POLICY AND PROCEDURE MANUAL

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| **Policy Title: Determination of Medical Necessity** | **Policy Number: I.06** |
| **Primary Department: Medical Management** | **NCQA Standard: N/A** |
| **Affiliated Department(s): N/A** | **URAC Standard: N/A** |
| **Last Revision Date: 03/07/2016**<br><br>**Revision Dates: 12/16/2011; 8/04/2012; 04/29/2013; 05/01/2014; 04/30/2015; 03/07/2016**<br><br>**Effective Date: 11/16/2010** | **Next Review Date: 03/2017**<br><br>**Review Dates: 01/14/2011; 12/16/2011; 09/26/2012; 06/28/2013; 06/27/2014; 06/26/2015; 03/25/2016** |
| **Special Instructions Alert:** N/A | |

| **State/Program** | **MI** | **IL** | **IA** | | |
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| **Medicare:** | ☐SNP ☐MMAI ☐MA ☐PDP | ☐SNP ☐MMAI ☐MA ☐PDP | ☐SNP ☐MMAI ☐MA ☐PDP | ☐SNP ☐MMAI ☐MA ☐PDP | ☐SNP ☐MMAI ☐MA ☐PDP |
| **Medicaid:** | ☐TANF ☐SPD ☐SCHIP | ☐TANF ☐SPD ☐SCHIP | ☐TANF ☐SPD ☐SCHIP | ☐TANF ☐SPD ☐SCHIP | ☐TANF ☐SPD ☐SCHIP |
| **Commercial:** | ☐Exchange | ☐Exchange | ☐Exchange | ☐Exchange | ☐Exchange |

**Policy:** The Medicare definition of medical necessity under the Social Security Act states "no Medicare payment shall be made for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." A service may be covered, but the coverage may be limited to certain diagnoses or, if a service is considered investigational, experimental, or without proven efficacy, the service may be denied as not reasonable and necessary, resulting in the denial of claims. To ensure that services being paid for by Medicare are medically necessary, National Coverage Determinations have been established by Centers for Medicare and Medicaid Services (CMS). Additionally, CMS directs Medicare contractors (i.e., Carriers/Fiscal Intermediaries (FI)/AB MACs) to establish Local Coverage Determination (LCD) policies.

The words "medical necessity" is frequently used in Medicaid and Medicare provider and beneficiary messages and communications. The Medicare definition of medical necessity has its roots in the Social Security Act of 1965, which established the Medicare Program. That document (1862 [a] [1] [A]) states that no payment may be made under Medicare Part A or Part B for any expenses incurred for items or services which, except for certain named exceptions "are not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body part".

The implication inherent in a medical necessity denial is that the diagnostic or therapeutic service, provided by the physician, was unnecessary, and, therefore, in some way bad or at very least superfluous. It is important to remember that the phrase is not a value judgment regarding the provider's diagnostic acumen, therapeutic decisions, and/or services. This has the effect of confusing patients and angering physicians.

What is not appreciated is the fact that Medicare has evolved, over the years, into a much defined benefit program. In Medicare terms, "not medically necessary" simply means that the service is not a benefit under this defined benefit, for this diagnosis, at this time. Time and diagnosis are the key words, in that neither is immutable. A given procedure may become medically necessary, for a given diagnosis, at a future time, and vice versa.

**Medical Decision-Making:** From a medical decision-making standpoint, physicians provide services and order tests based on their clinical judgment for treating patient illness or injury. Although a recommended treatment is based on the determination of medical necessity or appropriateness for care of the patient, and even though the treatment falls within the scope of professionally accepted medical practice, it does not mean the service will be covered. Even if a service is considered reasonable and necessary, coverage may be limited if the service is provided more frequently than allowed under a national or local coverage policy, or more frequently than the current standards of care.

Determination of coverage is based on plan documents and MHP Medical Policies. Technology reviews may include literature reviews, formal technology assessments, and inputs from providers. In the absence of applicable plan documents, medical policy, or technology review, coverage and medical necessity decisions will be based on Medicare coverage criteria.

**Procedure:** Documentation is integral to supporting the medical necessity for the service. Remember that from a coding and auditing perspective, nothing can be assumed. The most clear cut way to support medical necessity in an audit is documenting medical decision-making. Complete documentation of the physician "thought process," including issues being ruled out will support medical necessity and higher levels of services billed.

MHP will use the following criteria to determine the medical necessity of specific items and services:

- Consistent with the symptoms or diagnoses of the illness or injury under treatment
- Necessary and consistent with generally accepted professional medical standards (i.e., not experimental or investigational)
- Not furnished primarily for the convenience of the patient, the attending physician, or another physician or supplier
- Furnished at the most appropriate level that can be provided safely and effectively to the patient.
- Evidence that a similar outcome cannot be achieved through a lower-cost medically necessary alternative.

In making the determination of medical necessity, MHP will use current evidence based guidelines published by specialists listed in the American Board of Medical Specialties, Nationally recognized organizations such as National Guideline Clearinghouse, and Medicare Local and National Coverage Determinations. Additionally, Meridian will defer to coverage explicitly stated in the provider manual, or published on the State Medicaid Website.

"Medical necessity" has become a ubiquitous term in a vast array of Medicaid and Medicare documents, such as national coverage decisions, guidelines, claim denials, and provider education materials, as well as in LCDs.

CMS makes national coverage decisions (NCD) for Medicare & Medicaid Services. The NCDs are developed by CMS to describe the circumstances for which Medicare will cover specific services, procedures, or technologies on a national basis. They are communicated to the Carrier by a number of vehicles, and published in one of a number of places (Federal Register, Medicare Carriers Manual, Coverage Issues Manual, etc.).

LCDs deal with items and services that are not addressed by an NCD, and about which, clarification is necessary. LCDs cannot conflict with NCDs. Section 522 of the Benefits Improvement and Protection Act (BIPA) defines an LCD as a decision by a FI or carrier whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with Section 1862 (a)(1)(A) of the Social Security Act (e.g. a determination as to whether the service or item is reasonable and necessary)

*Please utilize the above procedural instruction when CPT code is not found on fee screen pertinent to line of business and also not stated as a non-covered benefit.

**Line of Business Applicability:**
For **Medicaid/Medicaid Expansion Plan** members, this policy will apply. Coverage is based on medical necessity criteria being met and the codes being submitted and considered for review being included on either the Michigan Medicaid Fee Schedule (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_42542_42543_42546_42551-159815--,00.html), the Illinois Medicaid Fee Schedule (located at: http://www.illinois.gov/hfs/MedicalProviders/MedicaidReimbursement/Pages/default.aspx), or the Iowa Medicaid Fee Schedule (located at: http://dhs.iowa.gov/ime/providers/csrp/fee-schedule). If there is a discrepancy between this policy and either the Michigan Medicaid Provider Manual (located at: http://www.michigan.gov/mdch/0,1607,7-132-2945_5100-87572--,00.html) the Illinois Medicaid Provider Manual (located at: http://www.illinois.gov/hfs/MedicalProviders/Handbooks/Pages/default.aspx), or the Iowa Medicaid Provider Manual (located at: http://dhs.iowa.gov/policy-manuals/medicaid-provider) the applicable Medicaid Provider Manual will govern.

For **Medicare** members, coverage is determined by the Centers for Medicare and Medicaid Services (CMS). If a coverage determination has not been adopted by CMS, this policy applies. Medicare Fee Schedules can be found on the CMS website (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index.html).

For **Exchange** members, please refer to the Meridian Choice Certificate of Coverage located here: https://share13.mhplan.com/sites/communications/Bronson%20Healthcare/MCH%20Certificate%20of%20Coverage%202016.pdf. If there is a discrepancy between this policy and the Certificate of Coverage for Meridian Choice, the Certificate will govern.

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| Approved by: _____<br>Corporate Chief Operating Officer | Date: 04/21/2016 |
| Reviewed and approved by Policy and Procedure Committee: | Date: 03/07/2016 |
| Reviewed and approved by Medical Policy Operations Committee: | Date: 03/11/2016 |
| Reviewed and approved by Physician Advisory Committee: | Date: 03/25/2016 |
| Reviewed and approved by Healthcare Compliance Subcommittee: | Date: 04/21/2016 |

**References:**


1. MDCH Medicaid Provider Manual. General Information for Providers (Version Date January 1, 2016).
2. Illinois Health and Family Services. Practioners Handbook (Version Date: August 2010).
3. Coding and Compliance Focus News June 2010 pages 3-4. http://wwwdev.medassets.com/ResourceCenter/CFN/CCFN_June2010.pdf
4. Iowa Medicaid Enterprise, Iowa DHS. All Providers, General Program Policies. (Version date May 1, 2014) https://dhs.iowa.gov/sites/default/files/All-I.pdf

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| **State Letters/ Bulletins** | | | | | |
| **CMS National/Local Coverage Determination (NCD/LCD)** | | | | | |
| **Medicare Managed Care Manual:** | Ch 16 General Exclusions from Coverage Sec 20 (Rev 1 10/2003) | | | | |
| **Medicaid CFR:** | | | | | |
| **State Administrative Codes:** | | | | | He-W546.01 |
| **Contract Requirements:** | | | | | |
| **Related Policies:** | | | | | |