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What Medicaid MCOs Need to Know: An IRO's Perspective

Medicaid: 50 different states with 50 different rules that vary widely. Eligibility requirements differ, as well as waiver programs and coverage guidelines. However, when reviewing beneficiaries, a largely ignored variance is definitions. In particular, the definition of "medical necessity".

Since the 2012 ruling on the constitutionality of the Affordable Care Act's individual mandate, state officials have had the option to choose whether or not to expand the reach of their Medicaid programs.[1] 36 states and D.C. have moved forward with expansion over the last seven years[2], and the state of Montana is currently considering undoing their previous Medicaid expansion.[3]

Unlike the federal Medicare program, which uses a National Coverage Determinations Manual, state Medicaid programs have no central point of reference for coverage determinations.[4] Of particular importance, Medicaid MCOs and HMOs write their own definition of what constitutes medical necessity in different scenarios and independently of the definitions their competitors use.[5] Cigna, for example, has four different definitions of medical necessity, varying based upon the age of the patient and whether or not the provider is a physician.[6] Understandably, this leads to confusion for providers, payers, and patients alike.

A 2018 study by *Health Affairs* found that Fee-for-service Medicaid is the most challenging type of insurer to bill, with a claim denial rate that is 17.8 percentage points higher than that for fee-for-service Medicare. Additionally, the denial rate for Medicaid managed care was 6 percentage points higher than that for fee-for-service Medicare.[7]

The bottom line? The definitions are not cut and dry when it comes to Medicaid, and that makes getting reimbursement a challenge even for the experienced provider.

Besides a poor customer experience and the health risks involved for patients, the stakes are high for providers and payers from a financial standpoint. Incorrect interpretation of coverage guidelines can lead to a proliferation of costly appeals escalating to the regional and state levels.

So what can you do to mitigate these risks and ensure you get paid?

1. You have the power to lessen some of the confusion with well written and readily accessible policies and procedures. Make sure your Member Handbook uses clear language and it is easily accessible via your website. By avoiding confusion about coverage guidelines and what constitutes "medical necessity" at the onset, you can avoid appeals later on.
2. Make sure your appeals are handled by an IRO (or IROs) with a proven track record of reviewing Medicaid MCO internal and external appeals. Additionally, look for an IRO with a robust physician review panel has the breadth and diversity of professionals to understand and properly apply the correct definition and factors associated with medical necessity.

If you're interested in learning more about how an IRO can help you to reduce appeals volumes, visit www.FHAS.com/IRO.

Sources: 1. Kaiser Family Foundation; 2. Advisory Board; 3. NPR; 4. American Academy of Family Physicians; 5. American Bar Association; 6. Cigna; 7. Health Affairs