CareSource

ADMINISTRATIVE POLICY STATEMENT
Ohio Marketplace

Policy Name & Number	Date Effective
Medical Necessity Determinations - OH MP - AD-0047	08/01/2022-01/31/2023
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Medical Necessity Determinations

B. Background

The term *medical necessity* has been used by health plans and providers to define benefit coverage. Medical necessity definitions vary among entities, including the Centers for Medicaid and Medicare Services (CMS), the American Medical Association (AMA) and most healthcare insurance providers, but definitions most often incorporate the idea that healthcare services must be "reasonable and necessary" or "appropriate," given a patient's condition and the current standards of clinical practice.

For all payors and insurance plans, even if a service is reasonable and necessary, coverage may be limited if the service is provided more frequently than allowed under a national coverage policy, a local medical policy, or a clinically accepted standard of practice.

ICD-10-CM codes should support medical necessity for any services reported. Diagnosis codes identify the medical necessity of services provided by describing the circumstances of the patient's condition. To better support medical necessity for services reported, providers should apply universally accepted healthcare principles that are documented in the patient's medical record, including diagnoses, coding with the highest level of specificity, specific descriptions of the patient's condition, illness, or disease and identification of emergent, acute and chronic conditions.

CareSource will determine medical necessity for a requested service, procedure, or product based on the hierarchy within this policy.

C. Definitions

- **Medically Necessary** - Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.
- **MCG Health** - Developed care guidelines that are in strict accordance with the principles of evidence-based medicine and evidence-based best practices that direct informed care.
- **Mental Health Parity and Addictions Equity Act (MHPAEA)** – A 2008 federal law that generally prevents group health plans and health insurance issuers that provide mental health and substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical coverage.

D. Policy

I. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy. The reviewer will determine medical necessity based on the following hierarchy:
   A. Benefit contract language.
   B. Federal regulation or state regulation, including state waiver regulations when applicable.
   C. CareSource medical policy statements.

D. Nationally accepted evidence-based clinical guidelines, such as MCG Health.
E. Professional judgment of the medical or behavioral health reviewer based on the following potential resources, which may include but are not limited to the following:
   1. Clinical practice guidelines published by consortiums of medical organizations and generally accepted as industry standard.
   2. Evidence from two (2) published studies from major scientific or medical peer-reviewed journals that are less than five (5) years old preferred and less than ten (10) years required to support the proposed use for the specific medical condition as safe and effective.
   3. National panels and consortiums such as NIH (National Institutes of Health), CDC (Centers for Disease Control and Prevention), AHRQ (Agency for Healthcare Research and Quality), NCCN (National Comprehensive Cancer Network), Substance Abuse and Mental Health Services Administration (SAMHSA). Studies must be approved by a United States (US) institutional review board (IRB) accredited by the Association for the Accreditation of Human Research Protection Programs, Inc. (AAHRPP) to protect vulnerable minors.
   4. Commercial External Review Organizations (CERO), such as Up-to-Date and Hayes, Inc.
   5. Consultation from a like-specialty peer.
   6. Specialty and sub-specialty societies listed below. This is not an all-inclusive list:

Sub-specialty	Specialty Society
Addiction Medicine	American Society of Addiction Medicine
Cardiology	American College of Cardiology
Clinical Cardiac Electrophysiology	Heart Rhythm Society
Critical Care Medicine	Society of Critical Care Medicine
Endocrinology, Diabetes and Metabolism	American Academy of Clinical Endocrinologists Endocrine Society
Gastroenterology	American Gastroenterological Association American College of Gastroenterology
Geriatric Medicine	American Geriatrics Society
Gynecology	American Congress of Obstetricians and Gynecologists Society of Gynecologic Oncologists
Gynecologic Oncology	Society of Gynecologic Oncologists
Hematology	American Society of Hematology
Hospice and Palliative Medicine	American Academy of Hospice and Palliative Medicine
Infectious Disease	Infectious Disease Society of America
Internal Medicine	UpToDate
Nephrology	American Society of Nephrology
Oncology	American Society of Clinical Oncology
Pediatrics	American Academy of Pediatrics
Psychiatry	American Psychiatric Association American Academy of Child & Adolescent Psychiatry
Pulmonary Disease	American College of Chest Physicians
Rheumatology	American College of Rheumatology

Sleep Medicine	American Academy of Sleep Medicine
Surgery of the Hand	American Society for Surgery of the Hand

E. Conditions of Coverage

The fact that a physician has performed or prescribed a procedure or treatment, or that it may be the only available treatment for an injury, sickness, or behavioral health disorder, or that the physician has determined that a particular health care service is medically necessary or medically appropriate does not mean that the procedure or treatment is a covered service under the plan and does not guarantee claims payment.

F. Related Policies/Rules

CareSource Evidence of Coverage

G. Review/Revision History

	DATES	ACTION
Date Issued	06/15/2012	
Date Revised	07/15/2013 07/15/2014 05/19/2015 12/15/2015 09/01/2017 12/11/2019 04/01/2020 01/25/2021 03/04/2022	 Criteria changes with specialty/sub-specialty table added to policy. Revise language to include 'professional judgment in the absence of evidence-based methodology' and change order of Plan hierarchy. Revised class/category and defined evidence criteria for article submissions. Added rule, removed hyperlinks, added definition, updated external review organizations and updated age restrictions. Added ASAM. Added waiver regulation. Updated background and references. Added Condition of Coverage.
Date Effective	08/01/2022	
Date Archived	01/31/2023	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. American Association of Professional Coders. What is Medical Necessity and Why Does It Matter? (2019, April 5). Retrieved March 4, 2022 from www.aapc.com.
2. American Medical Association. Definition of Medical Necessity. (n.d.) Retrieved March 4, 2022 from www.ama.com.
3. CareSource Evidences of Coverage. (2021) Retrieved March 4, 2022 from www.caresource.com.

The Administrative Policy Statement detailed above has received due consideration as defined in

The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.