MEDICAL REVIEW GUIDELINE
Determination of Medical Necessity

Adopted by Medical Care Management Committee on February 16, 2012
MCMC Approval Date October 16, 2025

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

The overall purpose is to define medical necessity for the following services: medical and behavioral healthcare services and procedures, pharmaceuticals and devices.

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

Unless defined differently by the members' Benefit Plan Contract (i.e. Medicaid, Medicare or MarketPlace) or the applicable provider agreement, the Health Plan uses the following definition:

Medically necessary or **medical necessity** shall mean health care services that are reasonable and necessary for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms.

The services must be:

- Consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies (i.e. in accordance with generally accepted standards of medical practice*); **and**
- Clinically appropriate in terms of type, frequency, duration and site of care (i.e. location of service or level of care) 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 services/technologies. The service must not be classified as experimental, investigational or unproven except if provided under the Member's health plan benefit for clinical trials; **and**
- Not be for cosmetic purposes even if also has a medical purpose unless specifically covered per the member's health care plan.
- 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.

*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.

PROCESS FOR REVIEW

Requests for services may be subject to utilization management review. The service will be reviewed under applicable utilization management including prior authorization, compliance with established coverage guidelines and medical necessity determination.

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 health 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.

- For a medical necessity determination, providers must submit all essential information needed for review including the member's information, the requesting and servicing providers information and complete clinical documentation to support the requested services.

- Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested. Prior authorization is a condition for reimbursement but not a guarantee of payment.

- If no medical records or insufficient information are submitted, medical necessity cannot be determined. Authorization will be denied as Not Medically Necessary.

- Additional medical records may be requested to determine medical necessity. Letters of explanation/medical necessity are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.
- Duplication of services (i.e. multiple providers rendering the same service at the same time, overlapping dates of services by same provider, etc.) are not medically necessary.
- Services for prior authorization may not be approved for more than 6 months unless the member's plan states otherwise.

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:

- Internally developed criteria known as Community Health Choice Medical Review Guidelines (MRGs)

- Nationally recognized decision support tools such as InterQual Criteria Clinical Decision Support Criteria or MCG (formerly Milliman Care Guidelines®)

- Texas Medicaid Provider Procedures Manual (TMPPM) for Medicaid members

- National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and Medicare Coverage Articles for dual Eligible Special Needs Plan (DSNP) members

- If there is no criteria from the above listed sources, then the Medical Director will consider the following resources, when available:

    - Evidence-based literature

    - Published expert opinions

    - 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, etc.)

    - Like specialty providers consultation 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, MRIoA, etc.) who may develop or adopt their own clinical criteria.

- Government funded or independent entities that assess and report on clinical care decisions and technology such as Hayes Knowledge Center, The National Comprehensive Cancer Network® (NCCN®) Guidelines, Agency for Healthcare Research and Quality (AHRQ), Up-to-Date, Cochrane Reviews, etc.

- Nationally recognized drug compendia resources such as DRUGDEX®, etc.

REFERENCES

1. Texas Administrative Code: Title 25; Part 1; Chapter 33; Subchapter A; Rule §33.
2. Social Security Act: Section 1862(a) (1) (A)
3. Community Health Choice Policy UM033 Utilization Management Program Process

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

Policy History (reviews and revisions)	Date	Approval Date
Policy developed	02/2012	02/2012
Archived policies: annually reviewed but policy history not recorded.	--	--
InterQual criteria added to resource list	06/2019	06/2019
No revisions	06/2020	06/2020
No revisions	06/2021	06/2021
No revisions	06/2022	06/2022
Removed MCG; Clarified Review Process; streamlined policy	06/2023	06/2023
Clarified definition of medical necessity; clarified clinical information; Added references and policy history	07/2024	10/17/2025
Included full approval dates. Added clarification for review resources. Added additional information to better explain investigational and experimental service. Added cosmetic services are not a medical necessity unless covered by health plan. Added insufficient information to result in denial for medical necessity.	10/2025	10/16/2025