ADMINISTRATIVE POLICY STATEMENT
Michigan Health Link

Policy Name & Number	Date Effective
Medical Necessity Determinations-MI Health Link-AD-1416	06/01/2024
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 even if the services are 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 supports 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.

Centers for Medicare and Medicaid Services (CMS) finalized the codification of existing medical necessity standards, adding when care can be delivered in more than one way or in more than one type of setting, and a contracted provider has ordered or requested Medicare covered items or services for a Medicare enrollee. CareSource will determine medical necessity for a requested service, procedure, or product based on the hierarchy within this policy.

C. Definitions

- **Acceptable Clinical Literature** – Information that includes (1) large, randomized controlled trials or prospective cohort studies with clear results published in a peer-reviewed journal and specifically designed to answer the relevant clinical question, or (2) large systematic reviews or meta-analyses summarizing the literature of the specific clinical question.
- **Coverage Criteria Not Fully Established** – Additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently, including the following:
  - Additional criteria provide clinical benefits highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services.
  - NCDs or LCDs include flexibility that explicitly allow for coverage in circumstances beyond specific indications listed in an NCD or LCD.

  - An absence of applicable Medicare statutes, regulations, NCDs or LCDs setting forth coverage criteria.
- **Health Care Services** – Services for the diagnosis, prevention, treatment, cure, or relief a health condition, illness, injury, or disease.
- **InterQual** – A criteria portfolio offering comprehensive clinical decision support designed to strengthen patient outcomes and reinforce appropriate utilization by providing access to evidence-based clinical criteria.
- **Local Coverage Determination (LCD)** – A determination by a fiscal intermediary or a carrier under part A or part B of Medicare, as applicable, respecting whether a particular item or service is covered on an intermediary or carrier-wide basis under such parts.
- **MCG Health** – Developed care guidelines in strict accordance with the principles of evidence-based medicine and best practices that direct informed care.
- **Medically Necessary/Medical Necessity** – Services administered in a way that provide all protections to covered individuals provided by Medicare and Michigan Medicaid. Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury, improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. § 1395y. Per Medicaid, determination that a specific service is medically (clinically) appropriate, necessary to meet needs, consistent with the person's diagnosis, symptomatology and functional impairments, is the most cost-effective option in the most integrated setting, and is consistent with clinical standards of care. Medical necessity includes, but is not limited to, those supports and services designed to assist the enrollee to attain or maintain a sufficient level of functioning to enable the person to live in his/her community.
- **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.
- **National Coverage Determination (NCD)** – A determination with respect to whether a particular item, service, or technology is covered nationally under Medicare but does not include a determination of what code, if any, is assigned to a particular item or service covered or a determination with respect to the amount of payment made for a particular item or service so covered.
- **Treatment Guidelines** – Widely used guidelines developed by organizations representing clinical medical specialties for the treatment of specific diseases or conditions.

D. Policy

I. 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. CareSource's guidelines will, at a minimum, be no more restrictive than Medicare standards for acute services and Medicaid standards for

Long-Term Services and Supports (LTSS) and community mental health and substance use disorder services. CareSource will ensure consistent application of review criteria for authorization decisions and consult with the requesting provider when appropriate.

Enrollees will have equitable access to care across the network. Authorization decisions will be constructed in a fair, impartial, and consistent manner that serves the best interests of the enrollees, based on the most current NCQA standards (when applicable), and will demonstrate the following characteristics, at a minimum:

A. developed with input from practicing physicians in the service area and in accordance with standards adopted by national accreditation organizations
B. illustrative of the State of Michigan's definition of medical necessity
C. updated annually or as new treatment, applications, and technologies are adopted as generally accepted medical practice
D. evidence-based, if practicable
E. applied in a manner considering the individual health care needs of the enrollee

II. CareSource will make medical necessity determinations based on all the following:
   A. Coverage and benefit criteria as specified as follows and may not deny coverage for basic benefits based on coverage criteria not specified below:
      1. CMS's national coverage determinations (NCDs)
      2. general coverage and benefit conditions included in traditional Medicare laws, unless superseded by laws applicable to MA plans
      3. written coverage decisions of local Medicare contractors with jurisdictions for claims in the geographic areas (ie, local coverage determinations [LCDs])
      4. CareSource regional plans in an MA region that covers more than one local coverage policy area will uniformly apply all of the local coverage policy determinations that apply in the selected local coverage policy area in that MA region to all parts of that same MA region
      5. selected local coverage policies will be readily available, including through the Internet, to enrollees and providers
      6. publicly accessible internal coverage criteria based on current evidence in widely used treatment guidelines or clinical literature when coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs
   B. Whether the provision of items or services is reasonable and necessary under § 1862(a)(1) of the Act
   C. Member medical history (ie, diagnoses, conditions, functional status), physician recommendations, and clinical notes
   D. Where appropriate, involvement of the organization's medical director as required at § 422.562(a)(4)

III. Reviewers will determine medical necessity based on the following hierarchy:
   A. Benefit contract language

B. Federal regulation or state regulation, including state waiver regulations when applicable, in compliance with criteria established above in section D.II.
   1. 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 LCDs from more than one MAC and outline 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. Nationally accepted, evidence-based, clinical guidelines, such as MCG Health, InterQual, or American Society for Addiction Medicine

D. CareSource medical policy statements

E. Professional judgment of the medical or behavioral health reviewer based on the following resources, 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/consortiums, including the following (not an all-inclusive list):
      a. National Institutes of Health (NIH)
      b. Centers for Disease Control and Prevention (CDC)
      c. Agency for Healthcare Research and Quality (AHRQ)
      d. National Cancer Institute (NCI)
      e. Substance Abuse and Mental Health Services Administration (SAMHSA)
      f. Association for the Accreditation of Human Research Protection Programs, Inc. (AAHRPP)
   4. External review organizations (ie, UptoDate, Hayes, AllMed)
   5. Consultation from a like-specialty peer
   6. Specialty and sub-specialty societies listed below (not an all-inclusive list):

General Area	Specialty Society	Subspecialty Example(s)
Addiction	American Society of Addiction Medicine	Addiction Psychiatry, Addiction Medicine
Allergy & Immunology	American Academy of Asthma, Allergy & Immunology; American College of Allergy, Asthma & Immunology	None
Anesthesiology	American Society of Anesthesiologists	Critical Care Medicine, Pain Medicine, Pediatric Anesthesiology, Sleep Medicine
Cardiology	American College of Cardiology, Society for Cardiovascular Angiography & Interventions	Adult Congenital Heart Disease, Advanced Heart Failure & Transplant Cardiology, Cardiovascular Disease, Clinical Cardiac Electrophysiology
Colorectal Care	American Society of Colon & Rectal Surgeons	None

Critical Care Medicine	Society of Critical Care Medicine	Multiple
Dermatology	American Academy of Dermatology	Dermatopathology, Pediatric Dermatology, Immunodermatology
Emergency Medicine	American College of Emergency Physicians	Anesthesiology Critical Care, Emergency Medical Services, Internal Medicine- Critical Care, Pediatric Emergency Medicine, Hyperbaric Medicine
Endocrinology, Diabetes & Metabolism	American Academy of Clinical Endocrinologists; Endocrine Society	Endocrinology, Diabetes & Metabolism
Family Medicine	American Academy of Family Practice	Adolescent Medicine, Geriatric Medicine
Gastroenterology	American Gastroenterological Assoc American College of Gastroenterology	Gastroenterology
Genetics	American College of Medical Genetics	Biochemical Genetics, Molecular Genetic Pathology
Geriatric Medicine	American Geriatrics Society	Multiple
Hematology	American Society of Hematology	Hematology
Hospice and Palliative Medicine	American Academy of Hospice and Palliative Medicine	Hospital, Home Care, Care Homes
Infectious Disease	Infectious Disease Society of America	Pediatric Infectious Disease
Internal Medicine	American College of Physicians	Infectious Disease, Transplant Hepatology
Nephrology	American Society of Nephrology	Nephrology
Neurology	American Association of Neurological Surgeons	Neuro-critical Care, Neuro-oncology, Geriatric Neurology
Nuclear Medicine	American College of Nuclear Medicine	None
Obstetrics & Gynecology	American Congress of Obstetricians & Gynecologists Society of Gynecologic Oncologists	Female Pelvic Medicine & Reconstructive Surgery, Gynecologic Oncology, Maternal & Fetal Medicine Reproductive Endocrinology/ Infertility
Oncology	American Society of Clinical Oncology	Medical Oncology, Surgical Oncology
Ophthalmology	American Academy of Ophthalmology	Pediatric
Orthopedic Surgery	American Academy of Orthopaedic Surgeons	Orthopedic Sports Medicine, Surgery of the Hand, Podiatry
Otolaryngology	American Academy of Otolaryngology-Head & Neck Surgery	Neurotology, Pediatric Otolaryngology
Pathology	College of American Pathologists American Society for Clinical Pathology	Clinical Informatics, Cytopathology, Neuropathology, Dermatopathology, Forensic Pathology
Pediatrics	American Academy of Pediatrics	Adolescent Medicine, Child Abuse & Neglect, Pediatric Hospital, Developmental Behavioral, Neurodevelopmental Disabilities
Physical Medicine & Rehabilitation	American Academy of Physical Medicine & Rehabilitation	Brain Injury, Neuromuscular Medicine, Sports Medicine, Pediatric Rehabilitation, Spinal Cord Injury
Plastic Surgery	American Society of Plastic Surgeons	Plastic Surgery - Head & Neck, Surgery of the Hand
Preventive Medicine	American College of Preventive Medicine	Occupational Medicine, Aerospace Medicine, Public Health & General Preventive

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

Psychiatry	American Psychiatric Association; American Academy of Child & Adolescent Psychiatry	Addiction Psychiatry, Child & Adolescent Psychiatry, Clinical Neurophysiology, Forensic Psychiatry, Geriatric Psychiatry
Pulmonary Disease	American College of Chest Physicians	Pulmonary Disease
Radiology	American College of Radiology American Society for Therapeutic Radiation & Oncology	Neuroradiology, Nuclear Radiology, Pediatric Radiology, Vascular & Interventional Radiology
Rheumatology	American College of Rheumatology	Rheumatology
Surgery & Vascular Surgery	American College of Surgeons	Complex General Surgical Oncology, Pediatric Surgery, Surgical Critical Care
Thoracic & Cardiac Surgery	Society of Thoracic Surgeons	Congenital Cardiac Surgery
Urology	American Urological Association	Female Pelvic Medicine & Reconstruction, Pediatric Urology

E. Conditions of Coverage

I. The following does not guarantee coverage or claims payment for a procedure or treatment under a plan (not an all-inclusive list):
   A. A physician has performed or prescribed a procedure or treatment.
   B. The procedure or treatment may be the only available treatment for an injury, illness, or behavioral health disorder.
   C. The physician has determined that a particular health care service is medically necessary or medically appropriate.

II. CareSource will not deny authorization(s) based on internal clinical criteria that go beyond Medicare coverage rules or will comply with § 422.101(b)(6) addressing standards for when internal coverage rules are permissible.

III. CareSource will determine medical necessity for a requested service, procedure, or product based on the hierarchy for Michigan Medicaid services once Medicare coverage has been determined or if Medicare benefit limits are exceeded.

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	12/13/2023	New policy. Approved at Committee.
Date Revised	03/13/2024	Annual review. Updated references. Approved at Committee.
Date Effective	06/01/2024	
Date Archived		

H. References

1. 42 U.S.C § 1395y (2023).
2. Coverage and Authorization of Services, 42 C.F.R. § 438.210 (2023).

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

3. Definition of medical necessity. American Medical Association. Policy – H-320.953. Accessed February 27, 2024. www.ama.com
4. Definitions, MICH. COMP. LAWS § 550.1903 (2016).
5. Glossary. Centers for Medicare and Medicaid Services. Accessed February 27, 2024. www.cms.gov
6. *Medicaid Provider Manual.* Michigan Dept of Health and Human Services. Updated January 1, 2024. Accessed February 27, 2024. www.mdch.state.mi.us
7. *Medical Necessity: Why It Matters and Ways to Demonstrate It.* American Association of Professional Coders; 2019. Accessed February 27, 2024. www.aapc.com
8. Medicare Program, 42 C.F.R. §§ 405-429 (2023).
9. 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).
10. Requirements Relating to Basic Benefits, 42 C.F.R. § 422.101 (2023).

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