

Additional Stakeholder Feedback to Proposed Medical Necessity Definition

P. Cook

What is missing is how the medical staff are asked to support a client. It is usually a ADL/ MI or some combination of issues that can be traced back to chronic disease. Behaviors drive need much more than tasks such as a J tube or pulmonary care.

That is what confuses medical necessity- need for oversight or direct supervision that impacts the health of the client.

Somehow, I would like medical necessity to reflect the reality of services.

So all that below [referring to proposed definition] is nice and legalese but not the real issue for asking for more supports in the home. Behavioral interventions for all ages demonstrate successful living. I suspect that this issue is well documented and when I catch up on some pressing work I will look for it to help you.

My experience for 25 years demonstrated that behaviors impacts overall chronic or acute care is really the driving factor plus how people/ families cope, learn and respond to change. I don't expect to win but sure would like the conversation to discuss this section.

A. Flores-Brennan

Below are some of my thoughts after the (January 13th) meeting and further review of materials.

We concur with many of the comments made during the meeting, and by way of follow up I consulted with our colleagues at OneColorado on LGBT implications. Here are some thoughts/comments.

First, it may be advisable to further clarify whether the entire definition presented is the definition of medical necessity, or if the first paragraph is the definition and the bulleted list is a standard for applying the definition.

Second, the structure of the first paragraph is not well aligned between the first and second sentences. The first sentence says "medical necessity means...good or service", but the second sentence begins "It may also include." Does "It" reference medical necessity or does "it" reference good or service.

Third, it may be necessary to explicitly specify in the second paragraph whether "A good or service" includes the previously referenced course of treatment.

Fourth, subparagraph (a) could potentially exclude many services for transgender people since the standards of care are international. Alternative language could be, "Consistent with generally

accepted practice parameters as recognized by health care providers in the same or similar specialty or those who typically treat or manage the diagnosis or condition.”

Fifth, in reference to subparagraph (b), further defining who determines clinical appropriateness is important. The definition of medical necessity seems to exclude any deference to the expertise of the treating provider. The treating provider, together with the patient, are in the best position to determine a course of treatment, not the Department, or an ALJ.

Sixth, we agree with the comments on subparagraph (c) and would encourage the department to delete the paragraph altogether. Fraud and utilization can be addressed elsewhere in regulation. At a minimum, the economic benefit and convenience clauses should be separated and the department should consider modifying convenience with “solely for the convenience of the client...”.

Seventh, we concur that subparagraph (e) should include the plural, settings, rather than setting.

Finally, we are concerned that 8.280.1.2.d referencing achieving functional capacity with ADLs has been removed and encourage the department to include this provision in its baseline Medical Necessity definition.