MEDICAL REVIEW GUIDELINE

Determination of Medical Necessity

Adopted by Medical Care Management
Committee on February 16, 2012.
Revised June 06, 2023

Title: Determination of Medical Necessity

This Medical Review Guideline (Guideline) is provided for informational purposes only and does not constitute medical advice. It is intended solely for the use of Community Health Choice, Inc. (Community) clinical staff as a guideline for use in determining medical necessity of requested procedures and therapy. This Guideline does not specifically address eligibility or benefit coverage. Other Policies and Coverage Determination Guidelines may apply. All reviewers must first identify enrollee eligibility, any federal or state regulatory requirements and the plan benefit coverage prior to use of this Medical Review Guideline. If there is a discrepancy between this Guideline and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern. Community reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

APPLIES TO:

☒ STAR
☒ CHIP/CHIP-P
☒ Health Insurance Marketplace
☒ Medicare Advantage (i.e. D-SNP)
☐ STAR+PLUS

PURPOSE:

This Guideline is intended to facilitate the utilization management process by providing an overview of how Community appropriately determines medical necessity. The goal of Community in adopting these guidelines is not to disrupt the physician-patient relationship nor to diminish physician autonomy. Instead, it is to promote patient safety and improved clinical outcomes through the adherence to evidence-based practices. Community has developed this Guideline via an ongoing process that includes a review of the most current evidence-based literature and input from clinical and program staff, and often from external clinical experts. If a particular service or supply is medically necessary, it does not guarantee that the service or supply is covered and will be paid by Community for a particular member.

GUIDELINE:

Generally accepted standards of medical practice mean standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

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"Medically necessary" is generally defined as services or items that are reasonable and necessary to prevent illnesses or medical conditions, or services to provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a member, or endanger life.

The services must be:

- Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies; **and**
- Clinically appropriate in terms of type, frequency, duration and site and considered effective to treat the member's illness, injury, or disease; **and**
- Not be more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency; **and**
- Not be experimental or investigative; **and**
- Not primarily for the convenience of the member or provider; **and**
- Cannot be more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member's illness, injury, or disease.

When reviewing a request for authorization, the Community clinical staff will first verify eligibility and plan benefits. See Policy UM033 Utilization Management Program Process

- The member's Health plan benefits determine coverage including what services are covered or excluded and which are subject to limitations or restrictions.
- If there is a discrepancy between this Guideline and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.
- This policy is only applicable when there is no existing language in the member's insurance plan benefit, the health plan contracts or health plan state regulations that would supersede it.

The clinical staff will then consider all relevant clinical information submitted.

- If no medical records are submitted, medical necessity cannot be determined.
- Duplication of services (i.e. multiple providers rendering the same service at the same time) are not medically necessary.

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The resources below are utilized to ensure Community decision-making is objective and evidence based. In addition, these resources ensure consistency and inter-reviewer reliability within Community utilization management.

All medical necessity decisions are based on, but not limited to review of the following resources:

- Community Health Choice Medical Review Guidelines
- InterQual Criteria
- Texas Medicaid Provider Procedures Manual (for Medicaid members)
- National and Local Coverage Determinations (for DSNP members)
- National Specialty Society Developed Guidelines (e.g., American Academy of Pediatrics, American College of Surgeons, American College of Obstetricians and Gynecologists, American College of Physicians, and others)
- Evidence-based medical literature
- The Community Medical Directors can consult like-providers (specialty) to assist in the evaluation of a request and the determination of accepted standards of medical practice.
- Community may delegate utilization management decisions of certain services to third-party delegates (ex. Allmed, etc.) who may develop or adopt their own clinical criteria.

This Guideline is reviewed annually and is approved by the Medical Care Management Committee.