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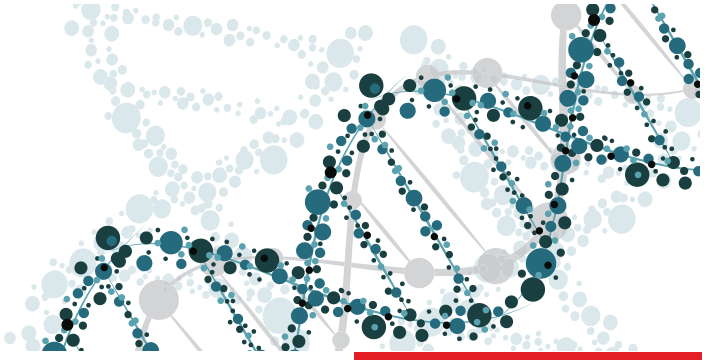
Global Health Brief



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Understanding Medically Necessary (Medical Necessity)

The goals of patients, medical care providers, and payers (e.g., insurers, governments) should align to provide the most effective processes to diagnose and treat a patient's health conditions. When cost enters the equation, however, friction can develop, as medical provider businesses seek to generate and maximize profit, insurers to mitigate their claim spend, and policyholders to make sure their medical needs are met, claims approved, and out-of-pocket outlays kept reasonable. To strengthen cost control, insurers generally specify they will only cover treatments defined as "Medically Necessary." Understanding this concept, and then applying it for medical claims, is increasingly essential.

This Global Health Brief provides an introduction and overview of the concepts involved. More information as well as detailed case studies can be found in RGA's Global Claims Manual. Additional information and training is available upon request from your local RGA Health Claims representative.

Sincerely,

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Vice President, Head of Global Health Claims
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The concept of "Medically Necessary" (also known as "medical necessity") refers to the care a physician, exercising prudent clinical judgment, provides to a patient. The phrase "prudent clinical judgment" is key here, as Medically Necessary care is much more than only what a physician or care facility recommends or provides. It is the standard of care developed and accepted by appropriate medical bodies and affirmed by peer-reviewed research.

Health insurers focus on making sure the medical resources they cover are utilized efficiently and effectively. Ensuring that treatments covered meet the "Medically Necessary" standard requires clear and precise policy language. This approach protects both insurers and patients, as it optimizes patient care, manages costs, limits overutilization, and reduces fraud, waste, and abuse.

Sample Definitional Language

Health insurance policies should state clearly that only treatments meeting the issuing insurer's "Medically Necessary" definition qualify for coverage.

This clarity is important, as a robust "Medically Necessary" definition, along with specific language around exclusions,

provides a fair and transparent mechanism for the assessment of claims and tools to challenge overutilization. A doctor's recommendation or prescription is not sufficient, as situations can occur where physicians or care facilities recommend unnecessary/unproven treatments, overprescribe, overtest, and over-hospitalize.

Sample Definitional Language:

"Medically Necessary'" (or Medical Necessity) shall mean healthcare services that a healthcare provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms that are:

- in accordance with current generally accepted standards of medical practice
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury, or disease
- not provided for the convenience of the patient or healthcare provider, the physician, or any other healthcare provider
- not experimental
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the patient's illness, injury or disease

For this purpose, "generally accepted standards of medical practice," shall mean:

- credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community
- physician and healthcare provider specialty society recommendations
- views of physicians and healthcare providers practicing in relevant clinical areas
- other relevant factors

Definitional language can be introduced either as part of the Statement of Cover (e.g., "This policy only provides cover for treatment that is Medically Necessary), or as an exclusion (e.g., "This Policy does not cover any treatment not Medically Necessary").

A good definition ensures claims assessors are alert to:

- Ordering of tests and monitoring unrelated or unnecessary to diagnose the claimed-for condition
- Extending treatment longer than necessary or appropriate
- Hospital admittance for treatments that can be provided on day patient or outpatient basis
- Keeping a patient in the hospital longer than needed, or admitting unnecessarily early (e.g., on the day prior to scheduled surgery if no tests or preparations need to be completed as an inpatient)
- Providing non-effective treatment (i.e., treatment that does not successfully treat the claimed-for condition)
- Prescribing a more expensive treatment than an alternative that would provide the same clinical efficacy
- Providing treatment in a higher clinical setting than needed (e.g., a hospital and not an outpatient clinic)
- Providing treatment based on the convenience of either the doctor or patient and not the medical need

It is important that claims assessors avoid stating a treatment was "not required." Comments should be restricted to whether the treatment received met the policy definition of "Medically Necessary."

Assessing Cases

Many factors will determine the scope of treatments patients receive. When reviewing a case, claims assessors need to examine not only the full treatment regimen, but also each of the elements. Although it is rare for a full regimen not to meet an insurer's "Medically Necessary" criteria, some elements of it may not. Assessors must be alert to these elements so that they can mitigate possible fraud and abuse.

A patient's ability to benefit from treatments can vary considerably, because of factors such as existing comorbidities and/or sensitivities, pharmaceutical contraindications, and genetic predispositions. If an individual treatment or treatment regimen differs from accepted clinical practice, insurers need a process in place so that an assessor, in association with their clinical team, can investigate the treatment recommendation, obtain an explanation for its use that is supported by appropriate evidence, and then use that information to reach an appropriate decision. If, for example, a claim shows elements of care that do not follow usual clinical practice or guidelines, the medical provider can be asked to explain the deviation and show appropriate evidence for its use.

An assessor would also need to validate which items of a treatment regime meet the insurer's "Medically Necessary" criteria and which do not, by comparing the treatment received against appropriate clinical guidelines.

Table 1: Examples of Acceptable Clinical Guidelines

Commercial ▪ MCG Health ▪ Change Healthcare (InterQual)
Medical societies /associations ▪ American Heart Association ▪ National Comprehensive Cancer Network
Government-sponsored ▪ National Institute for Health Care and Clinical Excellence (NICE) ▪ U.S. Health and Human Services' National Guideline Clearinghouse

If an appropriate clinical guideline is not available, insurers may develop internal guidelines and validate them with appropriate clinical staff.

A well-constructed health claim IT system can also support assessors by bringing consistency to claims evaluation. A good system will check and validate each element of treatment and its cost, and highlight any outliers, such as:

- Whether the treatment was appropriate for the diagnosis
- Whether a claimed inpatient procedure would normally be done on an outpatient or day-patient basis
- Whether the hospital stay exceeded the expected length of stay based on a patient of a similar age and gender receiving similar treatment
- Whether a brand-name drug was prescribed when a generic version was available.

Assessment Criteria

Insurers also need to have internal criteria against which they assess the medical necessity of claimed treatments. For example, the medical necessity of continued hospitalization is primarily determined by the presence of a medical condition of such severity that ongoing diagnostic or therapeutic intervention, or at least careful monitoring, is required.

Criteria to evaluate a patient's condition and care should include:

- Vital signs, including temperature, blood pressure, and heart rate
- Stability of pathology results
- Level of pain
- Ability to receive nutrition
- Ambulatory status
- Status of surgical wounds

Claims assessors should not rely solely on standard questionnaires. They should also ask questions appropriate for each patient, their treatments, and the clinical indications underpinning decisions that may fall outside of their company's definition of "Medically Necessary."

Best Practices

- **Pre-authorization**
  Many insurers require pre-authorization for scheduled surgical procedures, hospital admission, and advanced imaging. Good practice is also to authorize the expected length of stay in advance, and if an extension is needed, for the insurer to be notified so that it can authorize the extension. This allows an insurer to establish the medical necessity of the length of the admission and the extent of the planned treatment. If an unnecessary or extended admission is identified, the admitting physician can be asked to provide clinical justification in advance.
- **Concurrent Review**
  If a claimant is admitted for longer than expected, an insurer may undertake concurrent review of the treatment. This involves a claims assessor reviewing a patient's present condition against their current and ongoing clinical treatment plans to ensure both the ongoing admission and treatment elements are "Medically Necessary." The review should be undertaken in association with the patient's treating physicians and by appropriately qualified personnel.
- **Peer Review**
  In some markets, if there is a dispute about whether or not to cover a particular element of treatment, independent peer review, where a specialist physician conducts a post-treatment review, is possible. This process is normally requested and paid for by the insurer. The reviewer should be wholly independent of the insurance company, the patient, and the treating physician, be qualified in the specialist area concerned, and be of appropriate clinical standing. The reviewer will also need to be provided with access to complete medical records and details of all treatment, which will be evaluated against the latest best practice guidelines.

- **Additional Policy Language**
  If patterns of fraud or abuse around medical necessity are identified, insurers may consider adding specific policy language to the definition to clarify and address the patterns. For instance, if patients are routinely admitted early or discharged late without medical reason, insurers can add: “We will not pay for early admission or for late discharge charges.” Or, if patients are routinely admitted to hospitals for procedures that can be safely performed on an outpatient or day-patient basis, insurers can add: “We will not pay for treatment received as an inpatient when the treatment can be received on an outpatient or day-patient basis.” These guidelines can be relaxed if medical necessity is proven.
- **Appeals Process**
  Health insurers are advised to provide an appeal process for claimants to challenge a denial decision using “Medically Necessary” as the reason. This process should be transparent, fair, and timely.

Summary

RGA recommends health insurers include a clear, well-worded definition of “Medically Necessary” in their policies that requires all treatments be in line with current clinical practice. Insurers should also have systems and processes in place to identify and challenge inappropriate and unnecessary treatment. However, they should be willing to review evidence that may clarify and confirm a treatment’s medical necessity. ■