

Clinical Criteria for Review Determinations

Policy ADMIN-001

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Reviewed/Revised Date: 12/13/2023

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Disclaimer:

1. Policies are subject to change in accordance with State and Federal notice requirements.
2. Policies outline coverage determinations for U of U Health Plans Commercial and Healthy U (Medicaid). Refer to the "Policy" section for more information.
3. Services requiring prior-authorization may not be covered, if prior-authorization is not obtained.
4. **This Medical Policy does not guarantee coverage or payment of the service. The service must be a benefit in the member's plan and the member must be eligible for coverage at the time of service. Additional payment guidelines may be applied that are not included in this policy.**

Description:

University of Utah Health Plans (U of U Health Plans) reviews multiple procedures and therapies for medical necessity. U of U Health Plans references review criteria that are consistent with nationally accepted clinical practice guidelines.

In making these determinations U of U Health Plans employs a hierarchy of resources based on regulatory requirements and the strength of evidence supporting the requested Service. The hierarchy employed is based on regulatory or contractual requirements first and then use of authoritative resources related to the clinical evidence supporting the medical necessity or investigative nature of the service being requested. Hierarchy considerations are used by reviewing plan staff so as to afford consistency to the review process.

Medically Necessary or **Medical Necessity** means treatment, services, medicines, or supplies that are necessary and appropriate for the diagnosis or treatment of a Covered Person's Illness, Injury, or medical condition according to accepted standards of medical practice.

- a) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person's illness, injury or disease;
- b) Not primarily for the convenience of the covered person, physician or other health care provider; and
- c) Not more costly than an alternative service or sequence of services or supply, and at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the covered person's illness, injury or disease.

Policy Statement and Criteria

Clinical criteria review determinations may include the following other factors:

1. Decisions about covered benefits defined by the Specific Plan Design (SPD).
2. Decisions about care or services that could be considered either covered or not dependent on the circumstances. This review is conducted by the UM nurse and Medical Director to assure all situations are being taken into account. Benefit exception policy outlines the processes.
3. Decisions about dental surgical procedures that occur within or adjacent to the oral cavity or sinuses and are covered under the medical benefit i.e., cancer of the jaw.
4. Consideration of the individual member needs:
 - a) Age
 - b) Comorbidities
 - c) Complications
 - d) Progress of treatment
 - e) Psychosocial situation
 - f) Barriers to care such as home environment, when applicable
5. Availability of the services in the local provider network.
6. Provider/vendor and member engagement in the review process when there are questions or missing information to facilitate a timely review decision.
7. Resources utilized by the U of U Health Plans in determining medically necessary services include, but are not limited to the following:

Commercial Group and Individual Plans- Hierarchy of Criteria

1. Federal and state law
2. Plan Coverage document benefits and exclusions.
3. U of U Health Plans policies and procedures.
4. InterQual® evidence-based clinical Criteria
5. Hayes rating of "A"- Established benefit or "B"- Some proven benefit.
6. Peer-reviewed general medical textbooks such as UpToDate®, Current Medicine or similar authoritative texts
7. Evidence-based Clinical Guidelines published by Specialty Societies
8. Peer-reviewed published Systematic Reviews and Health Technology Assessments including such entities the Cochrane Libraries, Evidence Street®, California Health Technology Assessment, ECRI
9. CMS Local or National Coverage Determinations (LCD's/NCD's) or Articles (LCA's/NCA's)
10. Published peer reviewed literature from CMS approved journals

Utah Medicaid Plans- Hierarchy of Criteria

1. Federal and state law
2. Utah Medicaid Manual, Coverage Tool, and Information Bulletins
3. U of U Health Plans policies and procedures
4. InterQual evidence-based clinical Criteria
5. Hayes rating of "A"- Established benefit or "B"- Some proven benefit
6. Peer-reviewed general medical textbooks such as UpToDate, Current Medicine or similar authoritative texts
7. Evidence-based Clinical Guidelines published by Specialty Societies
8. Peer-reviewed published Systematic Reviews and Health Technology Assessments including such entities the Cochrane Libraries, Evidence Street, California Health Technology Assessment, ECRI
9. CMS Local or National Coverage Determinations (LCD's/NCD's) or Articles (LCA's/NCA's)
10. Evidence for a community standard of coverage as evidence by a review of published policies, updated within the last 12 months, of 3 commercial plans licensed to do business in the state of the member's plan
11. Published peer reviewed literature from CMS approved journals

Copies of specific criteria utilized in the determination of the authorization are available on request from the UM department to any requesting practitioner/provider and member. The criteria can be faxed, mailed, or emailed. The criteria are also available by telephone or in-person at U of U Health Plans.

The hierarchical criteria are reviewed, by the Medical Policy Committee, at least annually, to determine whether the standards utilized meet industry best practices, as well as the health care needs of the U of U Health Plans members.

Applicable Coding

No applicable codes

Disclaimer:

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate health care providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member's individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

U of U Health Plans makes no representations and accepts no liability with respect to the content of any external information cited or relied upon in this policy. U of U Health Plans updates its Coverage Policies regularly, and reserves the right to amend these policies and give notice in accordance with State and Federal requirements.

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