Resource:
Medical Necessity Determination Process for Covered Benefits

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MEDICAL NECESSITY DETERMINATION PROCESS FOR COVERED BENEFITS

This resource discusses the medical necessity determination process, which may involve multiple clinicians, for enrollees in health plans and health policies regulated by the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI).

Medical necessity, commonly referenced in health insurance and in related laws, is either explicitly or implicitly relevant to the proposed health insurance benefit legislation analyzed by the California Health Benefits Review Program (CHBRP) for the California Legislature. Generally, such a bill would require benefit coverage — and so would require that a particular enrollee at a particular time be able to access coverage[1] for the related tests, treatments, and services when those tests, treatments, or services are medically necessary.

A test, treatment, or service may be considered medically necessary if it is judged appropriate and consistent with a patient's diagnosis and, in accordance with locally accepted standards of practice, cannot be omitted without adversely affecting the patient's condition or quality of care. For enrollees in plans and policies regulated by DMHC or CDI, a number of similarly broad definitions exist (see the appendix). However, the application of such broad definitions to determine medical necessity for a particular enrollee requires one or more clinicians to consider a particular test, treatment, or service; the particulars of the enrollee's health at a moment in time; and the current state of medicine. Complicating the situation, as described below, multiple clinicians considering the same information may not all make the same determination.

Commercial/CalPERS Enrollees

For commercial enrollees in plans or policies regulated DMHC or CDI — as well as for California Public Employees' Retirement System (CalPERS) enrollees in DMHC-regulated plans — a medical necessity determination always begins with the initial provider. Most frequently, no further determination is required, and plans and insurers accept the provider's determination. The most commonly used test, treatments, and services are familiar and commonly recommended for a disease or condition (e.g., antibiotics for an infection), and most requests for coverage (as many as 94%) are approved by the plan/insurer through automatic systems (Singer and Bergthold, 2001). However, should the plan/insurer disagree with the initial provider's determination — and should an enrollee pursue all available appeals processes — multiple clinicians may become involved. In such cases, though each clinician's determination will be based on current data and current standards of care, determinations can differ. Listed below are the possible medical necessity determination steps.

1. **Initiate:** The initial provider makes a determination and submits a claim to the enrollee's health plan/insurer. Most frequently, plans and insurers accept the provider's determination (implicit in a submitted claim) and cover the test, treatment, or service. However, the plan/insurer can disagree and then deny the claim. An initial denial is generally based on clinical guidelines developed by the plan/insurer or on a combination of external and internal guidelines. The Milliman Care Guidelines[2] are a commonly used set of external guidelines. However, others exist and differences between guidelines illustrate differences in opinion for the medical necessity of particular tests treatments, or services for particular disease states or conditions.

2. **Appeal:** The science of medicine is not static and the practice of medicine is always evolving. In addition, there can be special circumstances for a particular patient, so the enrollee may ask the

[1] Instances in which the enrollee's plan contract or policy lists a test, treatment, or service as excluded from coverage (and so not a covered benefit) are not discussed in this resource. Hearing aids, for example, are a common exclusion, as is any test, treatment, or service currently considered experimental.
[2] Available at https://www.mcg.com/care-guidelines/care-guidelines/.

initial provider to submit additional information to the plan or insurer and appeal the denial. The plan or insurer is then required[3] to access one or more clinicians "competent to evaluate the specific clinical issues" to review the submitted information. If the medical necessity determinations of those clinicians disagree with the initial provider's, the plan/insurer will deny the appeal.

3. **Request Review:** After an appeal has been denied, an enrollee may then ask the appropriate regulator (DMHC or CDI) to review the plan/insurer denial. For cases related to medical necessity, consideration from another clinician is acquired through the Independent Medical Review (IMR) process[4,5] that the regulator is required[6] to maintain.[7] If that external and independent clinician's medical necessity determination disagrees with the plan/insurer's determination (and agrees with the initial provider), the decision of the plan/insurer will be overturned, and the plan/insurer will be required to cover the test, treatment, or service.

As previously mentioned, few enrollees use more than the first step because plans and insurers generally accept the initial provider's medical necessity determination. Of those enrollees who experience a denial, not all appeal or ask a regulator to review; some forgo care, and some switch to a test, treatment, or service more likely to be considered medically necessary by their plan or insurer. However, for enrollees making appeals and requesting reviews, the steps above illustrate the possible involvement of multiple clinicians in the medical necessity determination process.

Medi-Cal Beneficiaries

For Medi-Cal beneficiaries enrolled in DMHC-regulated plans, the medical necessity determination process is most frequently identical to that of commercial/CalPERS enrollees described above: initiate, appeal, and request review. As is the case with the commercial/CalPERS enrollees, few Medi-Cal beneficiaries would use more than the first step. However, for those beneficiaries whose appeal is denied and whose plan denial is upheld through DMHC's IMR process, a fourth step is possible:

4. **Request Hearing:** A Medi-Cal beneficiary may request a "Medi-Cal Fair Hearing."[8] These hearings are organized by the California Department of Social Services and are not limited to Medi-Cal issues, but can address benefit coverage denials based on medical necessity determinations. Hearing decisions are made by an administrative law judge (Coursolle, 2015). Should the hearing judge disagree with the plan's determination (and agree with the initial provider), the decision of the plan or insurer will be overturned, and the plan or insurer will be required to cover the test, treatment, or service.

For Medi-Cal beneficiaries, the sequence of steps and set of involved actors would differ for benefit coverage that is carved out. For the benefit coverage purchased from DMHC-regulated plans for Medi-Cal beneficiaries, the California Department of Healthcare Services (DHCS) can either cover some benefits itself or arrange for the benefit to be carved out (and so covered by other entities).[9] Specialty mental health services, for example, are a covered set of tests, treatments, and services that are standardly carved out.[10] For a carved out test, treatment, or service, the beneficiary's DMHC-regulated plan would not be involved and so DMHC's IMR process would not be an option. For this reason, there

[3] California Health & Safety Code 1370.2 or California Insurance Code 10112.81.
[4] See https://www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewandComplaintReports.aspx.
[5] See http://www.insurance.ca.gov/01-consumers/101-help/Independent-Medical-Review-Program.cfm.
[6] California Health & Safety Code 1374.30 and California Insurance Code 10169.
[7] Studies have indicated that the vast majority (72%) of all DMHC and CDI IMR cases relate to medical necessity (CHCF, 2012).
[8] See https://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx.
[9] Purchasers of enrollment in commercial plans and policies (including CalPERS) can also specify carve outs, but do not so commonly do so.
[10] See https://www.dhcs.ca.gov/services/Pages/Medi-cal_SMHS.aspx.

would be only three possible medical necessity determination steps: initiate, appeal, and request hearing. In such cases, either DHCS itself or the other entity covering the carved out benefit would take the place of the DMHC-regulated plan. DHCS or the other entity would consider the initial provider's determination, respond to any appeal made by the beneficiary, and be required to comply with any determination made by a Medi-Cal Fair Hearing judge.[11]

Conclusion

Medical necessity determinations always begin with an enrollee's provider — and most commonly end at that point, with the enrollee's DMHC-regulated plan or CDI-regulated insurer accepting the initial provider's determination. However, plans and insurers have their own criteria for determining whether a given procedure is medically necessary (criteria that may vary from plan to plan and insurer to insurer) and may disagree. When the plan/insurer disagrees with the initial provider's determination, further steps may occur. Such further steps generally involve determinations by other clinicians accessed by the plan/insurer or by the appropriate regulator. Throughout the process, all medical necessity determinations consider both the enrollee's current health and then current clinical standards of care.

[11] The same set of steps would be relevant for Medi-Cal beneficiaries enrolled in County Organized Health Systems (COHS) for tests, treatments, and services covered by the COHS (Coursolle and Landauer, 2014). For Medi-Cal beneficiaries accessing benefit coverage through the Medi-Cal fee-for-service (FFS) program, the same steps would also be relevant, with the Medi-Cal program itself, reviewing the initial provider's determination and any appeal, and being required to comply with any determination made by a hearing judge.

Appendix: Definitions of Medical Necessity

Although they offer limited guidance to determining the medical necessity of a particular test, treatment, or service for a particular enrollee at a particular time, a number of broad definitions may be applicable for enrollees in plans and policies regulated by DMHC or CDI.

For example, plans and insurers regulated by DMHC or CDI, in addition to referring to internal/external clinical guidelines, may adopt a broad definition of medical necessity. Such broad definitions may be similar to the one offered by the American Medical Association, which defines as medically necessary:

> Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or documented physician specialty society recommendations.[12]

Additionally, for all enrollees in DMHC-regulated plans and CDI-regulated policies, for treatments of mental health and substance use disorder, California law defines as medically necessary:

> A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following: (i) In accordance with the generally accepted standards of mental health and substance use disorder care. (ii) Clinically appropriate in terms of type, frequency, extent, site, and duration. (iii) Not primarily for the economic benefit of the disability insurer and insureds or for the convenience of the patient, treating physician, or other health care provider.[13]

Furthermore, for all Medi-Cal beneficiaries, including those enrolled in DMHC-regulated plans, for all tests, treatment, and services, California law indicates:

> A service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.[14]

[12] AMA Policy H-320.953. Available at: https://policysearch.ama-assn.org/policyfinder/detail/H-320.953?uri=%2FAMADoc%2FHOD.xml-0-2625.xml.
[13] Health and Safety Code 1374.72 (a)(3)(A) and Insurance Code 10144.5 (a)(3)(A).
[14] Welfare and Institutions Code 14059.5.

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