OH.CLI.1383 Medical Necessity Guidelines

Effective Date:	January 12, 2024	Accountable Dept.:	Medicaid Clinical Delivery Experience 10585
Last Reviewed Date:	November 30, 2023		

Summary of Changes:

None – new policy created.

Scope:

This policy applies to all physical and behavioral health prior authorization requests received by Humana Healthy Horizons® in Ohio.

Policy:

Humana Healthy Horizons® in Ohio uses established criteria guidelines to make medical necessity decisions and follows the below procedure. Decisions are made on a case-by-case basis, utilizing the information provided about the member's health status and an assessment of the local delivery system. Emergent services do not require a referral or preauthorization.

The Plan covers all benefits and services required in Ohio Administrative Code (OAC) chapter 5160 in the amount, duration, and scope for the same services furnished to members under the fee-for-service (FFS) Medicaid.

When the plan receives a request for a primary code that requires prior authorization and the primary code is denied for lack of medical necessity, any related secondary codes submitted on the authorization request will be denied based on lack of medical necessity. When a primary code is approved, related secondary codes requiring prior authorization will be reviewed individually for medically necessity determinations.

Please see Ohio Medicaid Prior Authorization and Notification List for a list of CPT and HCPCS codes that require prior authorization.

Humana Healthy Horizons® in Ohio will review requested non MCO covered codes and services as required for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) for medical necessity to ensure children and adolescents receive appropriate and preventative, dental, mental health, developmental and specialty services.

Humana Healthy Horizons® in Ohio does not cover services, items or devices that have not been approved by the Food and Drug Administration (FDA). Other factors affecting reimbursement supersede this policy. These factors include but are not limited to Federal and/or State statutes and regulations, the State Plan, the MCE Manual, physician or other provider contracts, the beneficiaries' benefit coverage documents, and/or other reimbursement, medical or drug policies.

Providers may submit authorization request(s) through the provider portal. A provider may request an urgent prior authorization in situations where the provider considers a delay in providing services, supplies or prescription drugs requiring prior authorization to be detrimental to the health of the member. The absence of authorization and/or notification prior to the date of a service could result in financial penalties for the practice and reduced benefits for the member, based on the healthcare provider's contract and the member's Certificate of Coverage. Services or medications provided without preauthorization may be subject to retrospective medical necessity review. We recommend individual practitioners making specific requests for services or medications verify benefits and preauthorization requirements with Humana prior to providing services.

Medical necessity documentation and rationale must be submitted with the prior authorization request.

Providers may access physical and behavioral clinical coverage policies and medical necessity criteria at the below links.

Physical Health:

www.humana.com/provider/medical-resources/ohio-medicaid/physical-health-clinical-coverage-policies

Behavioral Health:

www.humana.com/provider/medical-resources/ohio-medicaid/behavioral-health-clinical-coverage-policies

Members may request a copy of the medical necessity criteria by calling member services at 877-856-5702 (TTY:711), Monday-Friday, 7AM to 8PM EST.

Providers may request a copy of the medical necessity criteria by calling provider services at 877-856-5707 (TTY:711), Monday-Friday, 7AM to 8PM EST or emailing the request to OHMCDUM@humana.com.

Procedures:

1. The Plan uses the following hierarchy of guidelines to review for medical necessity:
    - 1.1 Federal or state regulation, including medical criteria published in the Ohio Administrative Code, Chapter 5160.
    - 1.2 Nationally accepted evidence based clinical guidelines: MCG (formerly Milliman Care Guidelines), American Society of Addiction Medicine (ASAM) Level of Care Adolescent Guidelines and American Society of Addiction Medicine (ASAM) Patient Placement Criteria (ASAM Admission Guidelines).
    - 1.3 Humana Healthy Horizons® in Ohio clinical policies
    - 1.4 In the case of no guidance from above, additional information that the clinical reviewer will consider, when available, includes;
        - 1.4.1 Clinical practice guidelines and reports from peer reviewed medical literature, from which a higher level of evidence and study quality is more strongly considered in determinations;
        - 1.4.2 Professional standards for safety and effectiveness recognized in the US for diagnosis, care, or treatment;
        - 1.4.3 Medical association publications;
        - 1.4.4 Government-funded or independent entities that assess and report on clinical care;

Decision and technology such as Agency for Healthcare Research and Quality (AHRQ), Hayes Technology Assessment, Up-To-Date, Cochrane Reviews, National Institute for Health and Care Excellence (NICE), etc.;

1.4.5 Published expert opinions;

1.4.6 Opinion of health professionals in the area of specialty involved;

1.4.7 Opinion of attending provider;

1.5 Dental: DentaQuest coverage guidelines and policies
Dental Coverage - Humana Healthy Horizons in Ohio | Humana

1.6 Vision: EyeMed coverage guidelines and policies
Vision Care - Humana Healthy Horizons - Ohio Medicaid | Humana

Humana Healthy Horizons® in Ohio uses medical criteria published in the Ohio Administrative Code, Chapter 5160 for:

- Acupuncture
- Air Ambulance
- Assertive Community Treatment
- Durable Medical Equipment
- Home Health Services
- Skilled Nursing Facility Admissions
- Therapeutic Behavioral Health Services
- Transplant (except kidney)

Humana Healthy Horizons® in Ohio uses medical criteria published in the American Society of Addiction Medicine (ASAM) for:

- Medically Monitoring Inpatient Withdrawal Management
- Substance Use Disorder Services in the Partial Hospitalization Program (PHP)
- Substance Use Disorder Residential Program.

Humana Healthy Horizons® in Ohio uses approved Humana Coverage Policies for:

- Breast Reconstruction
- Comparative Genomic Hybridization Chromosomal Microarray
- Gene Expression Profiling for Cancer Indications
- Inhaled Nitric Oxide
- Miscellaneous, Other and Not Otherwise Specified Codes
- Noninvasive Prenatal Testing
- Upper Prosthetics

For all other services and supplies not listed above, Humana Healthy Horizons® in Ohio uses nationally recognized and unedited medical necessity criteria guidelines in MCG, when available.

Only practitioners with the appropriate clinical expertise can make the decision to deny or reduce the amount, duration or scope of the services being requested.

Definitions:

1. Adverse Benefit Determination – As defined in OAC rule 5160-26-01, is a managed care entity's (MCEs):
    A. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
    B. Reduction, suspension, or termination or services prior to the member receiving the services previously authorized by the MCE;
    C. Failure to provide services in a timely manner as specified in rule 5160-26-03.1 of the Administrative Code;
    D. Failure to act within the resolution timeframes specified in rule 5160-26-08.4 of the Administrative Code;
    E. Denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities, if applicable; or
    F. Denial, in whole or part, of payment for a service. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a "clean claim" as defined in 42 C.F.R. 447.45(b) (October 1, 2021) is not an adverse benefit determination).
2. American Society of Addiction Medicine (ASAM) – a professional medical society representing over 7,000 physicians, clinicians, and associated professionals in the field of addiction medicine. ASAM produces a comprehensive set of standards for placement, continued stay, transfer or discharge of patients with addiction and co-occurring conditions used by clinical staff to determine whether to refer a service request for physician review based upon the clinical information submitted by the requestor.
3. MCG® – are nationally recognized guidelines used by clinical staff to determine whether to refer a service request for physician review based upon the clinical information submitted by the requestor.
4. Medically Necessary or Medical Necessity – Has the same meaning as OAC rule 5160-1-01:
    A. Medical necessity for individuals covered by early and periodic screening, diagnosis, and treatment (EPSDT) is criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate, correct, ameliorate, or treat as adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability.
    B. Medical necessity for individuals not covered by EPSDT is criteria of coverage for procedures, items, or services that prevent, diagnose, evaluate or treat an adverse health condition such as an illness, injury, disease or its symptoms, emotional or behavioral dysfunction, intellectual deficit, cognitive impairment, or developmental disability and without which the person can be expected to suffer prolonged, increased, or new morbidity; impairment of function; dysfunction of a body organ or part; or significant pain and discomfort.
    C. Conditions of medical necessity for a procedure, item, or service are met all the following apply:

a. It meets generally accepted standards of medical practice;
b. It is clinically appropriate in its type, frequency, extent, duration, and delivery setting;
c. It is appropriate to the adverse health condition for which it is provided and is expected to produce the desired outcome;
d. It is the lowest cost alternative that effectively addresses and treats the medical problem;
e. It provides unique, essential, and appropriate information if it is used for diagnostic purposes; and
f. It is not provided primarily for the economic benefit of the provider nor for the sole convenience of the provider or anyone else other than the recipient.

D. The fact that a physician, dentist, or other licensed practitioner renders, prescribes, orders, certifies, recommends, approves, or submits a claim for a procedure, item, or service does not, in and of itself make the procedure, item, or service medically necessary and does not guarantee payment.
E. The definition and conditions of medical necessity articulated in this rule apply throughout the entire medicaid program. More specific criteria regarding the conditions of medical necessity for particular categories of service may be set forth within the Ohio Department of Medicaid (ODM) coverage policies or rules.

References:

American Society of Addiction Medicine https://www.asam.org/

MCG https://www.mcg.com/care-guidelines/care-guidelines/

Ohio Administrative Code Chapter 5160 Ohio Department of Medicaid. Retrieved October 26, 2023, from Chapter 5160 - Ohio Administrative Code | Ohio Laws

Ohio Administrative Code 5160-1-01 Medicaid medical necessity: definitions and principles. Retrieved September 5, 2023, from Rule 5160-1-01 - Ohio Administrative Code | Ohio Laws

Ohio Administrative Code 5160-26-01 Medicaid medical necessity: definitions and principles. Retrieved September 5, 2023, from Rule 5160-26-01 - Ohio Administrative Code | Ohio Laws

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Version Control:

11/30/2023 – New policy created. – M. Joyce Medicaid Clinical Delivery Experience.