blue california
Promise Health Plan

Policy Title: Definition & Application of Medical Necessity Provision for Treatment Authorization Requests		POLICY #: 70.2.83 Line of business: ALL	
Department Name: Utilization Management	**Original Date** 7/14	**Effective Date** 5/19	**Revision Date** 12/18, 3/22
Department Head: Sr. Director, UM		**Date: 4/25/22**	
Medical Services/P&T Committee: (If Applicable) PHP CMO		**Date: 4/25/22**	

PURPOSE

To define medical necessity and describe how Blue Shield of California Promise Health Plan (Blue Shield Promise) 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 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's Chief Medical Officer (CMO) is responsible for ensuring that medical necessity determinations are made by qualified medical personnel. The CMO does not have any fiscal or administrative management responsibilities that would hinder his/her duties.

Definitions:

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 server pain through the diagnosis or treatment of disease, illness, or injury as under Title 22 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 physiological 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:
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:
- CMS National Coverage Determination
- CMS Local Coverage Determination
- CMS Benefit Interpretation Manual
- DHCS Medi-Cal UM Criteria
- MCG, 2021, 24th Edition, CareWebQI Online Version 12.3, Content Version 24.5
- National Guideline Clearinghouse
- Nelson Textbook of Pediatrics
- Optum 2019 Current Procedural Coding Expert
- Hayes Criteria
- World Professional Association for Transgender Health (WPATH)
- AIM Specialty Health Radiology Guidelines
- National Comprehensive Cancer Network Guidelines (NCCN)

Medical policies and criteria sources are made available via the Blue Shield Promise website provider webpage: https://www.blueshieldca.com/promise/providers/index.asp

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 documentation. 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 policy/criteria requirements for establishing/meeting medical necessity.
4. Blue Shield Promise 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 Medi-Cal, 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. TAR shall be processed in accordance with the guidelines established in P&P 10.2.11 Medi-Cal or 50.2.11 Medicare Advantage Authorization Denial, Pending/Deferral, and or Modification Notification and P&P 70.2.50 Prior Auth Review and Approval Process.

Non-Covered Benefit Denial Determinations Overturned through 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 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 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

- 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