEFINITION

November 2002

§ HFS 101.03 Wis. Admin Code

(96m) “Medically necessary” means a medical assistance service that is:

(a) required to prevent, identify, or treat a recipient’s illness, injury, ~~or~~ disability, **or the related functional deficits throughout the recipient’s lifespan**; and

- *In this section we added the language “related functional deficits throughout the recipient’s lifespan” in an attempt to incorporate the first of the Kennedy criteria. We hesitated about using the word “developmental” because we were concerned that it would be confused with “developmental disability.” We also did not want to inadvertently cause problems for some other group of potential MA recipients by tailoring this portion of the definition to the population we are primarily concerned about (kids with disabilities). In the end we retained it because we felt it accurately expressed our belief that development continues, slows and is sometimes arrested throughout a person’s lifetime and that often interventions that are essential to a recipient’s needs are more related to function and less tied to diagnosis. This additional language is added to address denials based on clients attaining a certain level of function that may no-longer meet new demands of their changing home, school, work, living environments. It is also added to include the need for episodic care demonstrated as a client grows, shows deterioration or regression in skills.*
- *We felt the remainder of the section was consistent with the Kennedy criteria so we retained it.*
- *This language is consistent with Medicaid Provider Update: May 2002-32.*

(b) Meets the following standards:

(c) Is consistent with the individual recipient’s symptoms or with prevention, diagnosis or treatment of the recipient’s illness, injury, ~~or~~ disability **or the related functional deficits throughout the recipient’s lifespan**.

- *We again added the functional deficit language to make it consistent with (a) above.*

1. Is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider and the setting in which the service is provided;

- *We left this section intact because we felt it allowed sufficient flexibility in the setting in which a service was delivered—thus it was consistent with Kennedy criteria #5.*
- *The subcommittee did not feel that site of service had been a stumbling block in prior authorization process for therapies. There was some discussion of the problem with respect to DME, but the identified problems stemmed not*

from the definition of “medically necessary” but from the code provisions dealing with DME.

2. Is appropriate with regard to generally accepted standards of medical practice;
 - *We retained this section intact as it relates, somewhat, to Kennedy criteria #.*
3. Is not medically contraindicated with regard to the recipient’s diagnosis, the recipient’s symptoms or other medically necessary services being provided to the recipient;
 - *We retained this section intact because it does no harm and offers recipient protection.*
4. Is of proven medical value or usefulness; is consistent **with available research findings, health care practice guidelines or standards issued by professionally recognized government agencies**; and, ~~consistent with~~ pursuant to s. HFS 107.035, is not experimental in nature.
 - *In this section we borrowed language from the model Kennedy language to express our belief that medically necessary services were being denied as experimental because the department was focusing too heavily on available research findings, rather than practice guidelines or professional standards. Current research in the areas of interventions with children & adults with disabilities is in its early stages of publication.*
 - *Initially we had considered removing the term “experimental” altogether. After discussions with department staff we retained the term “experimental” because, as we understand it, the term is a term of art necessary to determine MA coverage or non-coverage of drugs that have not been approved by the FDA. To remove the term “experimental” altogether could have created the unintended consequence of potential coverage of a large number of drugs that are currently not covered. We have no opinion as to whether the use of the term “experimental” is restricting MA coverage of beneficial drugs. The use of “experimental” in the context of drug coverage issues should be dealt with separately.*
 - *Language used here is consistent with WI Medicaid Update 2002-32(b) 5.*
5. Is not duplicative with respect to other services being provided to the recipient; **in this section “duplicative” means identical in all anticipated outcomes to another service**;
 - *After receiving feedback and reviewing a number of fair hearing decisions we decided that the term “duplicative” was ambiguous and needed to be defined. A standard dictionary definition of “duplicate” is “to make an exact copy” or “identically copied from an original.” We adopted the standard of “identical.” Under our definition, a service could not be denied as duplicative*

if it was not identical in all respects to another service. In the context of therapy decisions there have been a number denials of therapies because the requested therapies are “duplicative” of school-based therapy services. In these cases the department criteria being applied appears to be “substantially similar” rather than identical. In fact, it appears that many of the services denied as “duplicative” were actually complementary. We felt a clear and restrictive definition of “duplicative” was necessary to arrest the current trend of improper denials.

6. Is not solely for the convenience of the recipient, the recipient’s family or a provider;

- *We retained this section, although we believe it is unnecessary. We believe that any service which would fall into this category could be appropriately denied under any of several other criteria.*

7. With respect to prior authorization of a service and to other prospective coverage determinations made by the department, is cost-effective compared to **an alternative service that is consistent with (b) 1. and that can reasonably be expected to achieve the intended medical, functional or health outcomes for the recipient;**

- *We thought long and hard about deleting this section altogether because it clearly relates to rationing and cost of care; which we feel should be a separate test from Medical Necessity. We kept it because we believe that realistically if it were deleted here it may reappear somewhere else. We kept it so that we would, possibly, be in a better position to change it to reduce its harmful effect.*
- *Our attempt to change it consisted of dropping the term medically necessary from within it and more clearly stating that any service which is to be substituted for a preferred service because of cost must also meet the criteria in 1. above (meaning that it must be consistent with the individual recipient’s symptoms or with prevention, diagnosis or treatment of the recipient’s illness, injury, disability or related functional deficits appropriate to the recipient’s developmental framework over the recipient’s lifespan) and must also achieve the intended outcome of the preferred service*
- *Language is consistent with WI Medicaid Update: 2002-32-Attachment 2.*

8. Is the most appropriate supply or level of service that can safely and effectively be provided to the recipient.

- *We retained this section intact. Again, we had concerns that there were incidences of inappropriate denials under this category, but felt that it was most often used as a secondary justification for a denial primarily based on cost effectiveness or duplication of services.*

(d) In the case of services subject to prior authorization, if the department's preliminary determination is to deny or modify a service request based on a finding that the service is not medically necessary, the final medically necessary determination for that service shall be made by the medical director in collaboration with the primary care physician, the recipient, the recipient's family, the provider, and other parties identified by the recipient, the recipient's family or the provider.

- *This is an entirely new subparagraph. It only comes into play when the department is considering denying or modifying a PA request—not in all determinations of medical necessity. We felt it needed to be included in order to address Kennedy criteria #'s 2 and 3. This language is consistent with contemporary client/family-centered approach to healthcare and the peer review opportunities in recent Patient rights legislative initiatives.*
- *We were somewhat concerned that one of the problems with the current system is the department's overbroad documentation requirements. It is certainly not our intent to have this language simply mean that more paper needs to be submitted to the department. Our intent is to have the various players identified actually contacted and conversed with prior to a final determination.*