ADMINISTRATIVE POLICY STATEMENT
Michigan Medicaid

Policy Name & Number	Date Effective
Medical Necessity Determinations-MI MCD-AD-1375	01/01/2026
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, the American Medical Association, state regulatory bodies, and most healthcare insurance providers. 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 even 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.

C. Definitions

- **Covered Services** – All services provided under Medicaid, that HAP CareSource agrees to provide or arrange to be provided to or for members.
- **Evidence-based Standard** – The conscientious, explicit, and judicious use of the current, best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.
- **Health Care Services** – Services for the diagnosis, prevention, treatment, cure, or relief a health condition, illness, injury, or disease.
- **Medical or Scientific Evidence** – Evidence found in any of the following sources:
  - Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most published articles for review by experts who are not part of the editorial staff.
  - Peer-reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's US National Library of Medicine for indexing in the former Index Medicus or current online version, MEDLINE, and Elsevier B. V. for indexing in EMBASE.
  - Medical journals recognized by the secretary of the US Dept. of Health and Human Services under 42 U.S.C. § 1395x(t)(2)(B)(ii)(I).

- The following standard reference compendia:
  - American Hospital Formulary Service drug information
  - drug facts and comparisons
  - American Dental Association's accepted dental therapeutics
  - US Pharmacopoeia drug information
- Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes, including the following:
  - Agency for Healthcare Research and Quality (AHRQ)
  - National Institutes of Health (NIH)
  - National Cancer Institute (NCI)
  - National Academy of Sciences
  - Centers for Medicare and Medicaid Services (CMS)
  - US Food and Drug Administration (FDA)
  - Any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health care services.
- Any other medical or scientific evidence that is comparable to the sources listed in subparagraphs (i) to (v).

- **Medically Necessary/Medical Necessity** – Covered services which are (1) reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and (2) for which there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly.

  For members less than 21 years of age, a service that meets the EPSDT standard of *Medical Necessity* set forth in Section 1905(r) of the Social Security Act and 42 U.S.C. § 1396d(r)(5). Without limitation, includes all services necessary to achieve or maintain age-appropriate growth and development; attain, regain, or maintain functional capacity; or improve, support, or maintain the Enrollee's current health condition. Medical necessity is determined on a case-by-case basis, taking into account the individual needs of the child.
- **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 than on medical/surgical coverage.

D. Policy

I. Standards for determining medical necessity are no more restrictive than standards used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in Michigan statutes, regulations, the State Plan, *Medicaid Provider Manual*, and other State policy and procedures. HAP CareSource will ensure that services are sufficient in amount, duration, or scope to reasonably

achieve the purpose for which the services are furnished and will conform to professionally accepted standards of care.

II. According to the 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. Medical necessity is based on the following hierarchy:
   A. Benefit contract language.
   B. Federal and state laws and regulations, including state waiver regulations when applicable.
   C. Michigan Medicaid Provider Manual and Medicaid policies and procedures.
   D. Nationally accepted evidence-based clinical guidelines, such as MCG Health, and American Society for Addiction Medicine.
   E. HAP CareSource medical policy statements.
   F. 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. Medical/Scientific evidence from 2 published studies from major scientific or medical peer-reviewed journals that are less than 5 years old (preferred) and less than 10 years (required) to support the proposed use for the specific medical condition as safe and effective.
      3. National panels and consortiums such as National Institutes of Health, Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality, National Cancer Institute, Substance Abuse and Mental Health Services Administration. Studies must be approved by a United States institutional review board accredited by the Association for the Accreditation of Human Research Protection Programs, Inc. to protect vulnerable minors.
      4. Commercial external organizations, such as Up-to-Date and Hayes, Inc.
      5. Consultation from a like-specialty peer.
      6. Specialty and sub-specialty societies such as the American Psychiatric Association and the American Board of Internal Medicine.

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 physician has performed or prescribed a procedure or treatment.
- The procedure or treatment may be the only available treatment for an injury, illness, or behavioral health disorder.
- The physician 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	09/27/2023	Approved at Committee.
Date Revised	03/13/2024 10/08/2026	Annual review. Added definitions, D.I. from contract. Approved at Committee. Annual review: Removed chart from D.6.
Date Effective	01/01/2026	
Date Archived		

H. References

1. *Medicaid Provider Manual.* Michigan Dept of Health and Human Services. Updated July 1, 2025. Accessed August 12, 2025. www.mdch.state.mi.us
2. Patient's Right to Independent Review Act, MICH. COMP. LAWS § 550.1903 (2016).
3. Request for External Review; Commencement; Preliminary Review; Notice of Acceptance; Duties of Director; Incomplete Request; Nonacceptance; Assignment of Independent Review Organization; Duty of Health Carrier to Provide Documents; Reconsideration by Health Carrier of Its Adverse Determination; Recommendation; Considerations; Review by Director; Notice of Decision, MICH. COMP. LAWS § 550.1911 (2016).
4. Standard Electronic Prior Authorization Transaction Process; Requirements; Adverse Determination Process; Denial and Appeals; Standard Report; Modification Program; Definitions, MICH. COMP. LAWS § 500.2212e (2022).