

### Introduction

The definition of "medical necessity" raises two general issues of concern to consumers:

1. What benefits are covered? (E.g., are they limited to diagnosis and treatment, or do they also include preventive care? Are experimental services excluded? Does the definition recognize and mandate the complete EPSDT benefit package for children under 21?
2. Who determines whether the care is medically necessary?

### NHeLP Model

[INSERT INTO SERVICES/BENEFITS PACKAGE SECTION OF CONTRACTS RE:  
PHYSICAL/MEDICAL CARE SERVICES]

Complaint procedure provisions will be strengthened by a clear definition of medical necessity. We suggest:

"The health plan must provide all medically necessary care, including services, equipment, and pharmaceutical supplies. Medically necessary care is the care which, in the opinion of the treating physician, is reasonably needed:

- to prevent the onset or worsening of an illness, condition, or disability;
- to establish a diagnosis;
- to provide palliative, curative or restorative treatment for physical and/or mental health conditions; and/or
- to assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.

Each service must be performed in accordance with national standards of medical practice generally accepted at the time the services are rendered. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose; and the amount, duration and scope may not arbitrarily be denied or reduced solely because of the diagnosis, type of illness or condition (42 CFR 440.230). Children's medical necessity decisions will be governed by the EPSDT coverage rules (42 USC § 1396(r)(5) and 42 USC § 1396d(a)), described in Appendix \_\_\_\_."

### North Carolina

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[] (1996) [Effective Date: 1996 - 6/30/99]

## APPENDIX I:

**1.41[] Medically necessary services** - Those services which are in the opinion of the treating physician, reasonable and necessary in establishing a diagnosis and providing palliative, curative or restorative treatment for physical and/or mental health conditions in accordance with the standards of medical practice generally accepted at the time services are rendered. Each service must be sufficient in amount, duration, and scope to reasonably achieve its purpose; and the amount, duration, or scope of coverage, may not arbitrarily be denied or reduced solely because of the diagnosis, type of illness, or condition (42 CFR 440.230). Medicaid EPSDT coverage rules (42 USC §1396(r)(5) and 42 USC §1396 d(a)).