

September 26, 2008

Robert T. Maruca  
Senior Deputy Director  
Medical Assistance Administration  
DC Department of Health  
825 North Capital Street NE  
5<sup>th</sup> Floor  
Washington, DC 20002

**Re: Proposed Medical Necessity Regulations**

Dear Mr. Maruca:

The Legal Aid Society of the District of Columbia has reviewed the proposed regulations regarding medical necessity for the District's Medicaid enrollees published in the DC Register on August 29, 2008. *See* DC Register Vol. 55-No. 35, 8/29/2008. Thank you for the opportunity to comment on this very important issue.

As an initial matter, we want to thank MAA for the many improvements that appear in this set of proposed regulations compared to the proposed 2004 regulations. We look forward to continuing to work with MAA and other advocates to achieve a regulatory scheme that sufficiently balances the need for access to essential medical services with the District's need to ensure that it is paying for services that are necessary for the improvement and maintenance of health.

The following document provides Legal Aid's comments and recommendations on individual provisions of the proposed regulations. Our priority concerns, which are discussed in greater detail below, are:

- These regulations do not provide sufficient deference to the opinion of a Medicaid recipient's treating physician as to what course of treatment is medically necessary. Instead, his or her opinion is listed as a factor that must be considered but to which no deference is required. For services provided under EPSDT, federal courts have found that the treating physician's opinion must control. But whether the Medicaid services are provided for adults or children, the recipient's treating physician is most familiar with the recipient's medical condition, and therefore in the best position to know what treatments, items or services are likely to maintain or improve the beneficiary's health.
- Despite the improvements regarding due process and hearing requests from the last set of proposed regulations, these proposed regulations still must be clarified with regards to the timeframes that attach to MAA's time for making a medical necessity determination, and a recipient's right to request a fair hearing. Additionally, the regulations should also be amended to allow for oral hearing requests as described in District law.

- We are concerned that the language in these proposed regulations regarding EPSDT is inconsistent with the federal Medicaid statute and regulations. We would therefore recommend that the regulations cite to or incorporate – word for word – federal EPSDT language and explicitly state that medical necessity determinations for EPSDT services will be made according to federal law as interpreted by federal case law. However, we would certainly support any efforts to expand coverage for children under Medicaid consistent with federal law.
- These regulations are silent as to the circumstances under which MAA will conduct a retrospective coverage determination for services previously provided to a Medicaid recipient. This silence will create uncertainty for providers, who will have no way of knowing when a service provided will be subject to a retrospective determination. Providers, in turn, could be further deterred from participating in the Medicaid network if they do not know the circumstances under which they may have to repay MAA for services provided in good faith to a recipient. Moreover, the regulations also could be interpreted to allow the provider in turn to bill the patient for any recouped funds.

Legal Aid would therefore propose that MAA include safeguards such as time limits on the ability to do retrospective medical necessity determinations. Furthermore, Legal Aid proposes that MAA make clear that providers are prohibited from seeking reimbursement from Medicaid recipients.

- Finally, Legal Aid would like to express our hope that these regulations will be issued again in proposed fashion. Given the extensive comments that have been proposed by multiple advocacy organizations on this draft of regulations, it would be helpful to have an opportunity to see MAA’s response to these comments before a final rule is issued.

This remainder of this letter will address the concerns that Legal Aid has identified with these proposed regulations, request clarification on certain sections, and suggest specific changes in the regulatory language that should be included in the final regulations.

### **Comments and recommendations**

**§ 9000.3:** describes how MAA will make medical necessity determinations for EPSDT services, stating in part that EPSDT-covered treatments, items and services will be medically necessary “if relevant medical evidence demonstrates that the proposed or furnished treatment, item or service:

- (a) Is appropriate to the age and developmental status of the individual;
- (b) Is furnished in the most community-integrated setting appropriate to the specific needs of the child and family;
- (c) Is consistent with current and generally accepted standards of medical, behavioral or dental practice;

- (d) Is furnished as a part of a clinical investigational trial that meets Medicare-applicable standards; and
- (e) Is likely to assist in achieving one or more of the following:
  - (1) Promoting growth and development
  - (2) Ameliorating, at the earliest point possible in a child's growth and development, a physical, developmental, or mental condition, by preventing, diagnosing, detecting, or treating, the effects of a physical, mental, developmental, behavioral, genetic or congenital condition, injury or disability; or
  - (3) Achieving, maintaining, or restoring health and functional capabilities without regard to whether the underlying condition is congenital or a developmental anomaly."

Comment: Legal Aid has several concerns about this subsection in its entirety. First, the proposed regulation seems to paraphrase rather than directly quote federal EPSDT requirements. As a result, medical necessity decisions made pursuant to this language could conflict with the requirements under federal law.

Second, the proposed regulation states that "relevant medical evidence" will be considered in the ultimate medical necessity determination. Federal courts, interpreting the requirements of EPSDT, have held that the opinion of a child's primary care doctor should control in these determinations. *See Collins v. Hamilton*, 349 F.3d 371, 376, n. 8 (7th Cir. 2003) (noting that a state's discretion to exclude services that an EPSDT provider deems medically necessary has been circumscribed by express mandate of the statute); *see also Pediatric Specialty Care, Inc. v. Arkansas Dep't Human Services* 293 F.3d 427, 480-481 (8th Cir. 2002) (finding that a Medicaid eligible individual has a right to [EPSDT services] when a physician recommends such treatment). If this provision contemplates consideration of the same evidence and standards listed in proposed sections 9000.8 and 9000.9, such a determination could conflict with these federal requirements.

Legal Aid recommends the following changes: First, the final rule should either reference the federal requirements for determining medical necessity for EPSDT services, or copy the exact language of the federal requirements verbatim. However, Legal Aid supports any efforts by MAA to expand coverage under EPSDT consistent with federal law.

Second, it should be made clear that the treating physician's opinion will be controlling in medical necessity determinations for services provided under EPSDT.

**§ 9000.3 (b) states that:** Proposed treatments, items or services should be "furnished in the most community-integrated setting appropriate to the specific needs of the child and family;"

Comment: This section does not expressly consider the choice of the recipient, which is problematic because consumer choice is an important part of determining the most appropriate setting for a recipient.

Legal Aid recommends the following change: “furnished in the most community-integrated setting that is *desired by and* appropriate to the specific needs of the child or family.”

**§ 9000.3(d) states that:** EPSDT as described in § 9000.2(a), including investigational items and services furnished to Medicaid recipients under the age of twenty-one (21) shall be considered medically necessary, if relevant medical evidence demonstrates that the proposed or furnished treatment, item or services is, among other considerations, “furnished as part of a clinical investigational trial that meets Medicare-applicable standards.”

Comment: Subsection (d) is connected to the other requirements by an “and,” which would require that all EPSDT services be “furnished as a part of a clinical investigational trial that meets Medicare-applicable standards.” We assume that this was an error because it is not a requirement of federal EPSDT law that all such services be furnished as a part of a trial. *See* 42 USC § 1396d (r). In fact, this requirement would almost certainly result in illegal denial of EPSDT services to District Medicaid enrollees.

Legal Aid is also concerned about the use of “Medicare applicable standards” for determining whether services delivered as part of a clinical investigational trial would be deemed medically necessary. This is a narrow standard could make it very difficult for Medicaid patients to have access to investigational treatments.

Legal Aid recommends the following changes:

If this language is maintained, subsection (d) must be moved to the end of the list of criteria, and separated by an “or” rather than an “and.”

Legal Aid also recommends that a more expansive standard be used to evaluate medical necessity for experimental services. For example, MAA could require that an experimental service’s safety and efficacy be shown in one or more peer-reviewed journals. Such a standard would include the protections – for the Medicaid recipient and MAA -- of the Medicare standard but would be less restrictive to recipients in need of investigational items, treatments and services.

**§ 9000.4 states that:** “A proposed or furnished treatment, item or service shall be considered medically necessary in the case of a Medicaid recipient age twenty-one (21) or older, if it is covered under the State Plan, and if relevant medical evidence supports the conclusion that the treatment, item or service, is:” [Note – subsections (a) through (d) have been omitted from this citation.]

Comment: Legal Aid has three concerns about this section. First, the language is incomplete because it only mentions services provided pursuant to the State Plan, and does not reference other services to which Medicaid recipients are entitled. For instance, MR/DD waiver services and EPD waiver services seem to be codified in DC regulations, rather than the State Plan. *See* DCMR 29-1900, *et. al.*, (MR/DD waiver services and standards), and DCMR 29-4200, *et. al.*, (EPD waiver services and standards). As such, to say a treatment, item, or service is only covered if it's a part of the State Plan risks denying Medicaid recipients access to services they should be entitled to receive.

Second, § 9000.4(b) requires that proposed treatments, items or services should be “furnished in the most community-integrated setting appropriate to the specific needs of the child and family.” This section raises the same concern we raised in our discussion of § 9000.3(b) – that of consumer choice. This language does not expressly consider the desire and preference of the recipient, which is problematic because consumer choice is an important part of determining the most appropriate setting for a recipient.

Third, Legal Aid is concerned that § 9000.4 does not include the goal of ameliorating health issues, nor does it include maintaining health or functional status. For many individuals over 21 years old, particularly elderly and/or disabled recipients, ameliorating symptoms of health problems and maintaining good health and functional capacity are crucially important aspects of avoiding even more complicated health problems down the road. Additionally, it is crucially important that recipients be allowed access to medical care for the purpose of treating the effects of physical and/or mental health conditions, illnesses and disabilities. For instance, a cancer patient often suffers from pain as an effect of the disease and/or treatment, and Medicaid should cover the medication needed to treat this pain.

Legal Aid recommends the following changes: First, the language be revised to read: “A proposed or furnished treatment, item or service shall be considered medically necessary in the case of a Medicaid recipient aged twenty-one (21) or older, if it is covered under the State Plan, *or under any waiver obtained by the District from the federal government*, and if relevant evidence supports the conclusion that the treatment, item or service, is . . . .”

Second, § 9000.4(b) should be revised to require that services be “furnished in the most community-integrated setting *desired by and* appropriate to the specific needs of the individual.”

Third, the final regulations should explicitly incorporate amelioration of health issues, maintaining health and functional status, and treatment of effects of health problems as purposes for which treatments, items and services will be deemed medically necessary.

**§ 9000.5 states that:** “In the absence of relevant and countervailing evidence to the contrary, a proposed or furnished treatment, item or service shall be presumed medically necessary without additional review when furnished to individuals described in subsections (c) through (h) of § 9000.2.”

Comment: This section is vague and confusing because it does not explain what “relevant and countervailing evidence” means, nor does it explain how such evidence will be evaluated.

Legal Aid recommends the following changes: First, MAA should either eliminate the language regarding “relevant and countervailing evidence to the contrary” or, at the very least, eliminate the term “relevant.” Second, MAA should also explain what evidence would be considered countervailing. Third, MAA should explain how such evidence would be evaluated.

**§ 9000.8:** describes the medical evidence that may be furnished as part of the initial determination or a reconsideration of medical necessity.

Comment: Legal Aid has concerns about several of the evidentiary categories listed in this section. First, subsection (a) states that MAA will refer to the:

- (a) “Written and oral clinical judgments furnished by medical and health care professionals caring for the Medicaid recipient directly or on a consulting or referring basis;”

§ 9000.8(a) does not explain when a Medicaid recipient would be cared for “on a consulting or referring basis.” This language appears to allow MAA to refer Medicaid patients to MAA doctors for a consultative examination before approving a request for services. MAA has informed us that this is not the intent of this section, but this intent is not clear in the language as drafted. Especially in light of our concerns regarding deference to the treating physician’s judgment, as described in our comments to § 9000.9, MAA should change this section to clarify that consultative examinations by MAA doctors will not be a part of the medical necessity determination process.

Second, subsection (c) states that MAA will also refer to:

- (c) “Written and oral information furnished by the Medicaid recipient or when appropriate, the recipient’s family, guardian or caregiver, regarding health and functional status, symptoms, and the ability to gain health benefits or avert deterioration in health status from particular interventions and treatments;”

§ 9000.8(c) does not allow for a Medicaid recipient’s authorized designee to submit information to be used as Medical evidence. This section should be changed to allow information to be received from a source designated by the Medicaid recipient and should be further clarified to include improving functional status as a goal of submitting such evidence.

Legal Aid recommends the following changes: First, MAA should clarify its meaning concerning physicians caring for a Medicaid recipient “on a consulting or referring basis.” If MAA intended this section simply to include all medical sources of

information, including primary care physicians, specialists, and other medical professionals treating the recipient, then this language should be redrafted to clarify that meaning.

- (a) “Written and oral clinical judgments furnished by *any and all* medical and health care professionals caring for the Medicaid recipient.”

Second, Legal Aid supports the revision to subsection (c) proposed by University Legal Services:

- (c) Written and oral information furnished by the Medicaid recipient or, when appropriate, the recipient’s family, guardian or caregiver, or *anyone designated by the recipient for whom the recipient executes an appropriate HIPAA release authorization*, regarding, *the recipient’s health and functional status, symptoms, and the need for the requested services to enable the recipient to gain, health benefits or improve or maintain functioning capacity, or avert in health or functioning status from particular interventions or treatments.*

**§ 9000.9 states that:** “At a minimum, any adverse determination by the Department of Health, Medical Assistance Administration (MAA) regarding the medical necessity of covered items and services, including the transfer or discharge of residents from Medicaid-financed institutional facility placements, or eligibility for institutional care following preadmission screening and annual resident review, shall take into account the evidence described in § 9000.8 (a) through (c), made available to MAA.”

Comment: We are pleased that MAA will be required to consider the opinion of the treating physician in evaluating medical necessity. However, we are concerned that this language does not go far enough. This standard does not give any deference or presumption to the recommendation of a Medicaid recipient’s treating physician, but only requires that such evidence be “taken into account.” A Medicaid recipient’s treating physician will be most familiar with the recipient’s health condition, and is therefore in the best position to know what items and services are going to be the most effective way of treating this condition. Under the proposed language, it appears that any of the evidence listed in § 9000.8 (b) through (i) could be used to overrule the treating physician’s opinion as long as this opinion was considered by MAA. This language would therefore make it difficult to know how much evidence a recipient should submit in order to bolster a treating physician’s opinion or conversely, to what lengths MAA would go to find evidence that would counter this opinion.

Legal Aid recommends the following changes: MAA should make clear that the treating physicians’ request for an item or service, and evidence provided by a treating physician, will be given greater weight than is other evidence listed in § 9000.8.

Legal Aid suggests the following language, which closely reflects the Social Security Administration's standard for determining disability. This "treating source" rule can be found at 20 C.F.R. § 416.927 (d)(2).

*At a minimum, any adverse determination by the Department of Health, Medical Assistance Administration (MAA) regarding the medical necessity of covered items and services, including the transfer or discharge of residents from Medicaid-financed institutional facility placements, or eligibility for institutional care following preadmission screening and annual resident review, shall take into account the evidence described in § 9000.8 (a) through (c), made available to MAA. Furthermore, evidence and recommendations from a recipient's treating source will be given more deference than other forms of evidence described in § 9000.8. Evidence from a treating source will be given controlling weight when supported by clinical and laboratory diagnostic techniques and when not inconsistent with other evidence presented from treating sources. If MAA denies a requested treatment, item or service in spite of evidence from a treating source, MAA will include in the notice an explanation of why the evidence and/or recommendation of the treating physician was not given controlling weight.*

This language does not require that the treating physician's opinion be controlling in all situations. As in Social Security disability determinations, this language would require MAA to give such an opinion deference if it is supported by other evidence. In the event that MAA does not defer to the treating physician's opinion, the agency would have to explain its reasons and provide the recipient with a description of the evidence that the agency found more persuasive.

**§ 9000.11 states that:** "Optional items and services covered under the State Plan shall include all of the following . . . ."

Comment: All of the services, optional and mandatory, to which Medicaid recipients are entitled are spelled out in the State Plan and/or in DC statutes and regulations governing the Medicaid program. Therefore including another list of services in these regulations is unnecessary and risks causing conflict and confusion over what services are covered. For instance, the list of "optional items and services" included in these proposed regulations includes at least one *mandatory* service: medical and surgical services of a dentist. See 42 C.F.R. § 440.210. Additionally, none of the described services are "optional" within the context of children under 21 due to the requirements of EPSDT.

Legal Aid recommends the following change: MAA should either delete this list in its entirety, or must go back and ensure that none of the services described as "optional" are actually "mandatory" in some or all contexts.

**§ 9001.4 states that:** "Within ninety (90) calendar days but not later than one hundred and ten (110) calendar days after the receipt of all requested information, including but not limited to the recipient's medical records, MAA shall issue to the recipient a written notification of the results of the retrospective coverage determination."

Comment: Legal Aid is concerned about the time frames in this section because they are contradictory – 110 calendar days is not “within” 90 calendar days. Therefore, it is not clear whether the ultimate deadline for MAA’s decision is 90 days or 110 days. Additionally, federal regulations state that a final agency determination must ordinarily be made within 90 days of an appeal or fair hearing request. *See* 42 C.F.R. § 431.244.

Legal Aid recommends the following change: MAA should impose a 90 day timeframe to issue its written notification. The new language would then read “Within ninety (90) calendar days after the receipt of all requested information, including but not limited to the recipient’s medical records, MAA shall issue to the recipient a written notification of the results of the retrospective coverage determination.”

**§ 9001.7 states that:** “If an adverse determination, the notice shall contain:” [full list omitted].

Comment: Per Legal Aid’s comment and recommendation to § 9000.9 regarding deference to a treating physician, denial notices should include an explanation of why a treating physician’s judgment and/or recommendation was not followed.

Legal Aid Suggests the following change: add a subsection (f) to § 9001.7 that states:

(f) A specific explanation of how the evidence, judgment and/or recommendation provided by a Medicaid recipient’s treating physician was weighed against other evidence presented.

**§ 9001.9 states that:** the recipient or recipient’s representative may submit a written request for reconsideration of the adverse determination within ninety (90) calendar days but no later than one hundred and ten (110) calendar days of receipt of the adverse determination issued pursuant to § 9001.7.

Comment: Legal Aid has two concerns about this provision. First, the timeframes are confusing, and it is unclear whether the request should be submitted within 90 days or 110 days. Second, there is no provision for an oral request, which is crucially important for Medicaid recipients who are unable to submit a written request.

Legal Aid recommends the following change: First, MAA should set a 90 day deadline for submitting a request for reconsideration. Second, MAA should allow for oral requests to be made.

**§ 9001.10 states that:** “The recipient or recipient’s representative may request a hearing by submitting a written request to the Office of Administrative Hearings within ninety (90) calendar days from the date the adverse determination issued pursuant to § 9001.7 is mailed. The written request shall include a copy of the adverse determination.”

Comment: We are very pleased that these proposed rules allow an individual to challenge an adverse action directly with OAH or through a request for reconsideration within MAA. However, it is unclear from this section whether there are further appeal rights once a request for reconsideration has been denied at the agency level. If the intention was to allow an individual whose request for reconsideration is denied at the agency level to appeal to OAH, the timeframes could make that impossible.

With 90 days to file a request for reconsideration and 60 days for the agency to make a determination, an individual who files a request for reconsideration would likely not know the outcome of this request within 90 days of the original adverse determination.

Furthermore, this section is inconsistent with other sections of these proposed regulations, *i.e.* § 9002.12 (discussing concurrent determinations) and § 9003.7 (discussion prior authorizations) allow for hearing requests after an adverse determination at the both the initial request stage and the reconsideration stage.

Legal Aid is also concerned about the proposed requirement that the hearing request include a copy of the adverse determination. This requirement is contrary to District law regarding hearing requests, which only requires “a clear expression, oral or written, that he or she wants an opportunity to present his or her case to a higher authority.” *See* DC Code § 4-210.05. As such, this sentence should be deleted from § 9000.10.

Additionally, Legal Aid is concerned because the proposed section does not allow for oral hearing requests as required by the District in public benefits cases. District regulations governing the Office of Administrative Hearings (OAH) require that any government agency that receives an oral or telephone request for a hearing must fill out a written hearing request form and submit the form to the clerks office at OAH after no more than three (3) business days. *See* DCMR 2971.6.

Legal Aid recommends the following changes: First, MAA should make it clear that an individual has 90 days to request a fair hearing after an adverse determination of a request for reconsideration.

Second, MAA should delete the requirement that the hearing request include a copy of the adverse determination.

Third, the language of 9001.10 should reflect that OAH challenges to adverse Medicaid determinations can be made orally by adding the following language: “[t]he recipient or recipient’s representative may request a hearing, *either orally or in writing*, to the Office of Administrative Hearings . . . .”

**§ 9001.11 states that:** “services shall not be terminated or reduced if the recipient requests a reconsideration or a hearing before the date of action referenced in §9001.7 (a).”

Comment: Legal Aid is pleased that MAA is explicitly providing for the right to receive benefits during the pendency of a reconsideration or fair hearing. However, we are concerned that this language is more restrictive than is allowed under DC code and may result in individuals' not receiving their benefits pending should MAA not meet its required time frames.

The DC code states that “[i]n any case in which action was taken without timely notice, when timely notice is required by law, and the recipient requests a hearing within 10 days of the postmark of the written notice of the action, the Mayor shall reinstate assistance within 96 hours of the request for a hearing and assistance shall not be discontinued, withheld, terminated, suspended, reduced or made subject to additional conditions, nor may the manner or form of payment be changed” until a hearing has occurred. *See DC Code § 4-205.59.*

Legal Aid recommends the following change: “Services shall not be terminated or reduced if the recipient requests a reconsideration or hearing before the date of action referenced in §9001.7(a), *or within 10 days of the postmark on the notice, whichever is later.*”

**§ 9001.14 states that:** the written notice provided after a determination has been made on a request for reconsideration “shall comply with the requirements set forth in §§ 9001.6, 9001.7(a), (b) (c) and (e), and 9001.8 and include an explanation of the recipient’s right to request a hearing, including an explanation of the appeals process.”

Comment: Legal Aid wants to ensure that an individual who has received benefits pending the resolution of a request for reconsideration can continue to receive such benefits pending the outcomes of further appeals.

Legal Aid recommends: MAA add to the end of § 9001.14 “appeals process, *including the right to aid pending further appeal pursuant to § 9001.11.*”

**§ 9002.1 (a) states that:** “acute inpatient” services shall be prior-authorized by MAA and subject to the procedures governing prospective coverage determinations.

Comment: Legal Aid is concerned that requiring “acute inpatient” services to be pre-authorized could endanger the health of Medicaid recipients. Patients suffering from acute appendicitis, heart attack or a gunshot wound would not be able to wait for a prior authorization, even with an expedited request as described in § 9002.6 and 9002.14. MAA has indicated that it is not the intention of this subsection to require a prior authorization in actual medical emergencies, such as those situations described, but this intent is not clear from the current language.

Legal Aid recommends the following change: MAA should eliminate the term “acute inpatient” from section 9002.1 (a); or modify this section to clearly remove treatment of medical emergencies from the prior authorization requirement.

**§9002.1 (j), (n), (o) & (p) states that:** “various” extended home health care services, eye glasses and contact lenses, etc... will require a prior authorization.

Comment: In this context, the word “various” is quite vague. It is not clear from these sections what specific items and services, other than those listed, require prior authorizations.

Legal Aid recommends the following change: MAA must spell out, with specificity, which items and services in these sections will require a prior authorization.

**§ 9002.2 state that:** “The request for a prospective coverage determination may be made by the Medicaid recipient or recipient’s representative, the recipient’s primary care physician, or the health care professional or provider who has prescribed or will be furnishing the services or treatment.”

Comment: This section is too restrictive in who is allowed to make a request. For instance, under DC law, an individual’s representative may request a fair hearing on the individual’s behalf. The statute also explicitly states that a representative may either be either legal counsel or a lay person who is not a district employee. *See* DC Code § 4-210.04 (a). Many low-income individuals may not be able to secure representation of a legal representative, and this section’s use of the term “representative” is unclear. It should be clarified to make absolutely clear that other people, including family members, friends, or anyone else the recipient desires to act as his or her representative, will be allowed to make requests on their behalf and provide assistance.

Legal Aid recommends the following change: “The request for a prospective coverage determination may be made by the Medicaid recipient or recipient’s representative, *the recipient’s family, guardian or caregiver*, the recipient’s physician, or other health care professional or provider who has prescribed or will furnish the services or treatment, *or anyone designated by the recipient for whom the recipient executes an appropriate HIPAA release authorization.*”

**§ 9002.5 states that:** if an oral request for a prior authorization is made on an expedited basis “[a] written request consistent with the requirements set forth in §§ 9002.3 and 9002.4 shall be submitted to MAA within twenty-four (24) hours or the oral request. If requested, an extension of up to twenty-four (24) hours may be granted but in no event shall a request jeopardize the health and safety of the recipient.”

Comment: This section does not specify the steps MAA will take to request the written request for prior authorization upon receipt of an oral request. Will MAA contact the provider making the oral request to inform the provider that a written request is necessary? If so, how soon after the oral request will MAA contact the provider? What is the outcome if a written request is not submitted within the 24 hour (plus 24 hour extension) time-frame?

Legal Aid recommends the following change: As was done in proposed § 9001.5 above, MAA should elaborate on what actions MAA will take to acquire the documents necessary to make a determination on prior authorization requests.

**§ 9002.8 states that:** “Within sixty (60) calendar days of receipt of a non-expedited request, MAA shall issue a written notice of the results of the prospective coverage determination.”

Comment: Sixty days is a long time to wait for a request to be processed, and could delay treatment for people who need to schedule necessary hospitalizations, for instance. The length of time could lead recipients and their advocates to submit only expedited requests which could put an unnecessary strain on agency resources.

Legal Aid recommends the following change: MAA should shorten the time-frame for non-expedited, prior authorization requests to no more than 15 days.

**§ 9002.9 states that:** When an expedited request for prior authorization is denied, “the recipient, or recipient’s representative, health care professional or provider may request a reconsideration on an adverse determination no later than twenty-four (24) hours after the receipt of the determination.”

Comment: It is not clear in this section whether the request for reconsideration can be an oral request. Given that this section refers to expedited requests, Medicaid recipients and their representatives or providers should be allowed to make reconsiderations requests orally.

Legal Aid recommends the following change: “the recipient, or recipient’s representative, health care professional or provider may request, orally or in writing, a reconsideration on an adverse determination no later than twenty-four (24) hours after the receipt of the determination.” The section could then refer back to § 9002.5 regarding timeframes for submitting a written request to supplement the oral request (though see above comment on § 9002.5 – changes should be made to this section also).

**§ 9002.12 states that:** The recipient or recipient’s representative may request a hearing by submitting a written request to the Office of Administrative Hearings within ninety (90) calendar days from the date the adverse determination issued pursuant to §§ 9002.7, 9002.8, 9002.9 or 9002.10 is mailed. The written request shall include a copy of the adverse determination.”

Comment: Please see our comments to § 9001.10.

**§ 9003.6 states that:** “The recipient or recipient’s representative may submit a written request for reconsideration of the adverse determination within sixty (60) calendar days of receipt of the adverse determination issued pursuant to §9003.5.”

Comment: The timeframe on this request for reconsideration is inconsistent with other reconsideration requests in these regulations. Section 9001.9 allows for a reconsideration request within 90 calendar days after an adverse determination. Similarly, § 9002.10 allows for 90 calendar days for a non-expedited reconsideration request.

Legal Aid recommends the following change: In order to avoid confusion and promote consistency, this section should be changed to allow 90 days for reconsideration requests, consistent with other sections of these regulations.

**§ 9003.7 states that:** The recipient or recipient’s representative may request a hearing by submitting a written request to the Office of Administrative Hearings within ninety (90) calendar days from the date the adverse determination issued pursuant to §§9003.5 or 9003.8 is mailed. The written request shall include a copy of the adverse determination.

Comment: Please see our comments to § 9001.10.

**§ 9003.8 states that:** “Within sixty (60) calendar days of receipt of the request for reconsideration, MAA shall issue a written notice of the results of the reconsideration. If an adverse determination has been made, the notice shall comply with requirements set forth in § 9001.7 (a), (b), (c), (e), and include an explanation of the recipient’s right to request a hearing and of the appeals process. The written notice shall be issued to the recipient or recipient’s representative with copies to the treating health care professional or provider.”

Comment: Please see our comments to § 9002.8.

**§ 9003.9 states that:** “Services shall not be terminated or reduced if the recipient requests a reconsideration or hearing before the date of action referenced in §9001.7(a).”

Comment: See our comments and recommendations to § 9001.11.

### **§ 9004 Provider Appeals**

Comment: These proposed regulations appear to allow a provider to seek reimbursement from a Medicaid enrollee when MAA retroactively denies an item or services and requires reimbursement from the provider. Additionally, section 9004.6 states that MAA will seek reimbursement from providers in some cases following a retroactive denial of medical necessity.

Legal Aid has several concerns with the issue of retroactive reimbursement to MAA. First, this proposed retroactive determination process does not include any safeguards for Medicaid providers who deliver services to Medicaid recipients in good faith that they are covered. This could further discourage providers from participating in the Medicaid network.

Second, there is nothing explicit in these proposed regulations that would stop the provider or MAA from in turn billing the Medicaid recipient for the cost of the services provided. We understand that there are federal law and contract provisions that would prohibit such action but believe that it would be beneficial to explicitly state that language in these regulations as well.

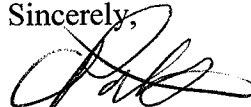
Legal Aid recommends the following changes: First, MAA consider the addition of provider safeguards such as a time limit on the ability to do a retroactive determination. A Medicaid provider should not have to worry that a service provided in 2000 will now be found to not have been medically necessary.

Second, MAA should add a new §9004.7 that would explicitly prohibit MAA and any Medicaid providers from “balance billing” a Medicaid recipient for any item that was retrospectively determined by MAA not to be medically necessary.

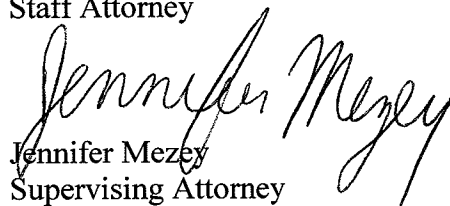
### **Conclusion**

Thank you again for the opportunity to submit these comments. We look forward to working with MAA on this and other Medicaid issues to ensure that all Medicaid recipients get the medically necessary services they need to maintain and improve their health.

Sincerely,



Andrew Patterson\*  
Staff Attorney



Jennifer Mezey  
Supervising Attorney

*\*Licensed to practice in the state of Maryland. Practicing in the District of Columbia under DC Court of Appeals Rule 49 (c)(9)(B). Supervised by Jennifer Mezey, District of Columbia Bar No. 462724.*