ADMINISTRATIVE POLICY STATEMENT
Ohio MyCare

Policy Name & Number	Date Effective
Medical Necessity Determinations-OH MyCare-AD-0751	10/01/2024
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.

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

- **MCG Health** – Developed care guidelines in strict accordance with the principles of evidence-based medicine and best practices that direct informed care.
- **Medicare**
  - **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 (NCD)** – A determination by the Secretary with respect to whether a particular item, service, or technology 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 (LCD)** – A determination by a fiscal intermediary or a carrier under part A or part B, as applicable, respecting whether a particular item or service is covered on an intermediary–or carrier–wide basis under such parts.

- **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.
- **Ohio Medicaid**
  - **Medically Necessary/Medical Necessity** –
    A. 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.
    B. 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.
    C. Conditions of medical necessity are met if **all** the following apply:
      1. meets generally accepted standards of medical practice
      2. clinically appropriate in its 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 it is 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
- **Waiver Services** – Home and Community-Based Services (HCBS) Waivers under Section 1915(c) of the Social Security Act allow the State to cover home and community services and provide programs designed to meet unique needs of individuals with disabilities who qualify for the level of care (LOC) provided in an institution but who, with special services, may remain in homes and communities.

D. Policy

I. 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. The reviewer 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 and Ohio Department of Medicaid (ODM)-developed criteria.

C. CareSource medical policy statements, as approved by ODM.
D. Nationally accepted evidence-based clinical guideline (ie, MCG Health, Interqual, the American Society of Addiction Medicine), as approved by the State.
E. Professional judgment of the medical or behavioral health reviewer based on the following potential 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 condition as safe and effective.
    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 (N ational Comprehensive Cancer Network), SAMHSA (Substance Abuse and Mental Health Services Administration). 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 Up-to-Date and Hayes, Inc.
    5. Consultation from a like-specialty peer.
    6. National specialty and sub-specialty societies such as the American Psychiatric Association and the American Board of Internal Medicine.

E. Conditions of Coverage

Coverage determinations are made in accordance with 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.

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, sickness, or behavioral health disorder.
C. The physician has determined that a particular health care service is medically necessary or medically appropriate.

F. Related Policies/Rules

MyCare Payer Sequencing Guideline

G. Review/Revision History

	DATES	ACTION
Date Issued	10/20/2015	
Date Revised	12/11/2019	Title changed to medical necessity, added rule, changed definition, removed graph, updated policy, new policy number was AD-0009.
	04/01/2020	Added ASAM.
	01/20/2021	Added waiver to definitions and to hierarchy.
	03/09/2022	Annual review. Updated background. Reordered hierarchy, I.B-D.
	05/26/2022	Added new diagram. Referenced the MyCare Payer Sequencing Guideline.
	05/10/2023	Annual review. Approved at Committee.
	06/21/2023	Annual review. Removed diagram. Updated hierarchy. Updated specialty chart. Approved at Committee.
	07/03/2024	Annual review: Removed specialty chart. Approved at Committee.
Date Effective	10/01/2024	
Date Archived		

H. References

1. Definition of Medical Necessity. American Medical Association. Accessed June 7, 2024. www.ama.com
2. Medicare Coverage Determination Process. Centers for Medicare & Medicaid Services. Updated January 31, 2024. Accessed June 7, 2024. www.medicare.gov
3. Medicaid Medical Necessity: Definition and Principles, OHIO ADMIN. CODE 5160-1-01 (2022).
4. Social Security Act § 1869, 42 U.S.C. § 1395ff (2023).
5. Social Security Act § 1915(c), 42 U.S.C. § 1396n(c) (2023).