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MEMORIAL HERMANN HEALTH PLAN HOLDINGS, LLC POLICY

POLICY TITLE: **MHHP MEDM-CO 304 Medical Necessity Determinations Commercial**

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VERSION: 1

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MEMORIAL HERMANN HEALTH SYSTEM
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POLICY

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POLICY PURPOSE:

To ensure that the Health Plan's coverage determination process for medical necessity is evidence-based, transparent, equitable and consistent, this policy provides guidance for evaluating individual medical necessity when a coverage request is made for an item or service covered under Medicare as a basic benefit without established clinical criteria. This coverage criteria outlines the information required for The Health Plan to make an individualized determination in accordance with the reasonable and necessary provisions defined in 1862(a)(1) of the Social Security Act (SSA) and Chapter 13, Section 13.5.4 of the Medicare Program Integrity Manual.

DEFINITIONS:

Adverse determination - A determination that the health care services provided or proposed to be provided to an enrollee are not medically necessary or appropriate or are experimental or investigational. An anticipated adverse determination must be referred to an appropriate doctor to determine medical necessity. The term does not include a denial of health care services due to the failure to request prospective or concurrent utilization review.

Clinical practice guidelines – Summary of the current medical knowledge that weighs the benefits and harms of diagnostic procedures and treatments and gives specific recommendations on how to diagnose and treat a medical condition based on this information. Clinical practice guidelines are often considered in determining the standard of medical practice.

Experimental or investigational - A health care treatment, service, or device for which there is early, developing scientific or clinical evidence demonstrating the potential efficacy of the treatment, service, or device, but that is not yet broadly accepted as the prevailing standard of care.

Generally accepted standards of medical practice - Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

Provider of Record- The physician, doctor, or other health care provider that has primary responsibility for the health care services rendered or requested on behalf of the enrollee or the physician, doctor, or other health care provider that has rendered or has been requested to provide the health care services to the enrollee. This includes any health care facility where health care services are rendered on an inpatient or outpatient basis.

Screening Criteria – The written policies, decision rules, medical protocols, or treatment guidelines used as part of the utilization review process to determine if the requested service can be approved. These criteria must be: (1) objective, (2) clinically valid, (3) aligned with healthcare principles, and (4) flexible enough to allow deviations from standard practices when clinically justified on a case-by-case basis.

SCOPE:

This policy provides a framework for reviewing health care services for self-insured and fully insured members. This policy applies only to requests for health care services lacking InterQual® Criteria, Hayes Technology, NCCN or UpToDate. When applicable, this policy guides medical necessity determinations made prospectively, concurrently, or retrospectively.

POLICY STATEMENT

The Health Plan is committed to reasonable standards for conducting utilization reviews that promote the delivery of quality health care in a cost-effective manner and fosters coordination between health care providers and The Health Plan. As such, The Health Plan adopts evidenced-based, scientifically valid, outcome-focused screening criteria and review procedures that are evaluated and updated with appropriate involvement from our Medical Director, practicing physicians, dentists, and other health care providers. InterQual® Criteria (InterQual®) is the evidence-based screening criteria that serves as the primary guideline for inpatient and outpatient services. However, InterQual® cannot specify all possible health care services that may result in a request for coverage. When this occurs, The Health Plan's generally accepted standards of medical practice, expert opinions, and consensus among healthcare professionals are

employed to make informed decisions about the appropriateness and necessity of health care services. This approach takes into account individual circumstances and the capabilities of the local delivery system within the medical community. By doing so, The Health Plan ensures that decisions remain grounded in professional medical judgment and accepted norms, even when specific evidence-based screening criteria are unavailable.

The Health Plan's screening criteria are used to determine only whether to approve the requested treatment. Treatment requests that are questionable will be referred to an appropriate physician, dentist, or other health care proved to determine medical necessity.
Medical necessity determinations assess whether the clinical evidence provided by the provider of record supports that a service is medically necessary for the enrollee.

PROCEDURE

1. **Initial Screening:** Apex Health Solutions will first determine if InterQual® screening criteria are available for the requested healthcare service. If such criteria are unavailable, the following steps will be taken to assess medical necessity.
2. **Review Process:**
    a. **Request Evaluation:** The Health Plan will evaluate coverage requests and supporting documentation to ascertain if additional information is required. The request must include:
        i. Enrollee Information: Details about the enrollee, benefit plan or claim, treating physician or healthcare provider, and the facilities providing care.
        ii. Clinical Information: Diagnostic testing data related to the enrollee's diagnoses, relevant medical history, prognosis, and the treatment plan prescribed by the provider, along with justification for the treatment plan.
    b. **Information Gathering:** If further information is needed, The Health Plan will initiate its outreach process to request relevant and updated information and medical records necessary for the review.
    c. **Medical Records:** The Health Plan does not routinely request complete medical records. During utilization review, only pertinent sections are required if there is difficulty in determining the medical necessity, appropriateness, or if the care is experimental or investigational.
    d. **Provider's Professional Opinion:** The Health Plan expects the provider to confidently state their professional opinions on which healthcare services should be covered, supported by clinical evidence. Considerations include:

i. Peer-reviewed medical journals
ii. Reviews of available studies
iii. Evidence-based consensus statements
iv. Expert opinions from healthcare professionals
v. Guidelines from nationally recognized healthcare organizations

e. **Documentation Adequacy:** If the provider fails to submit sufficient documentation to justify the requested service, The Health Plan will identify clinical practice guidelines that support accepted standards of medical practice specific to the service under review. The Health Plan has access to multiple resources for guidelines to assess these standards. These sources may include:

Agency for Healthcare Research and Quality (AHRQ) Evidenced-based Practice
American Academy of Child and Adolescent Psychiatric (AACAP) Guidelines
American Academy of Orthopedic Surgeons OrthoGuidelines
American Academy of Pediatrics
American College of Gastroenterology (ACG) Guidelines
American College of Physicians®
American Diabetes Association Standards of Medical Care in Diabetes
American Heart Associate Guidelines and Statements
American Psychological Association Professional Practice Guidelines
American Society of Clinical Oncology
American Society of Hematology
American Urological Association
Clinical Pharmacogenetics Implementation Consortium
ECRI Guideline Repository
Guideline Central Repository
HIV Info Medical Practice Guidelines
National Comprehensive Cancer Network (NCCN)
National Library of Medicine -PubMed
Trip Medical Database
U.S. Department of Veteran Affairs
U.S. Preventative Services Task Force

3. **Consultation with External Experts:** When applicable, The Health Plan will seek opinions from external healthcare professionals and summarize their insights.

4. **Evidence Summary:** Each medical necessity review will include a comprehensive summary of evidence supporting either coverage or non-coverage, detailing:
    a. A description of the requested healthcare service.
    b. Identification of specific information considered.
    c. A narrative of the scientific evidence reviewed.
5. **Physician Review:** The Health Plan physician will conduct a medical necessity review using the enrollee's medical history, including diagnosis, conditions, and functional status, as reflected in medical records and any other available documentation. This evaluation determines if the healthcare service is reasonable and necessary to prevent illnesses or medical conditions, provide early screening, interventions, or treatments for conditions that cause suffering, pain, physical deformity, functional limitations, threaten to worsen a handicap, cause illness or infirmity, or endanger life.
    a. **Criteria for Medical Necessity:** To be deemed medically necessary, the healthcare service, as defined in the applicable Certificate of Coverage, must be:
        i. Appropriate and necessary for the symptoms, diagnosis, or treatment of the medical condition.
        ii. Provided for diagnosis or direct care and treatment of the medical condition.
        iii. Within the standards of good medical practice of the organized medical community.
        iv. Not primarily for the convenience of the member, the member's provider, or any other medical professional.
        v. Provided in the most appropriate setting.
    b. **Approval of Medical Necessity:** The Health Plan will approve the request as medically necessary when the requested service:
        i. Aligns with healthcare practice guidelines and standards endorsed by recognized healthcare organizations or governmental agencies, considering special circumstances that may require deviation from those guidelines.
        ii. Is consistent with the member's diagnoses.
        iii. Is no more intrusive or restrictive than necessary to ensure a proper balance of safety, effectiveness, and efficiency.

iv. Is not experimental or investigational.

v. Is not primarily for the convenience of the member or provider.

vi. Is not more costly than an alternative service or sequence of services that is equally likely to produce equivalent therapeutic or diagnostic results for the member's illness, injury, or disease.

c. **Discussion of Medical Necessity:** If The Health Plan questions the medical necessity, appropriateness, or experimental nature of the healthcare services before issuing an adverse determination, it will provide the provider of record a reasonable opportunity to discuss the treatment plan with a physician licensed to practice medicine in Texas.

i. The discussion will include the clinical basis for Apex Health Solutions' decision and a description of any documentation or evidence that could be submitted on appeal to potentially alter the utilization review decision.

ii. If the healthcare service was ordered, requested, or provided by a physician, the opportunity will be with a physician licensed in Texas with the same or similar specialty.

Notification Procedure: The Health Plan will follow its procedure to notify the enrollee and the provider of record of its decision.

REFERENCES

1. 28 Texas Administrative Code §19.1701 - §19.1719