CLINICAL POLICY AND PROCEDURE MANUAL

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PA.252.CC Determination of Medical Necessity

Summary

This Clinical policy is intended to support the Utilization Management Medical Director decision process when a specific medical policy or set of criteria is not available to make a medical necessity determination for requested services.

Definitions

Per Illinois 215 ILCS 200 section 15, (*HB711*) Medical Necessity is defined as:

"Medically necessary" means a health care professional exercising prudent clinical judgment would provide care to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms and that are:

(i) in accordance with generally accepted standards of medical practice.

(ii) clinically appropriate in terms of type, frequency, extent, site, and duration and are considered effective for the patient's illness, injury, or disease; and

(iii) not primarily for the convenience of the patient, treating physician, other health care professional, caregiver, family member, or other interested party, but focused on what is best for the patient's health outcome.

Per the STATE OF ILLINOIS MCCN CONTRACT Section 1.1.127

Medically Necessary means services that, when recommended by a Provider for an Enrollee, are: for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms; to assist in the Enrollee's ability to attain, maintain, or regain functional capacity; for the opportunity for an Enrollee receiving LTSS to have access to the benefits of community living, to achieve person centered goals, and live and work in the setting of the Enrollee's choice; or, for an Enrollee to achieve age-appropriate growth and development. Medically Necessary services are requested in accordance with applicable policies and procedures, and provided in a manner that is: (1) in accordance with generally accepted standards of good medical practice in the medical community; (2) consistent with nationally recognized evidence-based guidelines; (3)

clinically appropriate, in terms of type, frequency, extent, site, and duration; and (4) not primarily for the economic benefit of the Contractor or for the convenience of the Enrollee or Provider.

A Medically Necessary service is a service that is appropriate, as indicated in State statutes and regulations for the diagnosis or treatment of a covered illness or injury, for the prevention of future disease; to assist in the Enrollee's ability to attain, maintain, or regain functional capacity; have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of the Enrollee's choice; or for Enrollee to achieve age-appropriate growth and development.

Investigational/Experimental Procedures
Are defined as a procedure, device or pharmaceutical agent that is still undergoing pre-clinical or clinical evaluation, and/or has not yet received regulatory approval. It is the use of a service, procedure or supply that is not recognized by the Plan as standard medical care for the condition, disease, illness or injury being treated. A service, procedure or supply includes but is not limited to the diagnostic service, treatment, facility, equipment, drug or device. When basic safety and efficacy have been demonstrated by the experimental scientific process, the investigational phase begins.

Coverage Determinations for Medical Necessity

CountyCare will use the following as guidelines to determine the medical necessity of specific items and services:

- Consistent with the symptoms or diagnoses of the illness or injury under treatment.
- Necessary and consistent with generally accepted professional medical standards as outlined in this policy.
- Not furnished primarily for the convenience of the patient, caregiver, the attending physician, or another physician or supplier.
- Furnished at the most appropriate level that can be provided safely and effectively to the patient.
- Evidence that a similar outcome cannot be achieved through a lower-cost medically necessary alternative.

In making the determination of medical necessity, CountyCare will use current evidence-based guidelines published by specialists listed in the American Board of Medical Specialties, nationally recognized organizations such as National Guideline Clearinghouse, and Medicare Local and National Coverage Determinations.

Additionally, CountyCare will defer to coverage explicitly stated in the provider manual member handbook, certificate of coverage, or published on the HFS State Medicaid Website.

Determination of coverage is based on plan documents and CountyCare Medical Policies. Technology reviews may include literature reviews, formal technology assessments, and inputs from providers.

Even if a service is considered reasonable and necessary, coverage may be limited if the service is provided more frequently than allowed under a national or local coverage policy, or more frequently than the current standards of care.

To ensure that services being paid for by Medicaid are medically necessary. CountyCare uses the following guidelines listed in order of significance below to make medical necessity decision on a case-by-case basis, based on the information provided on the member's health status

1st State law/guidelines (e.g., when State requirements trump or exceed federal requirements);
2nd CountyCare developed and/or approved medical policies.
3rd If no Plan policies exist, then InterQual Clinical Decision Support Criteria for physical health (PH) or ASAM criteria for behavioral health (BH) requests
4th If experimental/investigational: See Authorization Process #7
5th For Clinical Trials CountyCare considers routine care costs of members in Clinical Trials as medically necessary in accordance with: PA.078.CC Clinical Trials)
6th In the case of no guidance from above, additional information that the applicable Health Plan Medical Director will consider and includes:

- Medical necessity definition as supported by the Plan.
- Reports from peer reviewed medical literature, from which a higher level of evidence and study quality is more strongly considered.
- Evidence-based guidelines published by the American Board of Medical Specialties and other medical associations.
- Nationally recognized organizations such as National Guideline Clearinghouse,
- Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment.
- Nationally recognized drug compendia resources such as Facts & Comparisons® (NCCN, DRUGDEX®, and The National Comprehensive Cancer Network®) Guidelines.
- Government-funded or independent entities that assess and report on clinical care decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.

- Published expert opinions.
- Federal law (e.g., National Coverage Determinations (NCD), Local Coverage Determinations (LCD), and Medicare Coverage Articles for programs under Federal oversight such as Medicare);

Authorization Procedure Guidelines

1. After eligibility and coverage are determined, this policy will be applied.
2. In general, for prior approval to be granted, items or services must be appropriate to the patient's medical needs; necessary to avoid institutional care; and: medically necessary to preserve health, alleviate sickness, or correct a debilitating condition.
3. Documentation is integral to supporting the medical necessity for the service.
    a. The request should describe how the service/item is expected to correct or help the condition, and why the requested treatment plan is better than any other plan commonly used to treat similar diagnoses or conditions.
    b. Include anything unique to the medical condition or living arrangement affecting the choice of a recommended service or item should be explained.
    c. Include conditions being ruled out that will support medical necessity and levels of services billed.
4. Medical Decision-Making limitations
    a. Will approve a service/item that is most appropriate to meet the patient's medical needs necessity or appropriateness for care of the patient.
    b. Will not approve purchase of equipment if the patient already has equipment which is adequate and sufficient to meet his/her medical needs.
    c. May limit coverage to certain diagnoses or, if a service is considered investigational, experimental, or without proven efficacy
5. Review decisions shall be supervised by qualified medical, behavioral health or dental professionals and any decision to deny a Service Authorization Request or to authorize a service in an amount, duration or scope that is less than requested must be made by a qualified professional who has appropriate clinical expertise in treating the Enrollee's condition or disease
6. If medical necessity cannot be determined by the provision of clinical information and does no meet clinical criteria or guidelines as set forth in this policy, a lack of medical necessity coverage determination will be rendered in accordance with Denial Policy XXX.
7. Investigational/Experimental services are considered when the following could occur.
    a) In determining whether services are experimental or investigational, the plan will consider whether the services are in general use in the medical community, whether the services are under continued scientific testing and research, whether the

services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious.

b) In determining whether services are experimental or investigational, the plan will consider whether the services result in greater benefits for a particular illness or disease than other generally available services, and do not pose a significant risk to health or safety of the patient.

c) The supporting documentation upon which the criteria are established must be made available for review upon written request

References

1. Illinois General Assembly. Legislative Information System. Illinois Compiled Statutes. https://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=021501050K2
2. Illinois Department of Healthcare and Family Services. Medicaid Reimbursement. Practitioner Fee Schedule. https://hfs.illinois.gov/medicalproviders/medicaidreimbursement/practitioner.html
3. CountyCare & HealthChoice Illinois. Provider Manual. Provider Relations. January 1, 2023. https://countycare.com/wp-content/uploads/2023-Provider-Manual_033023.pdf
4. CountyCare & HealthChoice Illinois. Member Handbook. January 2023. https://countycare.com/wp-content/uploads/2023_Members-Handbook_011923.pdf
5. Illinois Department of Healthcare and Family Services. Welcome to the Department of Healthcare and Family Services. 2023. https://hfs.illinois.gov/
6. Illinois Department of Healthcare and Family Services. Handbook for Providers of Medical Services. Chapter 100. General Policy and Procedures. Issued: September 2017. https://hfs.illinois.gov/content/dam/soi/en/web/hfs/sitecollectiondocuments/Chapter100GeneralHandbook.pdf

Revision History

Revision	Date
Created Policy	04/20/2023

Disclaimer

CountyCare medical payment and prior authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. The policies constitute only the reimbursement and coverage guidelines of CountyCare

and its affiliated managed care entities. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies.

CountyCare reserves the right to review and update the medical payment and prior authorization guidelines in its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.