CareSource

ADMINISTRATIVE POLICY STATEMENT
Nevada Medicaid

Policy Name & Number	Date Effective
Medical Necessity Determinations-NV MCD-AD-1577	01/01/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements 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 thediagnosis or treatment of disease, illness, or injury and without which the patient can be expec ted 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 themember or provider. Medically necessary services also include those services defined in any Evidence of Coverage or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Administrative Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Administrative Polic y Statement. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the pl an contract, then the plan contract will be the controlling document used to make the determination.

Accordingto 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* is 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. These 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.

Payors 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.

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

C. Definitions
- **Early and Periodic Screening, Diagnosis and Treatment (EPSDT)** – Pursuant to Section 1905(r) of the Act and 42 CFR 441 Subpart B, a preventive health care program aimed at providing Medicaid-eligible children under the age of 21 the most effective preventive health care through the use of periodic examinations, standard immunizations, diagnostic services, and treatment services, which are Medically Necessary and designed to correct or ameliorate defects in physical or mental illnesses or conditions. In Nevada, EPSDT is also referred to as Healthy Kids.
- **Medically Necessary/Medical Necessity** – Health care services or products that a prudent physician would provide to a patient to prevent, diagnose or treat an illness, injury or disease, or any symptoms thereof, that are necessary and
  1. Provided in accordance with generally accepted standards of medical practice.
  2. Clinically appropriate with regard to type, frequency, extent, location and duration.
  3. Not primarily provided for the convenience of the patient, physician or other provider of health care.
  4. Required to improve a specific health condition of an insured or to preserve the existing state of health of the insured.

5. The most clinically appropriate level of health care that may be safely provided to the insured.

A request for a service that is for convenience or comfort of a member or their caregiver is not a consideration of medical necessity and is non-covered.

- **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.
- **Treatment** – A medical service, diagnosis, procedure, therapy, drug, or device.

D. Policy

I. Medical necessity determinations are based upon the following hierarchy:
   A. Benefit contract language.
   B. Federal and state law and regulation, including state waiver regulations, when applicable.
   C. State policy and procedures, including the Nevada Medicaid Services Manual.
   D. Nationally accepted evidence-based clinical guideline, such as MCG Health and American Society for Addiction Medicine.
   E. CareSource medical policy statements based on nationally recognized clinical criteria and standards of care.
   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. 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 (NIH), Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), National Comprehensive Cancer Network (NCCN), and Substance Abuse and Mental Health Services Administration (SAMHSA). Studies must be approved by a United States institutional review board (IRB) accredited by the Association for the Accreditation of Human Research Protection Programs, Inc. (AAHRPP) to protect vulnerable minors.
      4. Commercial review organizations, such as UpToDate and Hayes, Inc.
      5. Consultation from a like-specialty peer.
      6. National specialty/sub-specialty societies such as the American Psychiatric Association and the American Board of Internal Medicine.

According to the rules of 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.

II. Individuals under the age of 21 are subject to the requirements of EPSDT. Services not included in the Medicaid plan may be available to members based on medical necessity. Any items or services determined to be unsafe or ineffective, or are considered experimental are not covered. Treatments proven to be effective through evidence-based research and peer-reviewed studies will be considered non-experimental. Appropriate limits may be placed on EPSDT services based on medical necessity. This includes Well Baby/Child Services (Nevada Check Up).

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):

I. A physician has performed or prescribed a procedure or treatment.
II. The procedure or treatment may be the only available treatment for an injury, illness, or behavioral health disorder.
III. The physician has determined that a particular health care service is medically necessary or medically appropriate.

F. Related Policies/Rules

Experimental and Investigational Item or Service

G. Review/Revision History

	DATE	ACTION
Date Issued	11/19/2025	Approved at Committee.
Date Revised		
Date Effective	01/01/2026	
Date Archived		

H. References

1. "Medically Necessary" Defined, NEV. REV. STAT. § 695G.055 (2024).
2. Medical Necessity. *Medicaid Services Manual*. Division of Health Care Financing and Policy; 2025:103.1. Accessed November 10, 2025. www.dhcfp.nv.gov

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