

Medical Necessity For Children: Definitions That Include Oral Health

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The concept of medical necessity has come to play a central role in determining the extent to which individuals with chronic health conditions receive appropriate services in managed care systems. How this concept is defined and applied has major implications for whether needed services will be accessible to children with oral and craniofacial disorders. Understanding what medical necessity means to families, and adopting a collaborative approach to medical necessity decision-making will strengthen our Nation's service-delivery system.

A comprehensive understanding of medical necessity rests on the recognition that the medical, dental, social, and educational needs of children are all interconnected. The oral health of a young girl with spina bifida will shape her development over her lifetime just as surely as medications for her intermittent urinary tract infections. The outcomes of even the most technically brilliant surgeries to correct a cleft palate can be compromised by limited access to post-operative speech therapy.

Many administrators and medical directors of managed care organizations and state Medicaid agencies have yet to appreciate the urgency for reforming medical necessity decision-making. Few formal appeals come to their attention, and those that do are mostly decided in favor of the patient and family. Because appeals are few and judgments are favorable to consumers, the problem appears to be minor from an administrator's perspective.

In contrast, parents frequently encounter major problems related to medical necessity. These problems include long delays following a request for a special service or an "exception to policy," repeated justifications for on-going therapies, and unwillingness of case managers to either approve or disapprove a request in writing, often insisting that more information is needed to document the necessity of the service. One parent refers to this experience as "the non-denial denial." If a request is never formally denied, there are no opportunities to appeal because you can't appeal something that hasn't happened. In many cases, families give up and spend time on other more tractable problems. And so, the problem remains invisible to the administrators of public and private health plans.

The problem is less with narrow definitions than it is with the *process* of decision-making about what is medically necessary – a process that should involve the right persons with the right information deciding jointly what services will assist the child in reaching treatment objectives. The process of determining medical necessity should 1) incorporate appropriate outcomes within a developmental framework, 2) explicitly address the information needed in the decision-making process, 3) identify who will participate in the decision, 4) refer to specific standards appropriate to this population, and 5) support flexibility in sites of service delivery.

Another purpose for a clear definition of medical necessity is to distinguish it from "rationing." By definition, rationing means "to distribute equitably." It implies the withholding of treatment on the basis of both cost and outcome considerations. Rationing is a deliberate, if uncomfortable, decision to

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protect resources for the group as a whole at the expense of individual needs. Decisions about rationing must balance individual and group needs in light of expected costs. In contrast, decisions on medical necessity must be based on an individual's medical, health, and family situation, and not on cost. Here, the key question is: "Does this individual need a particular intervention to maintain to accomplish

Considerations of cost must be weighted carefully in deciding what services to cover and to what extent; and resources for society as a whole must be balanced against the needs of small populations. But linking these issues to definitions of medical necessity only serves to disguise society's difficulties in making the hard choices that rationing demands. Medical necessity should not be used in the service of rationing.

As we look ahead, several steps are needed, including: discovering appropriate ways to incorporate families in the decision-making process; assuring that more research is conducted on medical and dental outcomes in rare populations; developing focused practice guidelines and consensus statements from expert panels, including guidelines for dental care of children with serious craniofacial disorders; and establishing an ongoing quality assessment process that is separate from appeal or grievance processes.

Most versions of the patient bill of rights now under consideration in Congress include legislative language pertaining to medical necessity. Let us work, all of us, to assure that final legislation supports a comprehensive approach to medical necessity decision-making, and one that assure sufficient participation by families. If we can accomplish this goal, then we will have taken an important step toward strengthening the Nation's service system for children.

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