# ADMINISTRATIVE POLICY STATEMENT
# Arkansas PASSE

| Policy Name & Number | Date Effective |
|---|---|
| Medical Necessity Determinations-AR PASSE-AD-0866 | 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.

## Table of Contents

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), most healthcare insurance providers, and state regulatory bodies, 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 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. Some PASSE covered services are considered Nonmedical Community Supports and Services (NCSS) and are reviewed on a case-by-case basis, which are therefore not determined by medical necessity.

C. Definitions

- **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** – A service that is reasonably calculated to prevent, diagnose, correct, cure, alleviate, or prevent the worsening of conditions that endanger life, cause suffering or pain, result in illness or injury, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and if there is no other equally effective, although more conservative or less costly, course of treatment available or suitable for the beneficiary requesting the service. For this purpose, a "course of treatment" may include mere observation or, where appropriate, no treatment at all. The determination of medical necessity may be made by the Medical Director for the PASSE Program or by the PASSE Program Quality Improvement Organization (QIO).
- **Mental Health Parity and Addictions Equity Act (MHPAEA)** – A 2008 federal law that generally prevents group health plans and health insurance issuers providing

mental health and substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations than on medical/surgical coverage.

- **Nonmedical Community Supports and Services (NCSS)** – Supports and services nonmedical in nature but necessary to protect the health and safety of members and enable safe living in the community. NCSS are available under the federal authority of sections 1905, 1915(c), or 1915(i) or under state authority under Act 775 through an AR Medicaid enrolled provider as approved by a PASSE for a member and are provided to prevent or delay entry into an institutional setting or to assist or prepare a member to leave an institutional setting (i.e., the service should assist safe living in a member's home or in the community). Need is established by functional deficits identified on the Independent Assessment (ARIA). Actual services and supports are described in the PCSP. HCBS services with a clinical component must use the medical necessity standard.

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 or state regulation, including state waiver regulations when applicable.
C. CareSource medical policy statements.
D. Nationally accepted evidence-based clinical guidelines, such as MCG Health, Interqual, or American Society of Addiction Medicine (ASAM).
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 (National Comprehensive Cancer Network), or 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

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, sickness, 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

Nonmedical Community Supports and Services

G. Review/Revision History

| DATES | | ACTION |
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| **Date Issued** | 01/25/2021 | |
| **Date Revised** | 03/04/2022<br>07/21/2022<br>06/21/2023<br><br>07/03/2024 | Annual review.<br>Added NCSS statement to Conditions of Coverage.<br>Annual review. Updated specialty chart. Added Nonmedical Community Supports and Services as related policy. Approved at Committee.<br>Annual review: removed specialty chart from D.6. Approved at Committee |
| **Date Effective** | 10/01/2024 | |
| **Date Archived** | | |

H. References

1. American Medical Association. Definition of medical necessity. Accessed June 05, 2024. www.ama.com
2. *Provider-Led Arkansas Shared Savings Entity (PASSE) Provider Manual, IV – Glossary*. Arkansas Dept of Human Services; 2023. Accessed June 5, 2024. www.medicaid.mmis.arkansas.gov
3. Definitions, ARK. CODE ANN. § 23-99-1103 (2023).