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Origination	12/1/1996	Owner	Amanda Bigler: Manager, Clinical Compliance
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Clinical Criteria for UM Decisions & Medical Necessity Review

Purpose:

The Health Plan has specific criteria to determine the medical necessity and clinical appropriateness of medical, behavioral health services requiring approval. Criteria utilized by The Health Plan allows for medically appropriate decisions that are objective and based on medical evidence. This allows for utilization management decisions that are fair, impartial and consistent in order to serve the best interest of our members to maximize the effectiveness of their preventative, acute or chronic medical and behavioral healthcare services. Medical necessity review is a process to consider whether services are covered when criteria for medical necessity and clinical appropriateness are met.

Written UM Decision Making Criteria

Nationally recognized clinical criteria are utilized to perform reviews for medical appropriateness allow for consideration of the needs of the individual member, his / her circumstances, medical history, and consideration of care and services within The Health Plan's network (local delivery system).

Consideration of Individual Needs:

The Health Plan considers at least the following characteristics when applying criteria to each individual.

- Age
- Comorbidities

- Complications
- Progress of Treatment
- Psychosocial situation
- Home environment, when applicable.

The Health Plan utilizes InterQual® criteria and The Health Plan's Medical Policies as a screening guideline to assist reviewers in determining medical appropriateness of heath care services. Other criteria or guidelines may be used by The Health Plan if mandated by the State or if InterQual® criteria fails to have criteria. These may include but not limited to:

- West Virginia Bureau for Medical Services Criteria/Policy Manual (for W.V. Medicaid members)
- Centers for Medicare and Medicaid Services National Coverage Determinations
- Centers for Medicare and Medicaid Services Local Coverage Determinations
- Internal Committee review: Medical Director Oversight Committee (MDOC)
- External Committee review: Practitioner Advisory Committee (PAC)
- Medical Directories (e.g. Hayes Technology Review, UpToDate)
- Peer reviewed scientific literature, biomedical compendia and scientific studies published in medical journals that meet the requirements for scientific manuscripts or meet the criteria of the National Institute of Health's (NIH) National Library of Medicine (e.g. American Society of Addiction Medicine (ASAM), American College of Cardiology (ACC), American Diabetes Association (ADA) and American College of Obstetricians and Gynecologist (ACOG) published practice guidelines).
- Findings, studies and/or research conducted by or under the auspices of other federal government agencies and nationally recognized federal institutes such as:
    - Federal Agency for health Research and Quality
    - National Institute of Health
    - National Comprehensive Cancer Network
    - Centers for Medicare and Medicaid Services (CMS)

Practitioner Involvement

Practitioners with clinical expertise in the criteria being reviewed are sought annually, or as needed, to advise or comment on the development or adoption of UM criteria and on the instructions for applying the criteria. This is accomplished from physicians in the community and those who serve as members of the Physician Advisory Committee (PAC). In cases where specific clinical expertise is needed to perform a review, or an appeal, reviews are sent to a URAC or NCQA accredited vendor for specialty medical review serviced by a board-certified physician reviewer with the same or similar background.

Reviewing and Updating Criteria

The Health Plan reviews its UM criteria and procedures against current clinical and medical evidence and updates them, when appropriate. If new scientific evidence is not available, the Medical Director's Oversight Committee (MDOC) may determine if further review of a criterion is necessary. See Medical Policy Process for further information.

Medical Necessity Review - Definition

Certain services are required by The Health Plan to be reviewed for medical necessity prior to the services being rendered, concurrently with when the services are being rendered and/or after the services have been rendered. This policy is intended to define medical necessity more clearly with regard to clinical coverage determinations.

Services considered not to be medically necessary by review pursuant this policy will be deemed non-covered services.

Medical Necessity, or medically necessary services, is/are healthcare services or supplies that a provider, utilizing appropriate clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, and/or its signs/ symptoms, and that are:

- Aligned with generally accepted standards of medical practice; and
- Clinically appropriate, with regard to type, frequency, extent, site, and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient and/or the provider; and
- Not more costly than an appropriate alternative service or series of services demonstrated to be at least as likely to produce an equivalent or better therapeutic or diagnostic result when considered for the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence, published in national diagnosis or treatment guidelines and/ or peer-reviewed medical literature, and are generally recognized by the medical community and relevant Specialty Societies as standards of care.

UM Decisions that require Medical Necessity Review

Any service or benefit defined on The Health Plan's Medical & Behavioral Health Prior-Authorization lists.

Application of Medically Necessary Criteria

All reviews for medical/surgical and behavioral health/ substance use disorder appropriateness are based on the above criteria/ guidelines and plan documents. Criteria for decisions on coverage and medical necessity must be clearly documented, based on reasonable medical

evidence or a consensus of relevant health care professionals. Consideration is given to the member's individual circumstance taking into account the member's medical history. The capabilities of network practitioners/ providers and availability of appropriate alternative care settings are also included in the determination.

Decision making process:

1. The nurse navigator or referral coordinator obtains and reviews relevant clinical information for requested services. This written or verbal information may be in the form of current information, patient history, progress notes, clinical office or hospital documentation, crisis encounters treatment continuation forms and may be obtained from, but not limited to:
    - the primary care practitioner
    - appropriate practitioners/specialist practitioners
    - patient/family members
    - hospital designees - UR staff, social workers, discharge planners
2. The nurse navigator or referral coordinator make multiple attempts to obtain the necessary information for the request. The appropriate outreach is conducted per the 'Outreach for Information to Support Coverage Decisions' policy.
3. All relevant information gathered is utilized to support the decision-making process. The process is based on the needs of the individual patient. Some factors for consideration are the member's age, medical/surgical history, comorbidities, support systems, psycho-social, psychological or socioeconomic situations.
4. If criteria guidelines are not met or appropriate and a decision cannot be reached by the nurse navigator or referral coordinator and the request is for medical appropriateness, coverage or length of stay, the case is referred to the Medical Director for the decision. The Medical Director will be supplied with all relevant clinical information and may initiate communication with practitioners, specialist practitioner reviewers, and consulting practitioners, as appropriate for individual case discussion. Medical necessity review requires that denial decisions be made only by an appropriate clinical professional.
5. The characteristics of the member's local delivery system to provide for our members are reviewed for requested services. Consideration is given to available local or tertiary providers to provide acute, skilled or rehab levels of care for post hospital care along with home health agencies, DME providers or infusion providers.
6. Review decisions for medical appropriateness are not made solely based on criteria. Members are regarded as individuals with specific care needs.

Distribution of Medically Necessary Criteria / Clinical Practice Guidelines:

Practitioners

Clinical guidelines for Medical Appropriateness are addressed on The Health Plan's web site,

provider section. InterQual smart sheets (certified decision-making aids) if requested, are mailed, emailed or faxed to all relevant practitioners.

Enrollees and potential enrollees

Upon request, criteria guidelines for Medical Appropriateness are mailed, emailed or faxed to the enrollee or potential enrollee for review.

Utilization Management Practice Guidelines for Mountain Health Trust

The Health Plan must adopt and disseminate criteria guidelines for Medical Appropriateness that are based on valid and reliable medical evidence or a consensus of health care professionals in the particular field, consider the needs of the enrolled population, are developed in consultation with contracting health care professionals, and are reviewed annually and as needed.

BMS/WVCHIP will have the authority to override any of The Health Plan's utilization management guidelines on a case-by-case basis. The BMS/ WVCHIP Medical Director shall coordinate with The Health Plan's Medical Director in the event an override is appropriate based on thorough internal review (within the applicable MHT contract period)

The Health Plan must be responsible for payment should a utilization management guideline be overridden.

The Health Plan will ensure that services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are furnished.

Oxygen Concentrators

The Health Plan is prohibited from placing prior authorization requirements on oxygen concentrators.

Newborns and Mothers Health Protection Act the Managed Care Organization may not:

- Limit benefits for postpartum hospital stays to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section unless the attending provider, in consultation with the mother, makes the decision to discharge the mother or the newborn before that time; or
- Require that a provider obtain authorization from the plan before prescribing this length of stay.

This requirement must not preclude The Health Plan from requiring prior authorization or denying coverage for elective inductions and elective C-sections. (WV CHIP section 4.b.6)

WVCHIP

Appropriate limits on the covered services

The Health Plan may place appropriate limits on the covered services provided under the WV Mountain Health Trust contract within the applicable contract period on the basis of criteria applied under the WVCHIP State Plan or WVCHIP SPD, such as medical necessity or for the purpose of utilization control, provided The Health Plan approved services can reasonably be expected to achieve the purpose for which such services are furnished.

The Health Plan is prohibited from arbitrarily denying or reducing the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition of the beneficiary.

All Revision Dates

7/7/2023, 5/26/2022, 5/19/2021, 11/3/2020, 8/21/2020, 5/29/2020, 6/29/2018, 1/1/2014, 1/1/2008, 3/1/2003

Attachments

2023 Clinical Coverage Criteria Algorithm.pdf

Approval Signatures

Step Description	Approver	Date
EMT	Ed Kairis: Chief Medical Officer	7/7/2023
MDOC	Robert Cross: Medical Director	7/5/2023
	Heather Jones: Director, Utilization Management	5/22/2023
	Amanda Bigler: Manager, Clinical Compliance	5/9/2023