



## POLICY STATEMENT

# Essential Contractual Language for Medical Necessity in Children

## abstract

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The previous policy statement from the American Academy of Pediatrics, “Model Language for Medical Necessity in Children,” was published in July 2005. Since that time, there have been new and emerging delivery and payment models. The relationship established between health care providers and health plans should promote arrangements that are beneficial to all who are affected by these contractual arrangements. Pediatricians play an important role in ensuring that the needs of children are addressed in these emerging systems. It is important to recognize that health care plans designed for adults may not meet the needs of children. Language in health care contracts should reflect the health care needs of children and families. Informed pediatricians can make a difference in the care of children and influence the role of primary care physicians in the new paradigms. This policy highlights many of the important elements pediatricians should assess as providers develop a role in emerging care models. *Pediatrics* 2013;132:398–401

The American Academy of Pediatrics (AAP) published the policy statement “Model Contractual Language for Medical Necessity in Children” in July 2005.<sup>1</sup> The chief principles articulated in that statement are still relevant, but given the structural shifts in the health care delivery system, they no longer adequately address the unique needs of children. This revised policy statement is an update of the 2005 statement.

In light of the passage and ongoing implementation of the Patient Protection and Affordable Care Act (ACA [Pub L No. 111-148]) in 2010, contractual obligations, as expressed in health plan-provider and health plan-beneficiary agreements, have a new significance with respect to the array of health care benefits made available to children and families. In particular, a much used term—“medical necessity”—is, in fact, generally ill defined. As stated in the previous policy statement, “The term ‘medical necessity’ is used by Medicaid and Medicare and in insurance contracts to refer to medical services that are generally recognized as appropriate for the diagnosis, prevention, or treatment of disease and injury.” The term is found in insurance contractual language, and, as stated in the 2005 policy statement, “... an intervention will be covered if it is an otherwise covered category of service, not specifically excluded, and medically necessary.” It

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**KEY WORDS**

medical necessity, contractual language, pediatric care, children, insurance, health plans, payment

**ABBREVIATIONS**

AAP—American Academy of Pediatrics

ACA—Patient Protection and Affordable Care Act

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would appear that this statement provides a straightforward presentation of medical necessity. However, health insurance coverage is moderated by a host of federal regulations and statutes, state mandates, and other rules. Provider agreements are usually written to incorporate these rules and regulations. As the US Department of Health and Human Services moves to implement the provisions of the ACA, essential health care benefits are not guaranteed to be the same in every state. Consequently, benefits for children may vary from state to state or plan to plan and may contain specific exclusions. The AAP advocates for quality health care for children that promotes optimal growth and development with measures intended to prevent, diagnose, detect, ameliorate, or palliate the effects of physical, genetic, congenital, mental, or behavioral conditions, injuries, or disabilities.

Individuals with health insurance coverage, whether it be Medicaid, Medicare, or commercial insurance coverage, may be unaware of payment or benefit restrictions for the medical services they seek. In addition, services ordered by a physician might only be covered if conditions of medical necessity are met. Medical necessity means that a decision is needed about appropriateness for a specific treatment of a specific individual. The 2005 AAP statement drew on model language developed by Stanford University<sup>2</sup>; however, more specific considerations are needed for children because of their unique needs. Now, as the US Department of Health and Human Services is charged with implementation of the ACA, it is time to address medical necessity and the needs of children. Although Medicare has become the de facto standard of health care benefits and directly influences

commercial health care benefit plans, it is important to realize that health care standards designed for adult care often will not meet the needs of children. By and large, the Medicaid program provides coverage for a significant number of children, and it, too, can be influenced by health care standards designed for adults.

A definition of medical necessity for children must recognize that the needs of children differ from those of adults. The foundation for medical necessity for children should be based on the comprehensive, fully inclusive set of services provided by the Early and Periodic Screening, Diagnosis, and Treatment regimen embodied in Medicaid as well as the preventive care recommendations in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, as stipulated in Section 2713 of the ACA.<sup>3</sup> The language in the Stanford statement considered the scope of health problems, evidence of effectiveness, and value of the intervention. Medical necessity should be guided by these criteria, but health plan and even Medicare language generalizes across populations, as opposed to focusing on specific individuals or groups, including children, often in a manner that is blind to their particular needs. A definition of medical necessity is needed that is more functional or operational and specific to meet the needs of children. Informed pediatricians can help advance such a definition.

Variability in “Essential Health Benefits,” as intended by the ACA, is also cause for concern. There are 10 categories of Essential Health Benefits, including item 10—pediatric services including vision and oral care. The states are allowed individually to define the benefits for each of these 10 categories. Therefore, there is a great likelihood of significant variation

in pediatric benefits throughout the nation. States are likely to use different methods of determining medical necessity.

Some examples may help to illustrate the unique needs of children. One such example is the nuance between rehabilitative and habilitative services. Rehabilitative and habilitative services and devices are specifically addressed as 1 of 10 necessary categories of Essential Health Benefits in the ACA. Currently, in many instances, health care coverage is limited to rehabilitative services, referring to the need to restore a lost function. Habilitation suggests a function or skill not yet acquired or attained. More specifically, the National Association of Insurance Commissioners defines habilitation as “health care services that help a person keep, learn, or improve skills and functioning for daily living.” With today’s medical knowledge, conditions poorly understood in the past may now be subject to significant improvement, even functions that have not yet been acquired. Habilitation and rehabilitation services are usually provided by the same professionals, the only difference being the indication for therapeutic intervention. The case is also illustrated when one considers speech therapy for a child with autism or physical therapy for a child with hypotonia—motor skills and developmental milestones not yet achieved. Every newborn infant is a well of unknown potential. The terms habilitative and rehabilitative should be interchangeable where children are concerned. Developmental milestones represent standards achieved by most children in a given time frame, but not all children follow the same trajectory. A primary focus needs to be on the potential for functional gain—hence, habilitative services.

Evidence of effectiveness is a cornerstone of medical necessity, yet such data for children may not be readily available. It would be beneficial if medical necessity was governed by traditional evidence grading, and if not available, a hierarchy or algorithm of standards should be applied. The AAP has published 2 policy statements to aid decision makers in classifying clinical recommendations and ensuring transparency in issuing clinical guidelines.<sup>4,5</sup> If patient-centered or scientific evidence for children is insufficient, then professional standards of care for children must be considered. The AAP, other pediatric medical specialty societies, and consensus expert pediatric opinion could serve as references for defining essential pediatric care in the context of medically necessary services. **Hence, the pediatric definition of medical necessity should be as follows: health care interventions that are evidence based, evidence informed, or based on consensus advisory opinion and that are recommended by recognized health care professionals, such as the AAP, to promote optimal growth and development in a child and to prevent, detect, diagnose, treat, ameliorate, or palliate the effects of physical, genetic, congenital, developmental, behavioral, or mental conditions, injuries, or disabilities.**

Value is another parameter in the consideration of medical necessity. Value is not simply a cost-benefit assumption. Value, in fact, may be a subjective consideration. The recipient may have an entirely different perception of value than the provider or payer. Value implies quality (ie, access to age-appropriate care, in an appropriate setting, by appropriate personnel) plus desired outcome at a reasonable cost. Pediatricians

recognize the so-called marginal effect of some services—extensive interventions for limited or no essential benefit. However, children deserve the intent embedded in the Medicaid provision of the Early and Periodic Screening, Diagnosis, and Treatment regimen, specifically treatment. Given a pediatric definition of medical necessity as mentioned previously, the value of services might also be considered. Examples in which this is particularly true include children with autism spectrum disorders, neurodevelopmental disorders, or expressive speech delay, conditions for which needs are unique and improvement may be slow. Similarly, services that have been provided for an appropriate period of time by an appropriate provider could be discontinued if there is no measureable benefit. In short, services should be provided to children, but continuity is only ensured if there is evidence of a significant measureable benefit. It may be that the only therapeutic benefit is maintenance at a given level of function. If this facilitates more manageable daily living, then the service has value. This might best be exemplified by the continuation of occupational or physical therapy for a child with neurologic damage if only to facilitate safe transfers or to minimize the usual contractures. The goal is to achieve value for both the recipient and the provider. Resources are limited, but every child, with or without disability, deserves the opportunity to declare his or her potential for improvement in his or her daily life. Difficult decisions are part of medical necessity. Cost should not be the basis for denial of services, but the delivery of care in a setting that demonstrates lower cost could be acceptable if quality is not compromised.

Transparency in today's health care delivery system is essential to credibility. Health plans need to be clear with respect to the evaluation and determinations of medical necessity. The decision pathway, authority credentials of decision makers, and timeliness in the process should feature identifiable criteria or benchmarks in rendering decisions relevant to medical necessity. The expectations of all health plans, including Medicaid and Medicare, should be clear in anticipation of medical necessity requirements, and similarly, the decision-making process should be equally transparent. Consideration might be given to the role of a family advocate or ombudsmen in protecting children and families and intervening to aid in solving their problems related to medical necessity decisions.

As health care reform advances, contracts between providers of care and health care organizations, whether they are medical group practices, accountable care organizations, or health plans, will define expectations and obligations. Essential language should exist to address the unique needs of children in the context of medical necessity. The right of a child to optimal growth and development should be a universal expectation limited only by the restraints of physical or genetic conditions. New and emerging health care delivery models, including accountable care organizations, bundled payments covering hospital and physician services, disease-management models, and others, will influence how health care services are managed for beneficiaries. There will also be contractual arrangements with providers of primary and specialty care, and federal and/or state regulations will influence these contractual relationships. This time of transition affords pediatricians

an opportunity to affect not only overall health care benefits but also the medical necessity decisions that affect pediatric care. All of these agreements should feature essential language that recognizes the unique needs of children and ensures more equitable care for all children. The AAP and its member pediatricians are the informed advocates who can advance a better understanding of medical

necessity decisions on behalf of children.

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