ADMINISTRATIVE POLICY STATEMENT
Ohio Medicaid

Policy Name & Number	Date Effective
Medical Necessity Determinations-OH MCD-AD-0005	02/01/2026
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* 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, but definitions most often incorporate the idea that health care 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 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 the visit and support medical necessity for the reported services. Providers are to 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

- **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 of their 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 library of medicine for indexing in index medicus and elsevier science ltd. for indexing in excerpta medicus.
  - Findings, studies or research conducted by or under the auspices of a federal government agency or nationally recognized federal research institute, including any of the following:
    The federal agency for Health Care Research and Quality, the National Institutes of Health (NIH), the National Cancer Institute, the National Academy of Sciences, the Centers for Medicare and Medicaid Services, the Federal Food and Drug Administration, any national board recognized by the NIH for the purpose of evaluating the medical value of health care services.

- **Medically Necessary/Medical Necessity** –
  - Individuals covered by early and periodic screening, diagnosis, and treatment (EPSDT): Procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.
  - Individuals not covered by EPSDT – Procedures, items, or services that prevent, diagnose, evaluate, or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability, and without which the person 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.
  - Conditions of medical necessity are met if **ALL** the following apply:
    1. Meets generally accepted standards of medical practice.
    2. Clinically appropriate in type, frequency, extent, duration, and delivery setting.
    3. Appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome.
    4. Is the lowest cost alternative that effectively addresses and treats the medical problem.
    5. Provides unique, essential, and appropriate information if used for diagnostic purposes.
    6. Not provided primarily for the economic benefit of the provider nor for the convenience of the provider or anyone else other than the recipient.
- **Mental Health Parity and Addictions Equity Act (MHPAEA)** – Federal law that generally prevents group health plans and health insurance issuers who provide mental health and substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations than on medical/surgical coverage.

D. Policy

In accordance with MHPAEA, medical necessity determinations for MH/SUD benefits will not be subject to any limitations that are less favorable than those that apply to medical conditions as covered under this policy. All medical necessity determinations are based on the following hierarchy:

A. Benefit contract language.
B. Federal and state laws and regulations, including state waiver regulations as applicable, including Ohio Department of Medicaid (ODM)-developed criteria where it exists.
C. Clinically-accepted evidence-informed medical necessity criteria (eg, MCG, American Society of Addiction Medicine [ASAM]).
D. In the absence of the above, CareSource medical policy statements, as approved by ODM, and based upon evaluated, peer reviewed medical or scientific evidence published in the United States.
   1. Peer reviewed evidence must include investigations that have been reproduced by non-affiliated authoritative sources.

2. The literature must also include positive endorsements by national medical bodies or panels regarding scientific efficacy and rationale that is based upon well-designed research and endorsements by national medical bodies or panels regarding scientific efficacy and rationale.

E. Professional judgment of the medical or BH reviewer based upon the above criteria, which may include, but are not limited to:
   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, Centers for Disease Control and Prevention, Agency for Healthcare Research and Quality, National Comprehensive Cancer Network, 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 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.

E. Conditions of Coverage

The fact that a physician, dentist, or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself, make the procedure, item, or service medically necessary and does not guarantee payment.

F. Related Policies/Rules

State Regulations: Managed Care Programs, Ohio Admin. Code 5160-26 (2023), including, but not limited to the following:

- Managed Care: Covered Services, OHIO ADMIN. CODE 5160-26-03 (2022).
- Managed Care: Provider Services, OHIO ADMIN. CODE 5160-26-05.1 (2022).

Federal Regulations:

- Amendment of Protected Health Information, 45 C.F.R. § 164.526 (2024).
- Managed Care, 42 C.F.R. §§ 438 (2024).

CareSource Policy

- EPSDT Benefit
- Experimental or Investigational Item or Service

G. Review/Revision History

DATES		ACTION
Date Issued	06/15/2012	

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

Date Revised	07/15/2013 07/15/2014 05/19/2015 12/15/2015 04/01/2020 01/25/2021 03/04/2022 06/21/2023 01/17/2024 10/08/2025	 Criteria changes with specialty/sub-specialty table added to policy. Revised language to include 'professional judgment in the absence of evidence-based methodology' and change order of Plan hierarchy. Added rule, added definitions, removed hyperlinks, updated external review organizations and age restrictions. Annual Review. Added ASAM. Annual review. Updated background. Reordered hierarchy, I.B-D. Annual review. Updated hierarchy and specialty chart. Approved at Committee. Changed Conditions of Coverage language. Added related rules. Updated references. Annual review: Definitions updated, In D.I., MCG criteria placed above CareSource policies. Approved at Committee.
Date Effective	02/01/2026	
Date Archived		

H. References

1. Definitions, OHIO REV. CODE § 3922.01 (2025).
2. Definitions, OHIO REV. CODE § 5162.01 (2023).
3. Managed Care: Definitions, OHIO ADMIN. CODE 5160-26-01 (2022).
4. Medicaid Medical Necessity: Definitions and Principles, OHIO ADMIN. CODE 5160-1-01 (2022).

Approved by ODM 10/20/2025

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