MEDICAL COVERAGE POLICY	
SERVICE: Medical Necessity Definition	
Policy Number:	**243**
Effective Date:	**04/01/2021**
Last Review:	**02/25/2021**
Next Review Date:	**02/25/2022**

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 Necessity Definition

PRIOR AUTHORIZATION: Not applicable.

POLICY: For ALL products except Medicare and Medicaid, "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, and 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.

*"Generally accepted standards of medical practice" means:

- standards that are based on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community;
- physician specialty society recommendations;

For Medicaid products:

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."

For Medicare products, Novitas-Solutions, the CMS MAC for Texas has the following statement regarding "Reasonable and Necessary Guidelines:" https://www.novitas-solutions.com/webcenter/portal/MedicareJH/page/pagebyid?contentId=00099545&_afrLoop=2657166779472024#!%40%40%3F_afrLoop%3D2657166779472024%26contentId%3D00099545%26_adf.ctrl-state%3Dttw2rz4vq_89

In the absence of a Local Coverage Determination, National Coverage Determination, 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."

To be considered "reasonable and necessary" the patient's medical record must clearly document the item or service is:

- for the diagnosis or treatment, or to improve the functioning of a malformed body member
- appropriate for the symptoms and diagnosis or treatment of the patient's condition, illness, disease or injury
- furnished in accordance with current standards of good medical practice
- not primarily for the convenience of the patient or physician or health care provider
- the most appropriate supply or level of service that can be safely provided to the patient

- delivered in the most appropriate setting
- ordered and/or furnished by qualified personnel

CODES:

Important note:

CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

CPT Codes:	
CPT Not Covered:	
ICD10 codes:	
ICD10 Not covered:	

CMS:

POLICY HISTORY:

Status	Date	Action
New	01/23/2018	New policy
Reviewed	01/22/2019	No changes
Reviewed	03/28/2019	No changes
Reviewed	02/27/2020	No changes
Reviewed	02/25/2021	No changes

REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. SWHP/FirstCare 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/FirstCare 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.