MEDICAL COVERAGE POLICY	
SERVICE:	**Medical Necessity Determination**
Policy Number:	**213**
Effective Date:	**04/01/2020**
Last Review:	**02/27/2020**
Next Review Date:	**02/27/2021**

Important note
Unless otherwise indicated, this policy will apply to all lines of business.
Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

SERVICE: Medical Determination Review

PRIOR AUTHORIZATION: Not Applicable

POLICY: Scott & White Health Plan (SWHP), or the Insurance Company of Scott & White (ICSW), may not approve benefits for services rendered to a Covered Person which it determines are not Medically Necessary, are not Covered Services, or are not otherwise provided in accordance with the "Insurance policy" *.

For Medicare affiliated lines of business, SWHP will make coverage review determinations according to the following hierarchy of precedence:

1. National Coverage Determinations
2. Local Coverage Determinations
3. Internally developed criteria
4. InterQual®
5. Scientific Journals, Magazines or Online articles – source must be cited.

For other lines of business SWHP will make coverage review determinations according to the following hierarchy of precedence:

1. Applicable state and federal mandates
2. Insurance policy* terms, benefits, limitations and exclusions.
3. SWHP Medical Policy

When SWHP has no specific medical coverage policy addressing a requested procedure or service, the request will be reviewed using established standards of care in the following priority in determining Medical Necessity[i], including whether the requested services is Experimental, Investigational, or Unproven.

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

4. InterQual®
5. Evidence from peer-reviewed medical literature
6. Specialty Societies

In instances in which none of the above apply, SWHP/ICSW will follow the rules and regulations set forth by CMS (Center for Medicare and Medicaid Services).

If insufficient information is provided in order for the Medical Director to make a Determination, the request will be denied as "Not Medically Necessary" consistent with rules and regulations of Texas Department of Insurance.

For Coverage of Medications covered under the Medical Benefit please see SWHP Medical Coverage Policy 215.

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 windows.

POLICY HISTORY:

Status	Date	Action
New	08/07/2015	New policy
Review	08/18/2016	Updated Medicare review hierarchy
Review	08/22/2017	No changes
Review	07/03/2018	No changes
Review	03/28/2019	No changes
Review	02/27/2020	No changes

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. SWHP will continue to review clinical evidence related to this policy and may modify it at a later date 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 SWHP so the information can be reviewed by the Medical Coverage Policy

1. McKesson® The Gold Standard in Evidence-Based Clinical Decision Support: InterQual http://www.mckesson.com/about-mckesson/our-company/businesses/mckesson-health-solutions/interqual-decision-support/

Endnotes

[1]**Definition of Medical Necessity:** Medical Necessity is defined within the member's Explanation of Coverage or Summary Plan Description.

Model language for SWHP plans can be found in Medical Policy 243 Medical Necessity Definition.

Medicare and Medicaid have their own definitions of Medical Necessity:

Medicaid:

Per the Uniform Managed Care Contract: Medically Necessary has the meaning defined in T.A.C.,
Title 1, Part 15, Chapter 353.2, Subchapter A, Rule §353.2.(The excerpt from the Texas Administrative Code is:
http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=T&app=9&p_dir=F&p_rloc=168120&p_tloc=14959&p_ploc=1&pg=2&p_tac=&ti=1&pt=15&ch=353&rl=2)
"(60) 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 diagnoses;
   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."

Medicare:

SeniorCare, Medicare 1876 Cost product, has the following information regarding Medical Necessity definition:
From the 2015 Evidence of Coverage for SeniorCare (Cost)
Chapter 3. Using the plan's coverage for your medical services
Section 4.2: "SeniorCare (Cost) covers all medical services that are medically necessary, are listed in the plan's Medical Benefit Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules."

Chapter 4: ' "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.'