Medical Necessity Guideline

Medical Necessity Guideline (MNG) Title: Medical Necessity		
MNG #: 045	**☒SCO ☒One Care**	**Prior Authorization Needed? ☐Yes ☐No**
Clinical: ☐	**Operational: ☒**	**Informational: ☐**
Medicare Benefit: ☐Yes ☐No	**Approval Date:** 11/05/2020	**Effective Date:** 04/01/2021
Last Revised Date:	**Next Annual Review Date:** 11/05/2021	**Retire Date:**

OVERVIEW:

Medical necessity is a term that means health care services or products that a physician would provide to an individual member for the purpose of evaluating, diagnosing, or treating an illness or disease in a manner that is:

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 member's specific illness or disease
3. Not primarily for the convenience of the member, prescribing health care provider, or other health care providers
4. Not more costly than an alternative treatment or product that is likely to produce equivalent diagnostic or therapeutic results for the member's specific illness or disease

DECISION GUIDELINES:

Commonwealth Care Alliance reviews determinations of medical necessity for services based on federal regulations and coverage criteria including National Coverage Determinations and applicable Local Coverage Determinations, applicable state regulations and coverage criteria, Change Healthcare InterQual® criteria, and CCA Medical Necessity Guidelines. This specific policy only applies to determinations where these other policies and plan documents do not apply to the requested healthcare or product. In this situation, a CCA Medical Director will make a determination of medical necessity for the health care service or product based on this Medical Necessity Guideline and in accordance with Medicare and MassHealth definitions:

1. CMS describes the "reasonable and necessary" standard for medical necessity in the CMS Program Integrity Manual, including that a service is appropriate, including the duration and frequency that is considered appropriate for the item or service, in terms of whether it is: Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member; Furnished in a setting appropriate to the patient's medical needs and condition; Ordered and furnished by qualified personnel; One that meets, but does not exceed, the patient's medical need; and At least as beneficial as an existing and available medically appropriate alternative.

AND

2. CMS defines medical necessity to only allow Services or Supplies that: are proper and needed for the diagnosis or treatment of your medical condition, are provided for the diagnosis, direct care, and treatment of your medical condition, meet the standards of good medical practice in the local area, and aren't mainly for the convenience of you or your doctor.

Consistent with all CCA Medical Necessity Guidelines, CCA uses this MNG as a guide in making individualized coverage determinations. Requesting providers are advised that requests for healthcare services or products under this MNG should be accompanied by clear documentation of medical necessity. Supporting documentation should include justification that the request aligns with accepted standards of medical practice including: (1) Credible scientific evidence in reputable, peer-reviewed medical literature; (2) Physician or Health Care Provider Specialty Society Recommendations; and (3) Other relevant factors specific to the member.

Disclaimer:

This Medical Necessity Guideline is not a rigid rule. As with all of CCA's criteria, the fact that a member does not meet these criteria does not, in and of itself, indicate that no coverage can be issued for these services. Providers are advised, however, that if they request services for any member who they know does not meet our criteria, the request should be accompanied by clear and convincing documentation of medical necessity. The preferred type of documentation is the letter of medical necessity, indicating that a request should be covered either because there is supporting science indicating medical necessity (supporting literature (full text preferred) should be attached to the request), or describing the member's unique clinical circumstances, and describing why this service or supply will be more effective and/or costly than another service which would otherwise be covered. Note that both supporting scientific evidence and a description of the member's unique clinical circumstances will generally be required.

RELATED REFERENCES:

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c13.pdf
- https://www.ssa.gov/OP_Home/ssact/title18/1862.htm Section 1862(a)(1)(A)

ATTACHMENTS:

EXHIBIT A:	
EXHIBIT B	

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REVISION LOG:

REVISION DATE	DESCRIPTION

APPROVALS:

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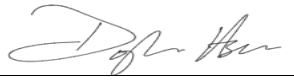
CCA Senior Clinical Lead [Print]

VP, Medical Policy and Utilization Review
Title [Print]


Signature

01/07/2021
Date

Lynne Bird
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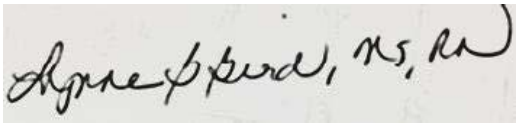
Signature

11/05/2020
Date

Lori Tishler, MD
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Signature

11/5/2020
Date