Clinical Policy: Medical Necessity Criteria

Reference Number: TX.CP.MP.500
Approved: 1/23

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

To provide the medical necessity criteria and related definitions for STAR, STAR+PLUS, STAR Kids, STAR Health, MMP, and CHIP members.

Policy/Criteria

I. Superior HealthPlan utilizes the following guidelines to make medical necessity decisions on a case-by-case basis, based on the information provided on the member's health status.
   A. Federal law
   B. State law/guidelines
   C. Plan-specific clinical policy
   D. Centene clinical policy
   E. If no Plan- or Centene-specific clinical policy exists, then the nationally recognized decision support tool, InterQual Clinical Decision Support Criteria ® are used.
   F. Texas Medicaid Provider Procedure Manual is used as a criteria source for certain requests depending on the service and age of the member
   G. In the absence of A-F, the medical director will utilize peer reviewed medical literature, medical association publications, professional standards, and/or nationally recognized resources.

II. In the case of no guidance from the above listed criteria in Section I, the following definitions may be utilized for medical necessity determinations for **Medicaid** members:
   A. Members birth through age 20 for physical and behavioral services:
   Medically necessary services are health care services, diagnostic services, treatments, and other measures necessary to correct or ameliorate any disability, physical or mental illness, or chronic conditions.
   A. **Members over age 20**, *ALL* of the following must be met for physical health services to be medically necessary:
      1. 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;
      2. provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;
      3. consistent with generally accepted standards of medical practice that are endorsed by professionally recognized health care organizations or governmental agencies;
      4. consistent with the member's medical need;
      5. no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;

6. not experimental or investigational; and
7. not primarily for the convenience of the member or provider.

1. **Members over age 20**, *ALL* of the following must be met for behavioral health services to be medically necessary: 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;
2. provided in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
3. furnished in the most appropriate and least restrictive setting in which services can be safely provided;
4. at the most appropriate level or supply of service that can safely be provided;
5. could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;
6. not experimental or investigative; and
7. not primarily for the convenience of the member or provider.

III. In the case of no guidance from any the above listed criteria in Section I, the following definitions may be utilized for medical necessity determinations for **CHIP** members:

1. **Physical health services,** *ALL* of the following must be met to be medically necessary: 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;
2. provided at appropriate facilities and at the appropriate levels of care for the treatment of a member's health conditions;
3. consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;
4. consistent with the member's diagnoses;
5. no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;
6. not experimental or investigative; and
7. not primarily for the convenience of the member or provider.

1. **Behavioral health services,** *ALL* of the following must be met to be medically necessary: reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;
2. in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;
3. furnished in the most appropriate and least restrictive setting in which services can be safely provided;
4. at the most appropriate level or supply of service that can safely be provided;
5. could not be omitted without adversely affecting the member's mental and/or physical health or the quality of care rendered;
6. not experimental or investigative; and

7. not primarily for the convenience of the member or provider.

Note: Section III does not apply to CHIP Perinate members

IV. Refer to the criteria in section II B-C for **STAR+PLUS MMP** members.

Definitions:

- **Generally accepted standards of medical practice** – standards that are based upon credible scientific evidence published in peer-reviewed medical literature recognized by the medical community at large or otherwise consistent with the standards set forth in policy issues involving clinical judgment.
- **Experimental or investigational** – a health care treatment, service, or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device, but that is not yet broadly accepted as the prevailing standard of care.
- **Utilization review** includes a system for prospective, concurrent, or retrospective review of the medical necessity and appropriateness of health care services and a system for prospective, concurrent, or retrospective review to determine the experimental or investigational nature of health care services. The term does not include a review in response to an elective request for clarification of coverage.

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2022, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
N/A	

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

+ Indicates a code requiring an additional character

ICD-10-CM Code	Description
N/A	

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	01/23	01/23

References

1. Title 1, Part 15, Texas Administrative Code, Chapter 353, Subchapter A, Medicaid Managed Care, Rule §353.2
2. Title 1, Part 15, Texas Administrative Code, Chapter 370, Subchapter A, State Children's Health Insurance Program, Rule §370.4
3. HealthCare.gov Glossary Terms
4. Contract Between US Department of HHSC Centers for Medicare &Medicaid Services In Partnership with Texas Health and Human Services and Superior HealthPlan, Inc.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.