Evolent Clinical Guideline 2740.CC for Definitions

Guideline Number:	Applicable Codes	
EVH_CG_2740.CC		
"Evolent" refers to Evolent Health LLC and Evolent Specialty Services, Inc.		
Original Date:	**Last Revised Date:**	**Implementation Date:**
July 1, 2025	February 19, 2026	March 1, 2026

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STATEMENT

General Information

- *It is an expectation that all members receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.*
- *Where a specific clinical indication is not directly addressed in this guideline, medical necessity determination will be made based on widely accepted standard of care criteria. These criteria are supported by evidence-based or peer-reviewed sources such as medical literature, societal guidelines, and state/national recommendations.*

Purpose

The purpose of this policy is to provide standard services authorization definitions as defined in DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES NOTICE OF EMERGENCY AMENDMENT.

Special Note

These definitions will be cross referenced in policies where the applicable definition applies.

POLICY

CountyCare applies the following **definitions** when applicable with service authorization procedures in accordance with the those identified in Section 140.76 Managed Care Utilization Review Standardization and Transparency Practices.

Definitions

- **Administrative days** means hospital long-term care days as defined in 89 Ill. Adm. Code 148.50(c)(1).
- **Adverse benefit determination** means the denial or limited authorization of a service authorization request for coverage of a health care service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized health care service; or the denial, in whole or in part, of payment for a service (unrelated to whether the claim is submitted timely or properly coded).
- **Enrollee** means any person who is eligible for medical assistance under Article V of the Public Aid Code, is not eligible for or enrolled in Medicare, and is enrolled in a managed care organization.
- **Generally accepted standards of care** for a health care service means standards of

care and clinical practice that are generally recognized by health care clinicians practicing in relevant clinical specialties for the illness, injury, or condition or its symptoms and comorbidities. Valid, evidence-based sources reflecting generally accepted standards of care include peer-reviewed scientific studies and medical literature, recommendations of nonprofit health care provider professional associations and specialty societies, including, but not limited to, enrollee placement criteria and clinical practice guidelines, recommendations of federal government agencies, and drug labeling approved by the United States Food and Drug Administration.

- **Health care service** means any medical or behavioral health service covered under the medical assistance program that is subject to review under a service authorization program, except for durable medical equipment as described in 89 Ill. Adm. Code 140.475 and pharmacy services as described in 89 Ill. Adm. Code 140.440.
- **Managed care organization** or **MCO** means any entity that contracts with the Department to provide health care services to enrollees where payment for services is made on a capitated basis. For purposes of this section, MCOs shall also mean an MCO's utilization review department, a peer review organization, a quality improvement organization, or a utilization review organization (URO) that contracts with an MCO to administer a service authorization program and make service authorization determinations. For purposes of this section, MCO does not mean an entity that contracts with the Department to provide health care services to Medicare-eligible enrollees where payment is made on a capitated basis.
- **Medically necessary** or **medical necessity** means (a) that a service addresses the specific needs of an enrollee for the purpose of (i) screening, preventing, diagnosing, managing, or treating an illness, injury, or condition and disorder that results in health impairments and/or disability or its symptoms and comorbidities; (ii) minimizing the progression of an illness, injury, or condition or its symptoms and comorbidities; (iii) achieving age-appropriate growth and development; (iv) attaining, maintaining, or regaining functional capacity and (b) in a manner that is all of the following: (i) in accordance with generally accepted standards of care; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration; and (iii) not primarily for the economic benefit of the MCO or for the convenience of the enrollee or provider.
- **Provider** means a facility or individual who is actively enrolled in the medical assistance program and licensed or otherwise authorized to order, prescribe, refer, or render health care services in this State.
- **Service authorization determination** means a decision made by a service authorization program in advance of, concurrent to, or after the provision of a health care service to approve, change the level of care, partially deny, deny, or otherwise limit coverage and reimbursement for a health care service upon review of a service authorization request.
- **Service authorization program** means any utilization review, utilization management, peer review, quality review, or other medical management activity conducted by an MCO including but not limited to, prior authorization, prior approval, pre-certification, concurrent review, retrospective review, or certification of admission, of health care services provided in an inpatient or outpatient hospital setting. Unless otherwise specifically stated in this section, inpatient hospital setting means as defined in 89 Ill.

Adm. Code 148.25 (b)(1). Outpatient hospital setting means as defined in 89 Ill. Adm. Code 148.25 (b)(2).

- **Service authorization request** means a request submitted by a provider to a service authorization program for a service authorization determination.

CODING AND STANDARDS

N/A

Applicable Lines of Business

☐	CHIP (Children's Health Insurance Program)
☐	Commercial
☐	Exchange/Marketplace
☒	Medicaid
☐	Medicare Advantage

POLICY HISTORY

Date	Summary
February 19, 2026	• Annual Review – Updated the 1st bullet under General Information to replace patient with member and removed the 3rd bullet
November 20, 2025	• This guideline replaces PA.262.CC Policy Name • Editorial changes to match the formatting and layout of the new template, no changes to clinical content

LEGAL AND COMPLIANCE

Guideline Approval

Committee

Reviewed / Approved by Evolent Administrative Services Medical Policy Committee

Disclaimer

Evolent Clinical Guidelines do not constitute medical advice. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Evolent uses Clinical Guidelines in accordance with its contractual obligations to provide utilization management. Coverage for services varies for individual members according to the terms of their health care coverage or government program. Individual members' health care coverage may not utilize some Evolent Clinical Guidelines. Evolent clinical guidelines contain guidance that requires prior authorization and service limitations. A list of procedure codes, services or drugs may not be all inclusive and does not imply that a service or drug is a covered or non-covered service or drug. Evolent reserves the right to review and update this Clinical Guideline in its sole discretion. Notice of any changes shall be provided as required by applicable provider agreements and laws or regulations. Members should contact their Plan customer service representative for specific coverage information.

REFERENCES

1. Illinois Department of Healthcare and Family Services. Notice of Emergency Amendment. Section 140.76 Managed Care Utilization Review Standardization and Transparency Practices.

   https://team-iha.org/getmedia/5789ff70-d722-4170-94c9-01ca99c737c0/Standardization-Rules.pdf?utm_campaign=Daily%20Briefing&utm_source=hs_email&utm_medium=email&_hsenc=p2ANqtz-_QRPlneUP34o-V0-ovdTztP9lF0Bh65o0oj2p-oPQOJG8vX6uVN5MHYCK9AZjlZbpoOE5K

2. Illinois Department of Healthcare and Family Services. Covered Hospital Services. Administrative Days. (89 III. Adm. Code 148.50(c)(1)).
   https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/part148hospitalservicessectionslisting.pdf

3. Illinois Department of Healthcare and Family Services. Medical Payment. (89 III. Adm. Code 140), Medical Equipment, Supplies, Prosthetic Devices and Orthotic Devices (89 Ill. Adm. Code 140.475) and Pharmacy Services (89 III. Adm. Code 140.440).

   https://regulations.justia.com/states/illinois/title-89/part-140/subpart-d/

4. Illinois Department of Healthcare and Family Services. Definitions and Applicability. (89 III. Adm. Code 148.25(b)(1) and (b)(2)).

   https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/part148hospitalservicessectionslisting.pdf