blue california
Promise Health Plan

POLICY & PROCEDURE
Medical Services

Policy Title: Definition and Application of Medical Necessity Provision for Treatment Authorization Requests		
Policy No: 70.2.83	**Original Date: 7/14**	
Effective Date: 12/18	**Revision Date: 12/18**	**Revision No: 1**
Department Head: Date:	**Medical Services/P&T Committee: Date:**	
P&P Committee: Date:	**Department(s):** **UM**	

PURPOSE:

To define medical necessity and describe how Blue Shield Promise Health Plan applies medical necessity criteria in making utilization management (UM) decisions.

POLICY:

Medical Necessity is the primary criterion that is considered in determining whether a health care service is eligible for coverage for a specific benefit under a member contract.

It is the policy of Blue Shield Promise Health Plan to ensure that decisions are based on the medical necessity of proposed healthcare services that are consistent with criteria and guidelines supported by scientific-based medical evidence and principles, and rendered in a method appropriate to the member's condition.

Blue Shield Promise Health Plan's Chief Medical Officer is responsible for ensuring that medical necessity determinations are made by qualified medical personnel. The Chief Medical Officer does not have any fiscal or administrate management responsibilities that would hinder his/her duties.

DEFINITONS:

Medicare definition of Medical Necessity,
Medically necessary services are those that are reasonable and necessary for diagnosis or treatment of illness or injury, or for the improvement of the functioning of a malformed body member, or otherwise medically necessary, under 42 U.S.C § 1395y;

Medi-Cal definition of Medical Necessity,

Medically necessary services are those services reasonable and necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury as under Title 22 California Code of Regulations (CCR), Section 51303.

Services and equipment are deemed medically necessary when an intervention is recommended by the treating health care provider and determined by the Health plan's designated qualified reviewer to be:

- Services for which there is no other medical service or site of service, comparable in effect, available and suitable for the enrollee requesting the service that is more conservative or less costly.
- Meet professionally recognized standards of healthcare substantiated by records, including evidence of such medical necessity and quality.
- The most clinically appropriate item or level of service in accordance with generally accepted standards of medical practice in terms of type, frequency, extent and duration, considering potential benefits and harms to the patient; and
- A treatment known to be effective in improving health outcomes and in accordance with generally accepted standards of medical practice for the illness, injury or disease; and
- Not primarily for the convenience of the member or health care provider.

Benefit
A benefit is health care items or services covered under a health insurance plan. The covered services include a comprehensive set of health benefits which may be accessed as medically necessary.

Determinations on decisions that are, or that could be considered covered benefits, are defined by Blue Shield Promise , including hospitalization and emergency services listed in the "evidence of coverage" or summary of benefits and care or service that could be considered either covered or non-covered depending on the circumstances of medically necessary.

Intervention
An intervention may be medically necessary yet not be a covered benefit. A ***Health Intervention*** is an item or service delivered or undertaken primary to ***treat*** (i.e., prevent, diagnose, detect, treat, or palliate) a medical ***condition*** (i.e., disease, illness, injury, genetic or congenital defect, pregnancy or a biological or psychological condition that lies outside the range of normal, age appropriate human variation) or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

Utilization Management (UM) Decision-making Criteria Sets:
UM Decision-making Criteria Sets are guidelines that are scientific and evidence-based, supported by sound clinical principles and processes, and are regularly reviewed and updated to

the most current version available, including prescription drug coverage. Criteria may include nationally recognized criteria sets, locally developed criteria sets, or pre-determined criteria sets that are established in accordance with insurance coverage, i.e. Medicare and Medi-Cal.

The criteria sources utilized by Blue Shield Promise include but are not limited to:

- MCG Guidelines (formerly known as Milliman Care Guidelines)
- Nelson's Textbook on Pediatrics
- Blue Shield Promise Health Plan Approved Criteria
- Ingenix Current Procedural Coding Expert, 2008 Edition
- National Guideline Clearinghouse
- Medicare Local Coverage Determinations
- Manual of Criteria for Medi-Cal Authorization (California

PROCEDURE:

1. It is the responsibility of the attending provider to make clinical decisions regarding medical treatment. These decisions must be made consistently with generally accepted principles of professional medical practice and in consultation with the member.

2. It is the responsibility of Blue Shield Promise Health Plan to determine benefit coverage based on the member's document. Blue Shield Promise Health Plan uses medical necessity guidelines/utilization review criteria, if applicable, to evaluate requests for coverage.

3. Documentation required for UM review to support the medical necessity of a provider's requested items/services may include but are not limited to:
    a. A completed authorization request or authorized referral request
    b. Any/all clinical documentation needed to fulfill Blue Shield Promise Health Plan policy/criteria requirements for establishing/meeting medical necessity.

4. Care1st authorizes services based on medical necessity only. These decisions will reflect appropriate application of Blue Shield Promise approved criteria.

5. Any decision to deny, modify, or delay a treatment authorization request, shall be made by a physician.
    a. Physician consultants from appropriate specialty areas of medicine and surgery who are eligible for certification by the applicable American Board of Medical Specialties will be utilized as necessary.

6. When considering approval of requested services, individuals circumstances (age, co-morbidities, complications, progress of treatment) and the local delivery system such as availability of specialists and requested services when making these decisions.
7. An intervention may be covered if it is indicated to be medically necessary, yet not a covered benefit. Specifically, for MediCal, the "Treatment Authorization Request (TAR) and Non-Benefit List" published by the Department of Health Care Services shall be used as a guideline only.

8. TARs hall be processed in accordance with the guidelines established in P&P 10.2.11 MediCal or 50.2.11 Medicare Authorization Denial, Pending/Deferral, and or Modification Notification and P&P 70.2.50 Prior Authorization Review and Approve Process.

Non-covered Benefit Denial Determinations Overturned through the Appeals

1. Upon receipt of a written notice of Blue Shield Promise Health Plan's decision to deny, terminate, or reduce services, Blue Shield Promise Health Plan members have the right to file an appeal.

2. Blue Shield Promise Health Plan tracks and trends Appeals by category.

3. All overturned Appeals for inappropriate interpretation of guidelines or benefits have been determined by internal Blue Shield Promise policy to go through special review as follows:
    a. The Appeals Department will notify the Blue Shield Promise CMO of all appealed cases that are overturned due to inappropriate interpretation of guidelines and/or benefits.
    b. The CMO will review the denial history and detail of the appeal case in full.
    c. The CMO will meet with the Medical Director or physician reviewer involved in the denial decision to discuss the error and provide guidance in rectifying a recurrence of the review deficiency in order to prevent similar occurrences in the future.

4. The Blue Shield Promise Quality Improvement Committee reviews trended Appeals information. For any adverse or repeated trends the committee may not act to improve the quality and efficiency of the process, or to initiate improvement activities, including corrective action plans that directly address the individual or systemic issues raised.

REFERENCES/AUTHORITIES:

- Title 22, Article 4, Section 51303

- National Committee for Quality Assurance (NCQA) 2011 Health Plan Standards and Guidelines for the Accreditation of Health Plans
- Title 42 U.S.C §1395y
- Blue Shield Promise P&P 10.2.11 or 50.2.11 and 70.2.50