MN.015.C Standards of Medical Necessity

Original Implementation Date: 12/1/2018
Version [C] Date: 09/18/2025
Last Reviewed Date: 09/17/2025

PRODUCT VARIATIONS

This policy applies to all Jefferson Health Plans/Health Partners Plans lines of business unless noted below.

POLICY STATEMENT

The plan will reimburse the provider for a service, item, procedure, or level of care included under the member's benefit plan when the service, item, procedure, or level of care (e.g., hospitalization, test, treatment, drug, durable medical equipment (DME) item or supply) has been determined to be medically appropriate. Please see specifics for each product line.

The plan will consider the following to determine if a service, item, procedure, or level of care is medically necessary:

1. Peer reviewed medical literature.
2. Medical opinions of professional providers(experts) in the generally recognized health specialty.
3. Guidelines published by nationally recognized healthcare organizations that include supporting scientific data.
4. Professional medical standards of safety and efficacy, which are recognized in the United States for diagnosis, medical care, or treatment.
5. Pertinent federal regulations, National and Local Coverage Determinations.
6. We use InterQual as evidence-based screening guidelines to assist in clinical decision making, with our medical directors applying criteria for final determinations of medical necessity on requested supplies or services.

Determining Compensability and Medical Necessity (by product lines):

Health Partners Medicaid

COMPENSABILITY: A service or benefit is medically necessary if it is compensable under the MA program and if it meets any one of the following standards:

1. The service, item, procedure, or level of care will, or is reasonably expected to, prevent the onset of an illness, condition, injury, or disability.
2. The service, item, procedure, or level of care will, or is reasonably expected to, reduce, or ameliorate the physical, mental, or developmental effects of an illness, condition, injury or disability.
3. The service, item, procedure, or level of care will assist the member to achieve or maintain maximum functional capacity in performing daily activities, considering the functional capacity of the member and those functional capacities that are appropriate for members of the same age group.
4. The most appropriate Supply, Procedure or Service that can safely be provided for the treatment of Member's condition. When applied to hospitalization, this further means that the member requires acute care as an Inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

DETERMINATION OF MEDICAL NECESSITY:

1. Determination of medical necessity for requested care and services, whether made on a prior authorization, concurrent review, retrospective review, or exception basis, must be documented in writing.
2. The determination is based on medical information provided by the member, the member's family/caretaker, and the primary care physician (PCP), or any other providers, programs or agencies that have evaluated the member.
3. All determinations must be made by a qualified and trained healthcare professional.

Jefferson Health Plans Medicare Advantage

COMPENSABILITY: A service or benefit is medically necessary if it is compensable under Medicare's program, and it meets the following criteria:

1. The services or supplies are determined to be proper and needed for the diagnosis, or treatment of an illness, injury, condition, or its symptoms meet the standards of medical

practice in the local area and aren't mainly for the convenience of the beneficiary or the beneficiary's doctor.

2. National and local coverage determinations are always considered during medical necessity reviews for Medicare members.

3. The most appropriate Supply, Procedure or Level of Service that can safely be provided for the treatment of Member's condition. When applied to hospitalization, this further means that the member requires acute care as an Inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

DETERMINATION OF MEDICAL NECESSITY:

1. Determination of medical necessity for requested care, services, and supplies, whether made on a prior authorization, concurrent review, retrospective review, or exception basis, must be documented in writing, and conveyed to members and providers.

2. Documentation of medical necessity for requested care, services, and supplies will be included in all written notification to the member and providers.

3. The determination will be based on medical information provided by the member, the member's family/caretaker, and the primary care physician (PCP), as well as any other providers, programs or agencies that have evaluated the member.

4. All such determinations must be made by a qualified and trained healthcare professional.

Health Partners Plans CHIP

COMPENSABILITY: A service or benefit is medically necessary if it is compensable under CHIP's program and if it meets the following:

1. The service, item, procedure, or level of care will, or is reasonably expected to, prevent the onset of an illness, condition, injury, or disability.

2. The service, item, procedure, or level of care will, or is reasonably expected to, reduce, or ameliorate the physical, mental, or developmental effects of an illness, condition, injury or disability.

3. The service, item, procedure, or level of care will assist the member to achieve or maintain maximum functional capacity in performing daily activities, considering the functional capacity of the member and those functional capacities that are appropriate for members of the same age group.

4. The most appropriate Supply, Procedure or Level of Service that can safely be provided for the treatment of Member's condition. When applied to hospitalization, this further means that the member requires acute care as an Inpatient due to the nature of the

services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

DETERMINATION OF MEDICAL NECESSITY

1. Determinations are based on covered services under a given benefit package, medical necessity and clinical appropriateness using clinical criteria and guidelines that are accepted for standard of care in the medical community. The physician reviewer can override the criteria when, in his/her professional judgment, the requested service is medically necessary. Every request is given individual consideration.

2. Determination of medical necessity for requested care and services, whether made on a prior authorization, concurrent review, retrospective review, or exception basis, must be documented in writing, and conveyed to members and providers.

3. The determination is based on medical information provided by the member, the member's family/caretaker, and the primary care physician (PCP), as well as any other providers, programs or agencies that have evaluated the member.

4. All such determinations must be made by a qualified and trained healthcare professional. A healthcare professional that makes such determinations of medical necessity is not considered to be providing a healthcare service under their agreement.

Jefferson Health Plans Individual and Family Plans

COMPENSABILITY: A service or benefit is medically necessary if it is compensable under the member's approved policy and if it meets any one of the following standards:

1. The service, item, procedure, or level of care will, or is reasonably expected to, prevent the onset of an illness, condition, injury, or disability.

2. The service, item, procedure, or level of care will, or is reasonably expected to, reduce, or ameliorate the physical, mental, or developmental effects of an illness, condition, injury or disability.

3. The service, item, procedure, or level of care will assist the member to achieve or maintain maximum functional capacity in performing daily activities, considering the functional capacity of the member and those functional capacities that are appropriate for members of the same age group.

4. The most appropriate Supply, Procedure or Service that can safely be provided for the treatment of Member's condition. When applied to hospitalization, this further means that the member requires acute care as an Inpatient due to the nature of the services

rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

DETERMINATION OF MEDICAL NECESSITY:

1. Determinations are based on covered services under a given benefit package, medical necessity and clinical appropriateness using clinical criteria and guidelines that are accepted for standard of care in the medical community. The physician reviewer can override the criteria when, in his/her professional judgment, the requested service is medically necessary. Every request is given individual consideration.

2. Determination of medical necessity for requested care and services, whether made on a prior authorization, concurrent review, retrospective review, or exception basis, must be documented in writing, and conveyed to members and providers.

3. The determination is based on medical information provided by the member, the member's family/caretaker, and the primary care physician (PCP), as well as any other providers, programs or agencies that have evaluated the member.

4. All such determinations must be made by a qualified and trained healthcare professional. A healthcare professional that makes such determinations of medical necessity is not considered to be providing a healthcare service under their agreement.

POLICY GUIDELINES

In all cases, the appropriate documentation supporting medical necessity must be kept on file and, upon request, presented to us.

The definition of medical necessity may vary by product due to state and federal regulatory requirements.

We use InterQual as a reliable, evidence-based clinical content that promotes consistent clinical decisions for appropriate, medically necessary care, services, or items. For certain services (tests, items, procedures) we have designated guidelines (policies) for medical necessity determination.

Physicians can request a copy of the used criteria for decision making.

In this case:

1. Administrative Assistant (AA) will reach out to the medical director (reviewer) to obtain the decision criteria.

2. Medical director (reviewer) will access case requested and copy and paste the applicable criteria into a Word document from the InterQual tab in HRCM or, the Policy and Procedure or, the information from the member's benefit packet and send the information back to the Administrative Assistant (AA).

3. The AA will prepare a letter through the criteria Request Template to send to the requesting provider.

4. The AA will prepare the response via a letter within three (3) business days from the date of the initial receipt of the request that includes:
    - Completed request for Criteria Template.
    - Copy of the decision criteria.
    - Copy of the original letter.

CODING

Note: The Current Procedural Terminology (CPT®), Healthcare Common Procedure Coding System (HCPCS), and the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10) codes that may be listed in this policy are for reference purposes only. Listing of a code in this policy does not imply that the service is covered and is not a guarantee of payment. Other policies and coverage guidelines may apply. When reporting services, providers/facilities should code to the highest level of specificity using the code that was in effect on the date the service was rendered. This list may not be all inclusive.

CPT Code	Description
N/A	
HCPCS Code	**Description**
N/A	
ICD-10 Codes	**Description**
N/A	

BENEFIT APPLICATION

Medical policies do not constitute a description of benefits. This medical necessity policy assists in the administration of the member's benefits, which may vary by line of business. Applicable benefit documents govern which services/items are eligible for coverage, subject to benefit limits or excluded completely from coverage. This policy is invoked only when the requested service is an eligible benefit. as defined in the member's applicable benefit contract on the date the service was rendered. Services determined by HPP to be investigational or experimental, cosmetic, or not medically necessary are excluded from coverage for all product lines.

DEFINITIONS

The terms "Medically Necessary" or "Medical Necessity" refer to services or supplies, provided by a provider, that a plan medical director determines are:

1. Appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease, or injury; and
2. Provided for the diagnosis or the direct care and treatment of the Member's condition, illness, disease, or injury.
3. In accordance with standards of good medical practice; and
4. Not primarily for the convenience of the Member or the Member's Provider; and
5. The most appropriate supply or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the member cannot receive safe or adequate care as an outpatient.

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making. Policy Bulletins are developed to assist in administering plan benefits and constitute neither offers of coverage nor medical advice. This Policy Bulletin may be updated and therefore is subject to change.

For Health Partners Plans Medicaid and Health Partners Plans Chip products: Any requests for services that do not meet criteria set in PARP will be evaluated on a case-by-case basis.

POLICY HISTORY

This section provides a high-level summary of changes to the policy since the previous version.

Summary	Version	Version Date
2025 Annual review. Addition to policy statement.	C	09/18/2025
2024 Annual review. No revisions to this version. Reissue.	B	09/01/2021
2023 Annual review. No revisions to this version. Reissue.	B	09/01/2021
2022 Annual policy review. No revisions to this version. Reissue.	B	09/01/2021
2021 Annual policy review. Policy Statement, Definition and Policy Guidelines sections were revised.	B	09/01/2021
2020 Annual policy review. No revisions to this version. Reissue.	A	12/01/2018
2019 Annual policy review. No revisions to this version. Reissue.	A	12/01/2018
This is a new policy.	A	12/01/2018

REFERENCES

1. Medicare.com What Medically Necessary means and how it affects your Medicare coverage. https://medicare.com/resources/what-medically-necessary-means-and-how-it-affects-your-medicare-coverage/

2. The Pennsylvania Code Definitions: § 1101.21. https://www.pacode.com/secure/data/055/chapter1101/s1101.21.html

3. Pennsylvania Department of Human Services Health Choices Agreement http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/p_040149.pdf

4. Social Security Act 1862 Exclusions from coverage and Medicare as secondary payor. https://www.ssa.gov/OP_Home/ssact/title18/1862.htm

5. U.S. Code, General Provisions, Chapter 7 42 U.S.C. § 1395 https://www.law.cornell.edu/uscode/text/42/1395y