Section (Primary Department) **Health Care Management**		**SUBJECT (Document Title)** **Clinical Criteria for Utilization Management Decisions - Core Process**	
Effective Date 09/15/2010	**Date of Last Review** 02/28/2019	**Date of Last Revision** 12/20/2019	**Dept. Approval Date** 12/20/2019
Department Approval/Signature :			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid**	☐ Arkansas	☐ Indiana	☐ Minnesota	☐ Tennessee
☐ **Medicare**	☐ California	☐ Iowa	☐ Nevada	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Kansas	☐ New Jersey	☐ Virginia
	☐ District of Columbia	☒ Kentucky	☐ New York – Empire	☐ Washington
	☐ Florida	☐ Louisiana	☐ New York (WNY)	☐ Wisconsin
	☐ Georgia	☐ Maryland	☐ South Carolina	☐ West Virginia

POLICY:

To define the following processes:

- Appropriate application of objective clinical criteria based on medical evidence to determine medical necessity of requested services; and
- Dissemination of clinical criteria to providers (as requested).

DEFINITIONS:

Appropriate Practitioner: A representative who makes utilization management denial decisions. Depending on the type of case, the reviewer may be a health plan Medical Director, or a physician, pharmacist, chiropractor, clinical psychologist, dentist or other licensed practitioner type as appropriate. Licensed health care professionals may include appropriately qualified practitioners in accordance with state laws.

Clinical Criteria Hierarchy: Medical necessity determinations and the appropriateness of physical and behavioral health services follow a clinical criteria hierarchy that could include benefit coverage, medical necessity and precertification requirements. The list below provides the sequence of criteria application. If the criteria does not address the requested service either in total or at the required level of specificity, move to the next level in the hierarchy.

1) State Manuals/State Contracts/State Policy
2) Federal Medicaid Mandates
3) Medical Policies
4) AIM
5) Clinical UM Guidelines IQ or MCG, as applicable

NOTE: Delegated vendors may use "Their" criteria provided it has been approved by MPTAC.

Criteria and Guidelines: The organization primarily utilizes current editions of Medical Policies, Clinical Utilization Management (UM) guidelines, InterQual® Level of Care and MCG® criteria to review the medical necessity and appropriateness of both physical and behavioral health services. These guidelines provide a rules-based system for screening proposed medical

care based on member-specific, best medical care processes and consistently match medical services to patient needs, based upon clinical appropriateness. The organization utilizes the current edition of American Society of Addiction Medicine (ASAM) Patient Placement Criteria for substance abuse decisions in the Iowa, Maryland, New Jersey, South Carolina, and Texas health plans in establishing the medical necessity of requests for substance abuse treatment precertifications, and in the Florida health plan as part of the discharge planning. Please refer to the grid below to determine state specific criteria to be utilized in reviews. Additional state specific information is located in the exception section of this policy.

Criteria	Review Types	Who Utilizes
AIM	Outpatient, Inpatient	Florida, Georgia, Iowa, Louisiana, Maryland, Nevada, New Jersey, New York, New York WNY, South Carolina Tennessee, Texas, Virginia, Washington, Wisconsin
InterQual Level of Care	Inpatient Level of Care: Inpatient Concurrent Reviews Home Care, Outpatient Rehabilitation & Chiropractic Reviews Additional review types for Kentucky: Durable Medical Equipment Imaging Molecular Diagnostics Procedures Child and Adolescent Psychiatry Adult and Geriatric Psychiatry Behavioral Health Procedures	All health plans except California, Georgia, Indiana, Louisiana, Virginia, West Virginia and Wisconsin
MCG Care Guidelines	Inpatient Concurrent Reviews Inpatient Reviews, Inpatient Concurrent Reviews, Home Care, Outpatient Rehabilitation & Chiropractic Reviews and Outpatient Reviews	California, Indiana, South Carolina, Virginia, West Virginia, New York, and Wisconsin. Indiana (but not for Chiropractic Reviews) All health plans and Corporate Behavioral Health Department except Kentucky and Georgia.
Medical Policies and Clinical UM Guidelines	Outpatient Reviews (based on hierarchy)	All health plans except Indiana, Kentucky, Wisconsin and Virginia

Minnesota Rule 25/Comprehensive Assessment	Substance Use Disorder	Minnesota
Corporate Medical/Coverage Guidelines and Clinical Guidelines	Inpatient and Outpatient Reviews (based on hierarchy) Behavioral Health Reviews	Indiana, Virginia, Wisconsin Corporate Behavioral Health Department Louisiana Outpatient Reviews Physical Health
American Society of Addiction Medicine	Behavioral Health Substance Abuse Reviews	Florida, Iowa, Maryland, Kentucky, Louisiana, New Jersey, Texas and Corporate Behavioral Health Department supporting Florida, Maryland, Kentucky, South Carolina, Nevada, and Virginia
Level of Care Utilization System (LOCUS)	Behavioral Health Adult Reviews	Kentucky, Louisiana
Child and Adolescent Service Intensity Instrument (CASII) or, Child and Adolescent Needs and Strengths Scale (CANS)	Behavioral Health Pediatric Reviews	Kentucky, Louisiana
Early Childhood Service Intensity Instrument (ECSII)	Behavioral Health Young Children Reviews	Kentucky

Health Plan Medical Advisory Committee (MAC): Charged with the responsibility to identify opportunities to improve services and clinical performance and to give advice to the health plan administration in any aspect of the health plan or operation affecting network providers or members. Part of this responsibility is discharged by the review of policies and procedures affecting the delivery of care to members. Each market's MAC is chaired by the health plan Medical Director. Included in the MAC membership are the health plan HCM Clinical Leader, the health plan Quality Management Leader and 6-10 fully credentialed, actively participating providers reflecting the local provider network and member base with representation from primary care, major specialty services, and delegated entity representation.

Medical Necessity: Refers to activities that may be justified as reasonable, necessary, or appropriate, based on objective and evidenced-based clinical standards of care. The following criteria are the basis for the determination that a service, procedure or supply is medically necessary:

1) The service or supply must be recommended by a physician or other licensed healthcare provider who is treating the member and practicing within the scope of his/her license.

2) The service, procedure or supply:
   a) Must be provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury or disease and not for experimental, investigational or cosmetic purposes.
   b) Must be consistent with the member's symptoms, diagnosis, condition or injury.
   c) Is recognized as the prevailing standard and is consistent with generally accepted scientifically supported evidence and usual customary practice patterns within the community.
   d) Must not be solely for the convenience of the member, the member's family or provider.
   e) Must be the most cost-efficient service that can be provided without sacrificing effectiveness or access to care.
   f) Is not duplicative in respect to other services being provided to the member.

The Medical Operations Committee (MOC): The MOC serves as the official approval body for Government Business Division medical policy and reviews, adopts and/or approves documents related to clinical guidelines, disease management programs, UM policies and procedures. The MOC has the ability to appoint subcommittees or work groups as the need arises. These are comprised of at least one member of the MOC plus others from health plans and relevant corporate functional areas.

Medical Policy & Technology Assessment Committee (MPTAC): Serves as the official medical/clinical policy approval body of the Company in development of clinical standards or review and adoption of nationally recognized standards. The MPTAC is a multiple disciplinary group including physicians from various medical specialties, clinical practice environments and geographic areas. When necessary the MPTAC may designate subcommittees for certain specialty topics to provide professional knowledge or clinical expertise on the development or adoption of criteria. (Reference – Medical Policy Formation Policy)

PROCEDURE:

1) The organization utilizes the Company's Medicaid Clinical Criteria Hierarchy to apply the sequence of criteria application. If the criteria does not address the requested service either in total or at the required level of specificity, move to the next level in the hierarchy.
   a) State Manuals/State Contracts/State Policies
   b) Federal Medicaid Mandates
   c) Medical Policies
   d) AIM
   e) Clinical UM Guidelines
   f) IQ or MCG, as applicable
   g) Delegated vendors may use "Their" criteria provided it has been approved by MPTAC.

2) The organization follows established procedures for applying clinical criteria based on the individual member's needs and the local delivery system for medical and behavioral health services. These procedures apply to pre-service, concurrent and retrospective reviews. The Health Care Management (HCM) UM and National Customer Care (NCC) clinical associates collect and review relevant clinical information to determine if the level-of-care (LOC)/service requested meets medical necessity.
   a) Clinical associates must consider the member circumstances such as, but not limited to:
      i) Age
      ii) Co-morbidities
      iii) Complications
      iv) Prior treatment
      v) Progress of treatment
      vi) Psycho-social situation
      vii) Home environment, when applicable
      viii) Capabilities of the local delivery system, such as the ability to provide medically necessary treatment and LOC.

3) For medically necessary services, the health plan may compare the cost-effectiveness of alternative services, place of service or supplies when determining which of the services or supplies will be covered.

4) All medical necessity determinations are subject to member eligibility and benefit availability at the time of the delivery of service, including benefit limitations. The organization may approve services that are non-covered except as otherwise required or as directed by the state.

5) The organization does not employ utilization controls or other coverage limits to automatically place limits on length-of-stay (LOS) for members requiring hospitalization or surgery, nor on length-of-service for outpatient LOC. LOS for a member's request for hospitalization or surgery or LOS for outpatient care is based on medical necessity, rather than on arbitrary limits. Members who require additional coverage decisions are managed by an assigned HCM clinical associate. The clinical review for these services specifies precertification for coverage limits as determined by clinical guidelines and individual needs. Subsequently, the HCM clinical associate working with the hospital, PCP/attending physician]] other parties monitors and continually reviews the case to determine discharge readiness and to facilitate discharge planning.

6) Services are not denied based solely on diagnosis, type of illness or condition. If the clinical criteria elements do not appear to be met, or are not appropriate for the individual member, the HCM/NCC clinical associate refers the case to the health plan Medical Director (or appropriate practitioner):

a) For a medical necessity or clinical determination
b) If there is no clinical criteria for the requested service
c) If no clinical information is received after attempts to obtain necessary clinical

The health plan Medical Director (or appropriate practitioner):

a) Is required to consider the individual circumstances and capabilities of the local delivery system when reaching a determination
b) Has the authority to deny requested services based on medical necessity review

*Appeal reviews and decisions are based on the criterion used to make the original medical necessity determination.

7) Annually, the MOC reviews UM criteria used to determine medical necessity coverage decisions. The MOC may review the criteria more frequently if a new version of the criteria is published before the annual review date.

8) MPTAC approved Clinical UM Guidelines are presented to the MOC for adoption to ensure consistency and a standardized process across the Government Business Division. Medical policies approved by MPTAC are presented to MOC for informational purposes only. The organization communicates to providers according to regulatory requirements.

9) MPTAC approved criteria is presented for adoption by each of the health plan MACs, if relevant to the member population following the MOC presentation.

10) Upon request, the organization provides practitioners with a copy of the criterion used to make UM determinations of medical necessity.
    a) The health plans are responsible for distribution and tracking of clinical criterion requests by utilizing the Clinical Criteria Disclosure Site located on the HCM UM Operations SharePoint Site.
    b) Annually, the National Provider Communications staff publishes this notification in an edition of the provider newsletter; if an intake request is submitted to National Provider Communications (NPC). The NPC staff distributes the newsletters via:
        i) Posting on the provider website;
        ii) If providers want a printed copy, they can either print from the website or call the National Call Center to have a copy printed and mailed to them.

The National Provider Communications staff is supported in the website posting effort by the Medicaid Digital Solutions.

REFERENCES:

42 CFR 438.210(a)(3)(i)

AHCA SMMC Contract
Florida Healthy Kids Contract
Indiana Medicaid Utilization Management Program Description 2016
Iowa RFP 3.2.15.1 and 11
Kentucky Medicaid Managed Care Contract §1.0, 21.1, 21.2
Kentucky Revised Statue (KRS) 304.17A-005, 304.17A.607
Louisiana State Contract (RFP) through amendment 15
Minnesota Contract PMAP, MinnesotaCare, MSC+, and MSHO. January 2018.
NCQA Accreditation Standards and Guidelines: Clinical Criteria for Utilization Management Decisions, Appropriate Professionals
New York Utilization Management Program Description
Texas Administrative Code (TAC): Title 28 §19.1703; §19.1705 (b)(c)(d); §19.1706
Texas Department of Insurance (TDI) Commissioner's Bulletin #B-008-19

Related Policies or Procedures
Development of Marketing and Member Communications
Government Business Division Medical Operations Committee
Inter-Rater Reliability (IRR) Assessments
Medical Necessity Coverage Decisions - TN
Medical Policy Formation (Enterprise)
Non-Covered and Cost Effective Alternative Services
Pre-Certification of Requested Services - Core Process
QIQM-02A Clinical Practice Guidelines - Review, Adoption, Distribution and Performance Monitoring
Medical Policy Formation

Prior Procedure Reference(s):
Medical Necessity Criteria

RESPONSIBLE DEPARTMENTS:

Primary Department: Health Care Management

Secondary Department(s): Behavioral Health
National Customer Care

EXCEPTIONS:

Kentucky:
Health Care Service: means health care procedures, treatments, or services rendered by a provider within the scope of practice for which the provider is licensed.

Medically Necessary or Medical Necessity: Covered Services which are medically necessary as defined under 907 KAR 3:130, meet national standards, if applicable, and provided in accordance with 42 C.F.R. § 440.230, including children's services pursuant to 42 U.S.C. 1396d(r).

Medically Necessary Health Care Services: means health care services that a provider would render to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:
(a) In accordance with generally accepted standards of medical practice; and
(b) Clinically appropriate in terms of type, frequency, extent, and duration.

Any medical necessity decision (Medical or Behavioral Health), to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested, must be made by a licensed physician who is of the same specialty and subspecialty, when possible, as the ordering provider, has appropriate clinical expertise in treating the Member's condition or disease and is consistent with state and federal regulations and state contracts. The health plan primarily utilizes current editions of InterQual® Criteria for Medical Necessity for both physical health and behavioral health services, except that the health plan utilizes ASAM for substance use. If InterQual® Criteria does not cover a behavioral health service, the health plan utilizes the following standardized tools for medical necessity determinations - for adults: LOCUS; for children: CASII or CANS; for young children; ECSII. If it is determined that one of the medical necessity criteria named in this section is not available or not specifically addressed for a service or for a particular population, the health plan shall submit its proposed medical necessity criteria to the Department for Medicaid Services (DMS) for approval. The health plan may also, at their discretion, require use of other criteria they create or identify for services or populations not otherwise covered by the aforementioned criteria/guidelines. The Health Plan will be given ninety (90) days to implement criteria the health plan may otherwise require.

The criteria's comprehensive range of level-of-care alternatives is sensitive to the differing needs of adults, adolescents, and children. When using the criteria to match a level of care to the member's current condition, all reviewers consider the severity of illness and co-morbidities, as well as episode-specific variables. Their goal is to view members in a holistic manner to ensure they receive necessary support services within a safe environment optimal for recovery.

These criteria and guidelines are objective and provide a rules-based system for screening proposed medical and behavioral health care based on patient-specific, best medical care processes and consistently match medical services to patient needs, based upon clinical appropriateness of services across the continuum of care: prospectively, concurrently and retrospectively.

The health plan shall have in place mechanisms to check the consistency of application of review criteria. The written clinical criteria and protocols shall provide for mechanisms to obtain all necessary information, including pertinent clinical information, and consultation with the attending physician or other health care provider as appropriate. The Medical Director and Behavioral Health Director supervise the UM program and are accessible and available for consultation as needed.

REVISION HISTORY:

Review Date	Changes
12/20/2019	• Off Cycle Edits • Update to TX exception language and TX references • Revised KY exception language and reference
09/04/2019	• Off cycle edit • Revision to GA exception
03/07/2019	• Off cycle edit • Revision to TX exception
02/28/2019	• Annual review • Added SC as an applicable market; removed KS • Revised policy statement; multiple revisions to Criteria and Guidelines grid • Added LA & NY contract references • Revised language for FL exceptions for Medicaid to reflect new state Medicaid contract effective 12/1/2018; Added FHK (FL) exception language • Removed KS & MN exception language; Revised KY, LA, NY, NYE & WA exception language; Added MD, SC & TN exception language
01/14/2019	• Off-cycle edit to add AR as an applicable market.
12/13/2018	• Off-cycle edit to add DC as an applicable market. Update MN go-live date to 1/1/19.
10/09/2018	• Off-cycle edits to revise criteria grid – revised MCG Care Guidelines; removed BH Medical Policies and Clinical Guidelines; added MN Rule 25/Comprehensive Assessment • Added MN contract reference
08/10/2018	• Off-cycle edit to add MN as an applicable market. Exception added to notate market go-live of 12/1/18.
06/07/2018	• FL Only – 2/1/18 - Off-cycle additional of FL-specific Medicaid Clinical Criteria Hierarchy

	• Reviewed prior to Utilization Management Committee vote to adopt in FL Simply/Amerigroup/Clear Health Alliance • Updated Plan name to reflect legal rebranding of Simply, Better and Amerigroup to Simply and separate branding for Clear Health Alliance as Simply Healthcare Plans, Inc. dba Clear Health Alliance
05/09/2018	• Off-cycle edits to add KY to Criteria and Guidelines grid; add KY contract reference; revise KY & TX exception language
04/29/2018	• Off-cycle edits to update Exceptions for NV
02/02/2018	• Annual review • Added definition of Clinical Criteria Hierarchy; revised grid in Criteria and Guidelines definition • Added Clinical Criteria Hierarchy to Procedure section • Revised IA, LA & WA exception language; added VA exception language
10/26/2017	• Off-cycle edit to add VA to Criteria and Guidelines under ASAM
03/13/2017	• Off-cycle edits to remove KY from criteria grid for AIM and add to MCG for Inpatient concurrent reviews • Revised KY exception language to remove Milliman
02/23/2017	• Annual review • Added AIM to criteria grid • Removed UniCare references • Added IA contract reference • Removed NPC as a secondary dept. • Revised IA exception language
12/16/2016	• Off-cycle edit to add NYW as an applicable market and add NYW exception language
11/17/2016	• Off-cycle edit to add KY exception language
11/11/2016	• Off-cycle edits to LA exception language
09/22/2016	• Off-cycle edits to add IN as an applicable market; add IN to Criteria and Guidelines grid, add IN references and exception language
01/28/2016	• Annual review by PPOC and MOC • Add language around services are not denied based solely on diagnosis, type of illness or condition. • Removed language around Medical Director denial of requested services based on medical necessity • Clarify National Provider Communications role in providing clinical criteria to providers • Removed Florida exception language
12/03/2015	• Off-cycle edits to add Iowa as an applicable market. Approved by Iowa DHS 12/03/2015 for use effective 04/01/2016.

	• Added Iowa to criteria guidelines • Added Iowa exception language
12/01/2015	• Off-cycle edits to Kentucky exception
10/15/2015	• Off Cycle review • LA BH Integration updates
06/10/2015	• Off-cycle edits to definitions, KY and WA exceptions sections.
02/26/2015	• Edits made due to 2015 WA Apple Health Contract
12/08/2014	• Annual Review
06/06/2014	• Off-cycle edits for NCQA UM standards
01/01/2014	• Added Kentucky health plan.
11/01/2013	• Off-cycle review to add Virginia as an applicable market. Add VA exception, remove OH exception and move to MBU template.