

Responsiveness Summary – Medical Necessity for Covered Services

Comment on HCAR 4.101.1(b): To make clear that “generally accepted medical practice standards” may be based on any of the three listed bases (credible scientific evidence, physician specialty society recommendations, and prevailing opinion of providers practicing in the relevant clinical area), the word “or” should be inserted between sub (1) and sub (2).

Response: The use of “or” at the end of the text at HCAR 4.101.1(b)(2) clearly indicates that “generally accepted medical practice standards” may be based on any of the three listed bases. The use of “or” in this list is consistent with its use in other lists in HCAR (e.g., HCAR 4.104), and we believe that changing its use here would only add confusion to the rule due to the inconsistency it would inject into the rule. The rule is not being revised.

Comment on HCAR 4.101.1(c)(1) and (2): Insert the words “will or are reasonably expected to” at the beginning of these paragraphs. When particular treatments or services are recommended, they are done so in the hopes that the treatment or service will help restore or maintain a beneficiary’s health, or prevent deterioration or palliate the beneficiary’s condition. There is no guarantee that a recommended treatment or service will absolutely achieve the desired effect.

Response: Neither the proposed rule nor the rule that is currently in effect, which is worded similarly to the proposed rule in regard to this comment, require that a treatment be “guaranteed” to “absolutely achieve a desired effect,” in order to be considered medically necessary. DVHA clinical staff who determine medical necessity do not require that a prescribed treatment be guaranteed to achieve a particular result. It is understood that it is not possible for a provider to guarantee that a particular outcome can be reached based upon a treatment as responses to treatment are so individualized. We are not aware of any situation in which the Medicaid Agency has denied services based upon an interpretation of medical necessity that requires that the success of a service be guaranteed. The rule is not being revised.

Comments on HCAR 4.101.1(c)(3)

This paragraph is new and constitutes an additional restriction on access to services. As such it should be deleted in its entirety.

VMS has concerns with the addition to the definition of “medically necessary” that the service be “the least costly, appropriate health care service that is available.” The definition of “medically necessary” already incorporates that the service be “appropriate in terms of type, amount, frequency, level, setting and duration.” Beyond those factors, the service should be clinically appropriate as further defined by items (C) (1), (2), (4) and (5). Adding cost to the list

of defining characteristics of the service complicates interpretation of this section as the list now blends cost and clinical factors and because it is unclear if the service has met all of the other criteria but may be more expensive (for example, because the location of the service provider is closer to the location where the patient lives) does this make the service no longer “medically necessary?”

Further, the prior authorization process anticipates separate consideration of medical necessity and cost (prior authorization can weigh whether “ the proposed health service is medically needed [and] that all appropriate, less-expensive alternatives have been given consideration...” (Previously Rule 7102). It makes interpretation difficult to incorporate both of these elements within the one definition and analysis of medically necessary.

Response: Most State Medicaid Agencies consider cost in deciding whether to cover a requested service and many consider cost as a factor in determining medical necessity (e.g., Connecticut, Massachusetts, New Hampshire, Oregon, Rhode Island, Colorado, Iowa, Maryland, Ohio, Tennessee, Washington).

Vermont Medicaid has always considered cost in determining whether a service will be covered. Cost is a longstanding required consideration whenever the Agency is requested to prior authorize any service (DVHA Covered Services Rule 7102.2 states that a “request for prior authorization of a covered health service will be approved if the health services is.... the least expensive, appropriate health service available.)

In response to a commenter’s question, a service that meets the criteria at proposed rule 4.101.1(c)(1), (2), (4), and (5) may be determined not medically necessary if there is another service that also meets these criteria and is also less costly, appropriate, and available. For example, Vermont Medicaid generally does not cover a name brand prescription medicine when a less costly generic is appropriate and available.

Vermont Medicaid is in the process of removing prior authorization requirements from many of its services. Accordingly, it is critical that cost be considered in determining whether medical necessity is met since many services will no longer undergo the prior authorization process.

The rule is not being revised.

Comment on HCAR 4.101.1(c)(4): This paragraph is new and constitutes an additional restriction on access to services. As such it should be deleted in its entirety.

Response: The commenter’s characterization of the proposed revision is not accurate. This rule change simply codifies Vermont Medicaid current practice of not covering services that are needed **solely** for the convenience of a provider or a beneficiary’s caregiver.

Many other Medicaid Agencies consider convenience when determining medical necessity (e.g., Connecticut, New Hampshire, Rhode Island, Colorado, Florida, Iowa, Maryland, Oregon, Tennessee). The majority of these states determine that a service is not medically necessary if it is “primarily” for the convenience of a caregiver, provider, or the beneficiary. By contrast, Vermont Medicaid proposes to align its approach with the approach taken by Oregon and Rhode Island, which require that a beneficiary’s request for services be denied for medical necessity only if the **sole** reason for the service is for the convenience of a provider or caregiver.

The rule is not being revised.

Comment on HCAR 4.101.1(c)(5): This paragraph is confusing. What is meant by “documentation of medical evidence?”

Response: We have revised the rule to eliminate the confusion suggested by the commenter.

Comment: The proposed rule omits from the definition of medically necessary, health services that “prevent the reasonably likely onset of a health problem or detect an incipient problem. This language is in the current definition of medically necessary health services at Rule 7102(C). As preventive care is a critical aspect of containing health care costs, this language should be retained in the proposed rule.

Response: The referenced language was removed as unnecessarily repetitive of the criteria at HCAR 4.101.1(c)(1), “help restore or **maintain the beneficiary’s health**,” criteria that is intended to provide for the coverage of preventive care services. The text is being removed solely because it is repetitive. The rule is not being revised.

Comments on HCAR 4.101.2(b):

[F]ails to include the full scope of EPSDT medical necessity as set forth in proposed 4.106 to include services that are “needed to achieve proper growth and development or prevent the onset or worsening of a health condition.”

VMS is concerned with the removal of weighing whether a service will help “achieve proper growth and development” from the definition of medical necessity for EPSDT services in 4.101.2 (b). The current rule for EPSDT services (7410) and proposed in 4.106.5 (b)(3) contain this phrase and VMS believes this is an important element of the EPSDT program. This phrase should be maintained in 4.101.2 (b).

Response: The text at issue - “needed to achieve proper growth and development or prevent the onset or worsening of a health condition-” is already set forth at HCAR 4.106.5(b)(3); however, we have moved this text from HCAR 4.106.5(b)(3) to the medical necessity rule in response to commenters’ recommendations.

