

Clinical Policy: Medical Necessity Criteria

Reference Number: MI.CP.MP.05

Last Review Date: 06/21

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Medical Necessity or Medically Necessary is defined as covered services:

1. Which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity; and
2. For which there is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly.¹

Policy/Criteria

It is the policy of MeridianHealth, will use the following guidelines to make medical necessity decisions (listed in order of significance) on a case-by-case basis, based on the information provided on the member's health status:

- A. Federal law;
- B. State law/guidelines (e.g., when State requirements trump or exceed federal requirements);
- C. Meridian-specific clinical policy (including plan-specific clinical policies in InterQual[®] as custom content);
- D. Centene clinical policy (including Centene clinical policies in InterQual as custom content);
- E. If no Meridian- or Centene-specific clinical policy exists, then nationally recognized decision support tools such as InterQual Clinical Decision Support Criteria. ;
- F. In the case of no guidance from A-E, additional information that the Meridian Medical Director will consider, when available, includes:
 1. Reports from peer reviewed medical literature, from which a higher level of evidence and study quality is more strongly considered in determinations;
 2. Professional standards of safety and effectiveness recognized in the US for diagnosis, care, or treatment;
 3. Nationally recognized drug compendia resources such as Facts & Comparisons[®], DRUGDEX[®], and The National Comprehensive Cancer Network[®] (NCCN[®]) Guidelines
 4. Medical association publications, such as those from American Society of Addiction Medicine, American College of Obstetricians and Gynecologists, etc.;
 5. Government-funded or independent entities that assess and report on clinical care decisions and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;
 6. Published expert opinions, including in UpToDate;
 7. Opinion of health professionals in the area of specialty involved;
 8. Opinion of attending provider in case at hand.

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Utilization Management decisions are made by qualified health professionals. Only appropriate practitioners who have clinical expertise regarding the service under review can make the decision to deny coverage based on medical necessity guidelines.^{2,4}

Practitioner types appropriate for making the following types of denial decisions include:

Provider Type	Denial Decision
Physicians, all types	Medical, behavioral healthcare, pharmaceutical, dental, chiropractic, vision, and physical therapy denials
Doctoral-level clinical psychologists or certified addiction-medicine specialists	Behavioral healthcare denials
Doctoral-level board-certified behavioral analysts, doctoral-level clinical psychologists, child and adolescent psychiatrist.	Applied Behavioral Analysis denials ad appeals.
Dentists	Dental denials

Definitions

Unless defined differently by the members' Benefit Plan Contract or the applicable provider agreement, the Health Plan uses the following definitions:

- A. **Medically necessary** or medical necessity shall mean health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:
1. In accordance with generally accepted standards of medical practice;
 2. Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury, or disease; and
 3. Not primarily for the convenience of the patient, physician, or other health care 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.

Medically necessary health care services may not include experimental and/or investigational technologies or carve-out days.

- B. **Generally accepted standards of medical practice** means 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.

- C. **Not medically necessary and not investigational:** evaluations and clinical recommendations that are assessed according to the scientific quality of the supporting evidence and rationale (e.g., national medical associations, independent panels, or technology

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assessment organizations). A service is considered not medically necessary and not investigational when:

1. There are no studies of the service described in recent, published peer-reviewed medical literature, *or*
2. There are no active or ongoing credible evaluations being undertaken of the service which has previously been considered not medically necessary, *or*
3. There is conclusive evidence in published peer-reviewed medical literature that the service is not effective, *or*
4. There are no peer-reviewed scientific studies published or accepted for publication by nationally recognized medical journals that demonstrate the safety and efficacy of the use of the service, *or*
5. It is contraindicated.

Background

Meridian clinical policies are intended to be reflective of current scientific research and clinical practice and judgment. They are developed with oversight of board-certified physicians and practitioners, reviewed on an annual basis for appropriateness and approved by the Meridian Clinical Policy & Procedure Committee. The Clinical Policy & Procedure Committee is composed of physicians and other medical and operational representatives, as appropriate, to assist in the identification of need, development, revision, and/or review of clinical policy. Clinical policies include medical, behavioral health, medical pharmacy benefits, durable medical equipment and devices. These policies include but are not limited to:

- New and emerging technologies
- New uses for existing technologies
- Clinical guidelines for the evaluation and treatment of specific conditions
- Criteria used in the authorization of drugs included on a Meridian prior authorization list
- Clinical/medical criteria or information used in pre- or post-service review

InterQual criteria are proprietary and cannot be publicly published and/or distributed. On an individual member basis, the specific criteria document used to make a medical necessity determination can be made available upon request. Registered providers can obtain the appropriate InterQual SmartSheet™ by logging in to the secure provider portal. The InterQual SmartSheet can be submitted with your authorization request to help expedite the process.

Change Healthcare is the owner/licensor of the InterQual Clinical Decision Support Criteria and related software. Change Healthcare has prepared this Work for exclusive use of its licensees of software applications embodying the Clinical Content. This Work contains confidential and trade secret information of Change Healthcare and is provided to licensees who have an existing license agreement in force only under the time-limited license as provided under that license agreement.

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Reviews, Revisions, and Approvals	Revision Date	Approval Date
Michigan Market-specific Policy Developed	04/21	06/21
Annual Review This is a Centene policy that was tailored for use in MI Market. Description updated. Experimental and investigations section removed, as well as serious and reportable events as separate policies exist for this. References updated. Formatting updates to align with Centene corporate policy template	06/25/21	06/25/21

References

1. State of Michigan Contract 01112021, Fiscal Year 21, Comprehensive Health Care Program for the Department of Health and Human Services, Definitions, Page 164, Effective February 1, 2021
2. State of Michigan Contract 01112021, Fiscal Year 21, Comprehensive Health Care Program for the Department of Health and Human Services, XI Quality Improvement and Program Development, I(3)(b), Page 81, Effective February 1, 2021
3. Change Healthcare InterQual[®] criteria.
4. National Committee for Quality Assurance. NCQA Health Plan Accreditation, UM Standards, 4 Appropriate Professionals A-F, Standards and Guidelines for the Accreditation of Health Plans 2020.