Understanding Medical Necessity

Today's Presenters

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Overview

- Introduction
- Medical necessity
- Evidence-Based Practice
- Level of Care Guidelines
- Best Practice Guidelines
- Examples of Evidence-Based Practice
- Case vignettes
- Preparing for a peer review discussion
- Cultural competency

Introduction

- Medical and mental health care: there is a trend toward measured outcomes, best practices and use of evidence-based practices

- Member-focused treatment:

  - The member's needs come first

  - Care is based on authorizing all services that are medically necessary, including community based services

  - Do what is known to work

Optum Idaho is committed to clinical excellence

- Our enhanced clinical program uses *nationally approved criteria* to identify cases that require further clinical review to ensure that members are:

  - Receiving services that support recovery and resiliency

  - In the right treatment at the right time in their lives

- Standardized clinical criteria support delivery of medically necessary treatment

- Evidence-based practices support

  - Diagnostic accuracy

  - Effective results

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What is medical necessity

The State of Idaho's regulatory definition of medical necessity:

A service is medically necessary if:

- It is reasonably calculated to prevent, diagnose, or treat conditions in the member that endanger life, cause pain, or cause functionally significant deformity or malfunction; and

- There is no equally effective course of treatment available or suitable for the member requesting the service which is more conservative or substantially less costly

- Medical services must be of a quality that meets professionally recognized standards of health care and must be substantiated by records including evidence of such medical necessity and quality

Location of definition: IDAPA 16.03.09.011.16:

http://adminrules.idaho.gov/rules/current/16/0309.pdf

What is medical necessity (continued)

Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Services

- Medically necessary services for eligible Medicaid participants under the age of twenty-one (21) are healthcare, diagnostic services, treatment, and other measures described in **Section 1905(a) of the Social Security Act** (SSA) necessary to correct or ameliorate defects, physical and mental illness, and conditions discovered by the screening services as defined in Section 1905(r) of the SSA, whether or not such services are covered under the State Plan

- Services must be considered safe, effective, and meet acceptable standards of medical practice

Location of definition: IDAPA 16.03.09.880:

http://adminrules.idaho.gov/rules/2014/16/0309.pdf

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What is medical necessity (continued)

The Optum Idaho Provider Manual defines medical necessity on page 16:

– Generally, the evaluation of health care services is to determine whether the services meet plan criteria for coverage: are medically appropriate and necessary to meet basic health needs; are consistent with the diagnosis or condition; are rendered in a cost-effective manner; and are consistent with national medical practice guidelines regarding type, frequency and duration of treatment. The Level of Care Guidelines and Best Practice Guidelines that are used by Optum Idaho Care Managers in the determination of medical necessity are available on optumidaho.com.

Location of manual:
https://m1.optumidaho.com/c/document_library/get_file?uuid=852658a4-9743-4700-a850-7ef7cd19ebb2&groupId=110293

Medically necessary treatment planning

Treatment planning should take into account significant variables including:

- The member's current clinical need

- The member's age and level of development

- The member's motivation for treatment (treatment methods may need to address low motivation for treatment)

- Are proposed services covered in the member's benefit plan?

- Are the proposed forms of treatment and the frequency and duration of treatment evidence-based?

- Are the proposed services available in or near the member's community?

- Are community resources such as support groups, peer services, and preventive health programs available to augment treatment?

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Appropriateness of care

- Services are clinically appropriate for the member's condition based on generally accepted standards of practice and benchmarks

- Optimal clinical outcomes results when evidence-based treatment is provided in an available level of care that is

  - Structured and intensive enough to safely and adequately treat the member's presenting problem

  - Support the member's recovery and resiliency

- Evidence-based practices are interventions that

  - Have been shown to be safe and effective

  - Have not been deemed experimental or investigative

  - Are appropriate for the treatment of the member's current condition

  - Sources of evidence include national standards as well as governmental standards

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Evidence-based practice (EBP)

A practice is considered evidence-based when:

- It is based on clinical trials published in peer-reviewed journals:
  - Measurable outcomes
  - Controlled and adequately-sized
  - Well-replicated in subsequent trials
  - Demonstrates adequate external validity

- Often described in Best Practice Guidelines by national professional organizations
  - Best Practice Guidelines are based on specific diagnoses
  - Some interventions strongly demonstrated effective in specific populations
  - Some interventions shown ineffective

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EBP, continued

- There has been a call for broad use of EBPs to *help improve care*
  - U.S. Surgeon General
  - Institute of Medicine (IOM)
  - President's New Freedom Commission Report on Mental Health
- Who has EBPs:
  - American Psychiatric Association (APA)
  - American Academy of Child and Adolescent Psychiatry (AACAP)
  - American Psychological Association (APA)
  - Governmental sources
    - Substance Abuse and Mental Health Services Administration (SAMHSA)
    - Center for Medicare and Medicaid Services (CMS)
    - U.S. Department of Veterans Affairs

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EBP, continued

- Optum's guidelines are derived from guidelines of the national health community

- *Help people get the care they need to reach recovery and resiliency*

- Our goal is to work with and provide training to providers about using Evidence-based practices for members

- An additional resource for information about evidence-based practices is Relias Learning, which is available at no cost to Optum Idaho providers

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Best Practice Guidelines

Links to the Best Practice Guidelines are located on the Optum website, Provider Express. These guidelines should be reviewed by all providers **prior** to rendering services to Optum Idaho members.

- The recommended guidelines for adults are developed and maintained by the American Psychiatric Association (APA)

- The recommended guidelines for children and adolescents are developed and maintained by the American Academy of Child and Adolescent Psychiatry (AACAP)

- Guidelines are always accessible at https://www.providerexpress.com/html/guidelines/preferredPracticeGuidelines/index.html

Level of Care Guidelines

Optum Idaho Level of Care Guidelines are reviewed and approved by both Optum and the Idaho Department of Health and Welfare (IDHW)

– These guidelines are always accessible at https://m1.optumidaho.com/web/optumidaho/providers Provider tab > Guidelines and Policies > Level of Care Guidelines

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Treatment of Oppositional Defiant Disorder (ODD)

- Overview of ODD
  - A pattern of behavioral and mood disturbance as defined in the DSM-5 which includes, but is not limited to
    - Irritable mood
    - Argumentative behaviors
  - Duration of symptoms is 6 months or more
  - Must cause clinical distress or impairment in functioning

  For a full description, please review the DSM-5

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Treatment of ODD, continued

According to the AACAP*, the two types of evidence-based treatments for youth with ODD are

1. Individual approaches in the form of **cognitive problem-solving skills training** during therapy services with Master's level clinicians

   – Individual approaches should be specific to problem encountered, behaviorally based, and as much as is possible oriented to the development of problem solving skills (Kazdin, 2005)

2. Family interventions in the form of **parent management training**

   – Family interventions are among the best-studied treatments in this context (Bearss and Eyberg, 1998)

* http://download.journals.elsevierhealth.com/pdfs/journals/0890-8567/PIIS0890856709619699.pdf

http://www.wjh.harvard.edu/~nock/nocklab/Nock_Kazdin_2005.pdf

http://pcit.phhp.ufl.edu/Literature.htm

Treatment of childhood depression

EBP guidelines for treatment of childhood depression, as outlined by the AACAP*

1. Family therapy

2. Medication management

3. Supportive psychotherapeutic management, which may include:

   - Active listening and reflection

   - Restoration of hope

   - Problem solving

   - Coping skills and strategies for maintaining participation in treatment.

   - Overall the effects of psychotherapy for the acute treatment of depressed youths are modest (Weisz et al., 2006)

* http://download.journals.elsevierhealth.com/pdfs/journals/0890-8567/PIIS0890856709620530.pdf

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2150594/

Treatment of childhood depression, continued

EBP guidelines for treatment of childhood depression:

- Literature regarding effective medication management approaches is extensive and changing

- Involvement of the family is essential for success

Vignettes for review

- The following vignettes were developed to provide general examples of treatment approaches relying on the Level of Care Guidelines and Best Practice Guidelines

- The vignettes are not based on actual cases, any resemblance is coincidental.

Adult clinical case

Mary is a 33-year-old female who lives with her mother and mother's boyfriend. She was recently hospitalized after a fight with her mother and brother and threatening to slit her wrists. She has been physically assaulting her family members and stated she wanted to kill her mother with a knife.

Mary's primary diagnosis is:

- Schizoaffective Disorder

- Medical concerns include Hypertension and Diabetes

During an interdisciplinary case conference the discharge planner reported Mary's mother does not dispense Mary's medications consistently. Mary also has difficulty with transportation to her physician appointments. Her sister was taking her to her appointments but as she is working now, she is unable to provide transportation to Mary at this time.

What would be your next steps/recommendations?

Recommendations

- Psychiatric management with effective medications

- Case management to coordinate transportation with AMR to medication appointments

- Family therapy to address family tension/violence (if the member and family agree to engage in family therapy)

- CBRS

  - Medication adherence skills, including development of medication self-administration skills

  - Improve anger awareness and support the use of anger management skills that are learned in therapy sessions (coordination of care is essential)

Child and adolescent clinical case

Robert is a 9-year-old who has defiant behavior at home and occasionally at school, throws tantrums, lies, refuses to be accountable for any misbehavior, instead blaming others. These behaviors have been present for 2+ years with gradual worsening over time. There are problems with inattention and impulsivity. He has not received a psychiatric evaluation, nor has he been evaluated for medications.

He lives with his mother, stepfather, and 2 younger siblings. He picks on his younger brother. His stepfather works the day shift and sees the children as the mother's responsibility. The mother describes being overwhelmed with Robert's behaviors and "at a loss" as to what to do.

What would be your next steps/recommendations?

Recommendations

- Diagnostic clarification to rule out considerations with consistent symptom patterns such as ADHD, depression or anxiety disorders, possible in-utero drug exposure or developmental delays

- Medication evaluation

- Family therapy (to include parenting skills training)

  – Empower the parents to be more effective

- Individual therapy

  – Development of problem-solving skills (including coping skills such as progressive relaxation or therapeutic visualization exercises)

  – Anger management skill training

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Child and adolescent clinical case #2:

Bobby is a 17-year-old male who was diagnosed with Schizophrenia at age 6. He has been stable on Risperdal for approximately 5 years with near cessation of auditory hallucinations and delusions. He had several hospitalizations prior to age 10 but has not been hospitalized since.

His family has been supportive. As he transitions into adulthood he wants to acquire skills for independent living and to pursue vocational rehabilitation services. Due to his "odd" behaviors, he has few friends and does not date. He requires reminders/prompts from his parents to bathe, maintain his basic hygiene and to take his medications. There are no legal issues. He does well at his alternative school setting.

Because of his illness, he has delays in maturation and his social skills are limited. He has difficulty generalizing behaviors from one setting to another.

What would be your next steps/recommendations?

Recommendations

- Continue receiving medication management services with his psychiatrist

- Supportive individual therapy to address life changes

- Family therapy

- CBRS

  – Medication adherence (compliance) skills

  – Development of living skills to address residual deficits that exist despite optimal medication management (including hygiene and basic independent living skills, such as shopping, cooking, laundry, housekeeping, etc.)

  – Skills to enhance community integration (interactions with the public, appropriate behavior in public settings, management of negative symptoms)

  – Mental health hygiene (sleep schedule, diet, recognition and management of an increase in symptoms)

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Child and adolescent clinical case scenario #3:

Joe is an 11-year-old who exhibits disruptive behavior in all environments. He has received a psychiatric evaluation and does not have depression, anxiety or ADHD and was not appropriate for medications due to the absence of a co-morbid disorder that would respond to medications.

His behaviors include punching his sisters, throwing objects at peers and overt defiance at school towards his teachers and other authority figures. He frequently receives detention. He does not have an individualized education plan (IEP).

Treatment in accordance with medical necessity standards has been in place for over 6 months with little to no improvement. He has been receiving individual therapy with problem-solving skills training. Family therapy with parenting skills training on a weekly basis has been tried.

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Child and adolescent clinical case #3, continued

Office based services were initiated for 3 months but due to the lack of improvement, home-based family therapy was tried for 3 additional months. Both parents are active substance abusers and have a highly conflicted relationship. They refuse to collaborate in the best interest of their child. Their behaviors and the lack of consistency increases Joe's "conditioned non-compliance".

A second opinion consultation with an experienced family therapist skilled in parenting skills training has occurred without any recommendations for change in technique.

What would be your next steps/recommendations?

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Recommendations

- Continue individual psychotherapy with problem-solving skills training

- Although CBRS is not a medically necessary treatment in this case, due to the failure of an adequate exposure to family therapy with parenting skills training, a request for a CBRS case specific exception can be made during the authorization process

- Continue to closely monitor family dynamics for any issues that require reporting to Child Protective Services

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Utilization management process

- **Level 1: Case review by master's-level Care Advocate**
  - Authorizations can be approved but not denied
    - *Level of Care Guidelines (LOCG)*
    - *Best Practices Guidelines*
    - *Evidence-Based Practices (EBP)*
- **Level 2: Peer-to-peer review by doctoral level clinician**
  - Authorizations can be approved or denied
    - *Additional EBP information*
    - *Special circumstances (case specific exceptions)*
- **Level 3: Appeal review by another doctoral level clinician**
  - Authorization decision can be upheld or over-turned

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Preparing for a peer review discussion

- A peer review is a clinical case review with another clinician (peer) that is used to make a determination regarding the medical necessity of services that are being requested

- Because this is a review with a clinician, it is recommended that another clinician (independently licensed) conduct these reviews

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Preparing for a peer review discussion

- When preparing for a peer-to-peer review, it is important to consider what you want to communicate to the peer reviewer. Items to consider include:

  - Details on how the service being requested will be used to reach treatment goals

  - Any modifications/changes to the treatment plan

  - If services have been occurring for an extended period of time, why are continued services needed

  - Any changes in behaviors or symptoms since the last review occurred

  - If access to services are limited due to where the member lives or issues related to transportation, this information must be shared with the peer reviewer

Goals of the Optum Idaho Cultural Competency Plan

Cultural Competence

- Understanding required to establish a culturally competent practice and/or organization

Understand

- Define the various cultures in Idaho
- Describe the unique medical and behavioral health issues for these respective cultures

Provide the Framework

- Clarify the importance of cultural competence for the behavioral health clinician providing care, services or treatment to a culturally diverse population

Introduce CLAS

- Culturally and Linguistically Appropriate Services in Healthcare (CLAS) outlines standards for cultural competency

Optum Idaho Cultural Competency Plan, continued

Provide a quantitative and qualitative analysis	• Member-focused quality improvement efforts are based upon a range of factors including, but not limited to:
	   • Age, gender, sexual orientation, presence of disability (i.e., intellectual, physical and/or visual/hearing)
	   • Geographic location and languages spoken

Assess diversity	• Ability of the Provider network and Optum Idaho to represent and address the linguistic, cultural and ethnic demographic needs

Provide a summary analysis	• Populations' clinical and risk characteristics
	   • Targeting current and future quality improvement efforts
	   • Identifying appropriate supportive education
	   • Developing prevention activities

Assist providers	• Integrate cultural and linguistically competent-related measures into
	   • Internal audits and performance improvement programs
	   • Member satisfaction assessments
	   • Outcomes-based evaluations

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Striking disparities

Striking Disparities

Disparities impose a greater disability burden on minorities who:

☑ Have less access to and availability of mental health services

☑ Are less likely to receive needed mental health services

☑ Receive a poorer quality of mental health care

☑ Are underrepresented in mental health research

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Thank You