Clinical Policy: Medical Necessity Criteria

Reference Number: IL.CP.MP.531
Last Review Date: 06/21

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Per the Illinois Department of Healthcare and Family Services (IDHFS), **"medically necessary"** means a service that is appropriate, no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures, and meets the standards of good medical practice in the medical community, as determined by the Provider in accordance with Contractor's guidelines, policies, or procedures, for the diagnosis or treatment of a covered illness or injury; for the prevention of future disease; to assist in the Enrollee's ability to attain, maintain, or regain functional capacity; for the opportunity for an Enrollee receiving LTSS to have access to the benefits of community living, to achieve person centered goals, and live and work in the setting of the Enrollee's choice; or for an Erollee to achieve age-appropriate growth and development.

Policy/Criteria

It is the policy of MeridianHealth affiliated with Centene Corporation® that Meridian will use the following guidelines to make medical necessity decisions (listed in order of significance) on a case-by-case basis, based on the information provided on the member's health status:

A. State law/guidelines (e.g., when State requirements trump or exceed federal requirements);
B. Meridian specific clinical policy (including plan-specific clinical policies in InterQual® as custom content);
C. Centene clinical policy (including Centene clinical policies in InterQual as custom content);
D. If no Meridian or Centene-specific clinical policy exists, then nationally recognized decision support tools such as InterQual Clinical Decision Support Criteria.
E. In the case of no guidance from A-E, additional information that the Meridian Medical Director will consider, when available, includes:
F. Reports from peer reviewed medical literature, from which a higher level of evidence and study quality is more strongly considered in determinations;
    1. Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment;
    2. Nationally recognized drug compendia resources such as Facts & Comparisons® DRUGDEX®, and The National Comprehensive Cancer Network® (NCCN®) Guidelines
    3. Medical association publications, such as those from American Society of Addiction Medicine, American College of Obstetricians and Gynecologist, etc.;

4. Government-funded or independent entities that assess and report on clinical care decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;
5. Published and expert opinions, including in UpToDate;
6. Opinion of health professionals in the area of specialty involved;
7. Opinion of attending provider in case at hand.
8. Utilization Management decisions are made by qualified health professionals. Only appropriate practitioners who have clinical expertise regarding the service under review can make the decision to deny coverage based on medical necessity guidelines. Practitioner types appropriate for making the following types of denial decisions include:

Provider Type	Denial Decision
Physicians, all types	Medical, behavioral healthcare, pharmaceutical, dental, chiropractic, vision, and physical therapy denials
Doctoral-level clinical psychologists or certified addiction-medicine specialists	Behavioral healthcare denials
Doctoral-level board-certified behavioral analysts, doctoral-level clinical psychologists, child and adolescent psychiatrist.	Applied Behavioral Analysis denials and appeals.

Definitions
Unless defined differently by the members' Benefit Plan Contract or the applicable provider agreement, the Health Plan uses the following definitions:

A. **Medically necessary** or medical necessity shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:
    1. In accordance with generally accepted standards of medical practice;
    2. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and
    3. Not primarily for the convenience of the patient, physician, or other health care provider, and not 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 that patient's illness, injury, or disease.

    Medically necessary health care services may not include experimental and/or investigational technologies or carve-out days.

B. **Generally accepted standards of medical practice** means standards that are based upon credible scientific evidence published in peer-reviewed medical literature recognized by the medical community at large or otherwise consistent with the standards set forth in policy issues involving clinical judgment.

C. Not medically necessary and not investigational: evaluations and clinical recommendations that are assessed according to the scientific quality of the supporting evidence and rationale (e.g., national medication associations, independent panels, or technology assessment organizations). A service is considered not medically necessary and not investigational when:

1. There are no studies of the service described in recent, published peer-reviewed medical literature, *or*
2. There are no active or ongoing credible evaluations being undertaken of the service which has previously been considered not medical necessary, *or*
3. There is conclusive evidence in published peer-reviewed medical literature that the service is not effective, *or*
4. There are no peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals that demonstrate the safety and efficacy of the use of the service, *or*
5. It is contraindicated.

Background

Meridian clinical policies are intended to be reflective of current scientific research and clinical practice and judgment. They are developed with oversight of board-certified physicians and practitioners, reviewed on an annual basis for appropriateness and approved by the Meridian Clinical Policy & Procedure Committee. The Clinical Policy & Procedure Committee is composed of physicians and other medial and operational representatives, as appropriate, to assist in the identification of need, development, revision, and/or review of clinical policy. Clinical policies include medical, behavioral health, medical pharmacy benefits, durable medical equipment and devices. These policies include but are not limited to:

- New and emerging technologies
- New uses for existing technologies
- Clinical guidelines for the evaluation and treatment of specific conditions
- Criteria used in the authorization of drugs include on a Meridian prior authorization list
- Clinical/medical criteria or information used in pre- or post-service review

InterQual criteria are proprietary and cannot be publicly published and/or distributed. On an individual member basis, the specific criteria document used to make a medical necessity determination can be made available upon request. Registered providers can obtain the appropriate InterQual SmartSheet™ by logging in to the secure provider portal. The InterQual SmartSheet can be submitted with your authorization request to help expedite the process.

Change Healthcare is the owner/licensor of the InterQual Clinical Decision Support Criteria and related software. Change Healthcare has prepared this Work for exclusive use of its licensees of software applications embodying the Clinical Content. This Work contains confidential and trade secret information of Change Healthcare and is provided to licensees who have an existing

license agreement in force only under the time-limited license as provided under that license agreement.

Licensee and any recipient thereunder shall use the Clinical Content in accordance with the terms and conditions of the license agreement.

Reviews, Revisions, and Approvals	Date	Approval Date
Illinois Market-specific Policy Developed	04/21	06/21

References

1. State of Illinois Contract between the Department of Healthcare and Family Services and Meridian Health Plan of Illinois, 2018-24-601, Definitions, 1.1.127 Medically Necessary
2. State of Illinois Contract between the Department of Healthcare and Family Services and Meridian Health Plan of Illinois, 2018-24-601, Preauthorization and Concurrent Review Requirements, 1.1.2.3.3
3. Change Healthcare InterQual® criteria.
4. National Committee for Quality Assurance. NCQA Health Plan Accreditation, UM Standards, 4 Appropriate Professionals A-F, Standards and Guidelines for the Accreditation of Health Plans 2020.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or

regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.