



ADMINISTRATIVE POLICY STATEMENT

Indiana Medicaid

Policy Name & Number	Date Effective
Medical Necessity Determinations-IN MCD-AD-1618	04/01/2026
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), state regulatory bodies, 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.

Payers and insurance plans may limit coverage for services that are reasonable and necessary 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.

International Classification of Diseases (ICD) guidelines instruct the clinician to choose a diagnosis code that accurately describes a clinical condition or reason for a visit and support medical necessity for services reported. 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

- **Medical Necessity** – Services/supplies that are needed for the finding or treatment of a condition. They also meet approved standards of medical practice.

D. Policy

Medical necessity determinations are based on the following hierarchy:

- Federal law and federal regulations regarding Medicaid-specific requirements
- Indiana Code, including Medicaid-specific provisions
- State plan
- Indiana Administrative Code, including Medicaid-specific provisions
- National clinical guidelines, such as MCG, which may be customized by CareSource and approved by the State
- CareSource developed criteria, which must be approved by the State
- Indiana Health Coverage Programs policy and criteria
- Medicare NCDs and LCDs, when clinically appropriate
- Professional society guidelines based upon published peer-reviewed literature

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

- Professional references/subject matter experts guided by published peer-reviewed literature
- Best standards of care guided by published peer-reviewed literature

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

E. Conditions of Coverage

The following does not guarantee coverage or claims payment for a procedure or treatment under a plan (not an all-inclusive list):

- A. A provider has performed or prescribed a procedure or treatment.
- B. The procedure or treatment may be the only available treatment for an injury, sickness, or behavioral health disorder.
- C. The provider has determined that a particular health care service is medically necessary or medically appropriate.

F. Related Policies/Rules

Experimental or Investigational Item or Service

G. Review/Revision History

DATE		ACTION
Date Issued	10/08/2025	Approved at Committee.
Date Revised		
Date Effective	04/01/2026	
Date Archived		

H. References

1. Medical review criteria hierarchy. Indiana Health Coverage Programs. July 1, 2025. BT2025102. www.in.gov