



Administrative Policy Statement OHIO MEDICARE ADVANTAGE PLANS

Policy Name		Policy Number	Date Effective
Medical Necessity Determinations		AD-0009	08/01/2020
Policy Type			
Medical	ADMINISTRATIVE	Pharmacy	Reimbursement

Administrative Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) 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 CSMG Co. and its affiliates (including CareSource) 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.

Table of Contents

Administrative Policy Statement	1
A. Subject	2
B. Background	2
C. Definitions.....	2
D. Policy.....	2
E. Conditions of Coverage	4
F. Related Policies/Rules.....	4
G. Review/Revision History	4
H. References	4



A. Subject

Medical Necessity Determinations

B. Background

Coverage determinations for CareSource Medicare Advantage members are made in accordance with the applicable Centers for Medicare and Medicaid Services (CMS) payment policies, National and Local Coverage Determinations, Medicare Evidence of Coverage, and Summary of Benefits documents. These documents and the other policies described herein are utilized to determine on a case-by-case basis limitations, exclusions and/or covered benefits of health services for our members.

C. Definitions

- **Medically necessary:** Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.
- **National coverage determination:** A determination by the Secretary with respect to whether or not a particular item or service is covered nationally under this title, but does not include a determination of what code, if any, is assigned to a particular item or service covered under this title or a determination with respect to the amount of payment made for a particular item or service so covered.
- **Local coverage determination:** A determination by a fiscal intermediary or a carrier under part A or part B, as applicable, respecting whether or not a particular item or service is covered on an intermediary—or carrier—wide basis under such parts.

D. Policy

- I. The reviewer will determine medical necessity based on the following hierarchy:
 - A. Benefit contract language.
 - B. Federal regulation or state regulation.
 1. CareSource makes coverage determinations in accordance with criteria defined by applicable state and federal guidelines. Specifically, CareSource complies with all current CMS payment policies, and National Coverage Determinations (NCDs).
 2. In the absence of an NCD, CareSource utilizes criteria outlined by applicable Local Coverage Determinations (LCDs) under the direction of the local Medicare Administrative Contractor (MAC). When services are covered by LCD's from more than one MAC outlining differing medical review policies and/or criteria, CareSource will apply the LCD of the MAC with jurisdiction over the State where the member resides.
 - C. CareSource medical policy statements.
 - D. Nationally-accepted evidence-based clinical guideline (MCG).
 - E. Professional judgment of the medical or behavioral health reviewer based on the following potential resources (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 **TWO** published studies from major scientific or medical peer-reviewed journals that are < 5 years old preferred and < 10 years required to support the proposed use for the specific medical condition as safe and effective.



Effective Date: 08/01/2020

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 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

F. Related Policies/Rules

G. Review/Revision History

DATES		ACTION
Date Issued	10/20/2015	
Date Revised	12/11/2019 04/01/2020	Added rule, changed title, changed definitions, removed hyperlinks, removed graph, updated external review organizations and age restrictions. Added ASAM
Date Effective	08/01/2020	
Date Archived	07/01/2021	

H. References

1. Social Security Administration. (2014, April 1). Determinations; Appeals Sec. 1869. [42 U.S.C. 1395ff] (a) Initial Determinations. Retrieved from <https://www.ssa.gov>
2. U.S. Centers for Medicare & Medicaid Services. (n.d.). Glossary. Retrieved from <https://www.medicare.gov>

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