MN.015.B Standards of Medical Necessity

Health Partners Plans

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PRODUCT VARIATIONS

This policy applies to all Health Partners Plans product lines unless noted below.

POLICY STATEMENT

Health Partners Plans 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.

Health Partners Plans 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 generally recognized in the United States for diagnosis, medical care or treatment.
5) Pertinent federal regulations, National and Local Coverage Determinations.
6) HPP uses InterQual as our evidence-based screening guideline to assist is clinical decision making, with HPP medical directors applying medical necessity criteria for final determinations on supplies or services rendered.

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, taking into account 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, procedures 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.

Health Partners Medicare

- **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, disease, 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, procedures 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.

KidzPartners (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, taking into account 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, procedures 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 Health Partners Plans.

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

HPP uses InterQual as our reliable, evidence-based clinical content that promotes consistent clinical decisions for appropriate, medically necessary care, services or items. For certain services (tests, items, procedures) HPP has 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:
    - Copy of the original letter
    - Completed request for Criteria Template
    - Copy of the decision criteria

CODING

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

CPT® is a registered trademark of the American Medical Association.

DEFINITIONS

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

A. Appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease or injury; and
B. Provided for the diagnosis or the direct care and treatment of the member's condition, illness, disease or injury;
C. In accordance with standards of good medical practice; and
D. Not primarily for the convenience of the member or the member's Provider; and
E. 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.

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.

DESCRIPTION OF SERVICES

N/A

CLINICAL EVIDENCE

N/A

DISCLAIMER

Approval or denial of payment does not constitute medical advice and is neither intended to guide nor influence medical decision making.

POLICY HISTORY

Summary	Version	Version Effective Date
2022 Annual policy review. No revisions to this version. Reissue.	B	9/1/2021
2021 Annual policy review. Policy Statement and Policy Guidelines sections were revised for clarity purposes.	B	9/1/2021
2020 Annual policy review. No revisions to this version. Reissue.	A	12/1/2018
2019 Annual policy review. No revisions to this version. Reissue.	A	12/1/2018
This is a new policy.	A	12/1/2018

REFERENCES

1. Centers for Medicare and Medicaid Services CMS.Gov Glossary
   https://www.cms.gov/apps/glossary/default.asp?Letter=M&Language=English
2. 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/
3. The Pennsylvania Code Definitions: § 1101.21.
   https://www.pacode.com/secure/data/055/chapter1101/s1101.21.html
4. Pennsylvania Department of Human Services Health Choices Agreement
   http://www.dhs.pa.gov/cs/groups/webcontent/documents/document/p_040149.pdf
5. Social Security Act 1862 Exclusions from coverage and Medicare as secondary payor.
   https://www.ssa.gov/OP_Home/ssact/title18/1862.htm
6. U.S. Code, General Provisions, Chapter 7 42 U.S.C. § 1395
   https://www.law.cornell.edu/uscode/text/42/1395y