MEDICAL COVERAGE POLICY

SERVICE: **Medical Necessity Determination**

Policy Number:	**213**
Effective Date:	**02/01/2025**
Last Review:	**01/13/2025**
Next Review:	**01/13/2026**

Important note: *Unless otherwise indicated, medical policies will apply to all lines of business.*
Medical necessity as defined by this policy does not ensure the benefit is covered. This medical policy does not replace existing federal or state rules and regulations for the applicable service or supply. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan documents. See the member plan specific benefit plan document for a complete description of plan benefits, exclusions, limitations, and conditions of coverage. In the event of a discrepancy, the plan document always supersedes the information in this policy.

SERVICE: Medical Determination Review

PRIOR AUTHORIZATION: Not Applicable

POLICY: Baylor Scott & White Health Plan (BSWHP), or the Insurance Company of Scott & White (ICSW), may not approve benefits for services rendered to a Covered Person which it determines are not Covered Services (based on individual insurance policy terms, benefits, limitations, and exclusions), are not Medically Necessary, or are not otherwise provided in accordance with the "Insurance Policy."

"Insurance Policy" is an umbrella term that BSWHP / ICSW uses to encompass the following contracts between Members and BSWHP / ICSW; Contractual Document (Medicaid), Evidence of Coverage (BSWHP except Medicaid), Insurance Policy (ICSW), Summary Plan Document (ASO).

"Medical Necessity" is defined within the member's Explanation of Coverage or Summary Plan Description documents. Additional details regarding medical necessity definitions for Medicare / Medicaid / Other Plans can be found in the "Appendix" section of this policy.

For Medicare plans, BSWHP will make coverage review determinations according to the following hierarchy:

1. National Coverage Determinations (NCDs) / Local Coverage Determinations (LCDs) - In the absence of Texas LCD coverage guidance, BSWHP will make coverage determinations based on internal research.
2. Internally developed criteria / BSWHP Medical Policy (based on peer-reviewed medical literature)
3. InterQual Medicare Products (When the InterQual® criteria-set only includes Commercial Product sources, those sources may be used to review requests for Medicare lines of business when appropriate.)
4. Generally accepted standards of medical practice (standards based on credible scientific evidence published in peer-reviewed medical literature, specialty society guidelines, online resources (i.e., UpToDate, NCCN, non-Texas LCD resources, etc.)

* Coverage criteria shall not be more restrictive than general coverage and benefit conditions included in traditional Medicare laws, unless superseded by laws applicable to Medicare Advantage plans (i.e., payment criteria for inpatient admission payment of SNF care, Home Health Services, and Inpatient Rehabilitation Facility care)

For Medicaid plans, BSWHP will make coverage review determinations according to the following hierarchy:

1. Texas Medicaid Provider Procedures Manual | TMHP (TMPPM)
2. Internally developed criteria / BSWHP Medical Policy (based on peer-reviewed medical literature)
3. InterQual Commercial Products (When the InterQual® criteria-set only includes Medicare Product sources, i.e., National or Local Coverage Determinations, those sources may be used to review requests for Medicaid lines of business when appropriate.)
4. Generally accepted standards of medical practice (standards based on credible scientific evidence published in peer-reviewed medical literature, specialty society guidelines, online resources (i.e., UpToDate, NCCN, etc.)

* Coverage criteria shall not be more restrictive than general coverage and benefit conditions included in the Texas Medicaid Provider Procedures Manual. To ensure timely services / care, BSWHP may not require prior authorization (PA) in certain instances where the TMPPM has recommended PA.

For all other plans, BSWHP will make coverage review determinations according to the following hierarchy:

1. Applicable state and federal mandates
2. Internally developed criteria / BSWHP Medical Policy (based on peer-reviewed medical literature)
5. InterQual Commercia Products (When the InterQual® criteria-set only includes Medicare Product sources, i.e., National or Local Coverage Determinations, those sources may be used to review requests for non-Medicaid / non-Medicare lines of business when appropriate.)
3. Generally accepted standards of medical practice (standards based on credible scientific evidence published in peer-reviewed medical literature, specialty society guidelines, online resources (i.e., UpToDate, NCCN, etc.)
4. In instances where none of the above apply, BSWHP / ICSW / FirstCare will follow the rules and regulations set forth by the Center for Medicare and Medicaid Services (CMS).

Notes:

1. Consistent with the rules and regulations of Texas Department of Insurance (TDI), CMS, TMPPM; if insufficient information is provided to make a determination, the request will be denied as “Not Medically Necessary” by the reviewing Medical Director.
2. When a denial for a request is made for lack of medical necessity, the requesting provider has opportunity for the decision to be rescinded / reconsidered via the peer-to-peer process or by formally appealing the decision within regulatory defined time frames.
3. For medications covered under the Medical Benefit please see BSWHP Medical Coverage Policy 215 – Medications Covered Under Medical Insurance Policy.
4. Coverage criteria / Medical Policies are publicly accessible
   a. Internal coverage criteria / Medical Policies can be found on the Medical Resources for Providers website.
   b. Coverage criteria / Medical Policies for delegated vendors can be found on the eviCore Clinical Guidelines and OncoHealth Criteria websites.

5. Communication regarding internal new policies / policy updates are communicated through a variety of channels (email, fax, provider portal, etc.).
6. Medical Policies adhere to CMS and TMHP / TMPPM where applicable and are based on current widely used treatment guidelines or clinical literature. They are also reviewed by practicing physicians who are independent and free of conflict from the BSWHP.

POLICY HISTORY:

Status	Date	Action
New	08/07/2015	New policy
Updated	08/18/2016	Updated Medicare review hierarchy
Reviewed	08/22/2017	No changes
Reviewed	07/03/2018	No changes
Reviewed	03/28/2019	No changes
Reviewed	02/27/2020	No changes
Reviewed	02/25/2021	No changes
Reviewed	02/24/2022	No changes
Reviewed	02/23/2023	No changes
Updated	11/29/2023	Updated / included language for compliance with the CMS Final Rule. Language for all other plans clarified. Medical Necessity Definition section added as an appendix.
Updated	03/11/2024	Updated language to describe use of alternate InterQual Products when InterQual criteria do not exist for a specific line of business (i.e., use of InterQual Medicare Product for Commercial lines of business, if an InterQual Commercial Product does not exist, included use of non-Texas LCDs as resources when appropriate.
Reviewed	01/13/2025	Minor formatting changes. Moved appendix section to the last pages of the policy. Ending note section updated to align with business entity changes.

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. BSWHP will continue to review clinical evidence related to this policy and make modifications based upon the evolution of the published clinical evidence. Should additional scientific studies become available, and they are not included in the list, please forward the reference(s) to BSWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

1. Change Healthcare (InterQual) https://www.changehealthcare.com/clinical-decision-support/interqual
2. 2024 Medicare Advantage and Part D Final Rule(CMS-4201-F) https://www.cms.gov/newsroom/fact-sheets/2024-

medicare-advantage-and-part-d-final-rule-cms-4201-f
3. Novitas Solutions Reasonable & Necessary Guidelines (November 2023) https://www.novitas-solutions.com/webcenter/portal/MedicareJH/pagebyid?contentId=00099545
4. Texas Administrative Code (November 2023) https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=T&app=9&p_dir=F&p_rloc=205713&p_tloc=14808&p_ploc=1&pg=2&p_tac=&ti=1&pt=15&ch=353&rl=2
5. Texas Medicaid and CHIP Reference Guide Texas Medicaid and CHIP Reference Guide
6. Texas Medicaid Provider Procedures Manual https://www.tmhp.com/resources/provider-manuals/tmppm

APPENDIX - Medical Necessity Definitions

For Medicare plans, per Novitas-Solutions, the CMS MAC for Texas, "Reasonable and Necessary Guidelines" is defined as:

"In the absence of a Local Coverage Determination (JH)(JL), National Coverage Determination (NCD), or the Centers for Medicare & Medicaid Services Manual Instruction, reasonable and necessary guidelines still apply.

Section 1862(a) (1) (A) of the Social Security Act directs the following:

No payment may be made under Part A or Part B for any expenses incurred for items or services not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Note: malformed is defined as (of a person or part of the body) abnormally formed; misshapen.

The Medicare Administrative Contractor will determine if an item or service is "reasonable and necessary" under §1862(a) (1) (A) of the Act if the service is:

- Safe and effective;
- Not experimental or investigational; and
- Appropriate, including the duration and frequency in terms of whether the service or item is:
    - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the beneficiary's condition or to improve the function of a malformed body member;
    - Furnished in a setting appropriate to the beneficiary's medical needs and condition;
    - Ordered and furnished by qualified personnel; and
    - One that meets, but does not exceed, the beneficiary's medical need"

For Medicaid plans, per Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter A, Rule §353.2 - Definitions (Texas Administrative Code (state.tx.us), **"**Medically Necessary" is defined as:

"(71) Medically necessary--
(A) For Medicaid members birth through age 20, the following Texas Health Steps services:
(i) screening, vision, dental, and hearing services; and
(ii) other health care services or dental services that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:
(I) must comply with the requirements of a final court order that applies to the Texas Medicaid program or the Texas Medicaid managed care program as a whole; and
(II) may include consideration of other relevant factors, such as the criteria described in subparagraphs (B)(ii) - (vii) and (C)(ii) - (vii) of this paragraph.
(B) For Medicaid members over age 20, non-behavioral health services that are:
(i) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a disability, cause illness or infirmity of a member, or endanger life;

(ii) provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;
(iii) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
(iv) consistent with the member's medical need;
(v) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
(vi) not experimental or investigative; and
(vii) not primarily for the convenience of the member or provider.
(C) For Medicaid members over age 20, behavioral health services that:
(i) are reasonable and necessary for the diagnosis or treatment of a mental health or substance use disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
(ii) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
(iii) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;
(iv) are the most appropriate level or supply of service that can safely be provided;
(v) could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;
(vi) are not experimental or investigative; and
(vii) are not primarily for the convenience of the member or provider."

For all other plans, "Medically Necessary" or "Medical Necessity" shall mean:
Health care services that a healthcare provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms, that are:

a. In accordance with the generally accepted standards of medical practice*;
b. Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
c. Not primarily for the convenience of the patient or healthcare provider, a physician or any other healthcare provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.