HEALTH PLANS
UNIVERSITY OF UTAH

Administrative Policy

Medical Services Level of Care Determination

Related Policies:
Admin-002 Behavioral Health Services Level of Care Determination

Policy ADMIN-003

Origination Date: 04/06/2018

Reviewed/Revised Date: 12/13/2023

Next Review Date: 12/13/2024

Current Effective Date: 12/13/2023

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, CHIP and Healthy U (Medicaid) plans. 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:

The University of Utah Health Plan (U of U Health Plans) uses several sources in determining the appropriate level of care for patients to optimize their outcomes and the efficiency of care delivery. These sources include the CMS inpatient only list, InterQual guidelines, Summary of Plan Description (SPD) and clinical judgement. These sources are employed in a hierarchical fashion.

Policy Statement and Criteria

1. **Commercial Plans/CHIP**
   The hierarchy of consideration for determining the level of care for Medical Services is as follows:
   A. SPD coverage exclusions or limitations
   B. Internal U of U Health Plans policies
   C. InterQual® criteria for determining medical necessity for the following levels of care:
      i. Acute inpatient services
      ii. SNF services

iii. Rehabilitation services
iv. Home Health
v. Outpatient Surgery
vi. LTAC (Long term acute care)

D. For surgical services, If InterQual does not provide adequate guidance, the CMS inpatient only list is employed for determining inpatient versus outpatient level of care

E. If no guidance is provided in InterQual, SPD, or CMS guidelines or if an exception is requested for a certain level of care (inpatient – outpatient, outpatient to inpatient) outside the standards defined by InterQual or CMS the cases are sent to physician review for consideration of granting an exception based on comorbidities and other clinical considerations

For behavioral health services please see Administrative Policy #002 Behavioral Health Level of Care outlines the level of care determination of care criteria for behavioral health services.

2. **Medicaid Plans**
Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website at: https://medicaid.utah.gov/utah-medicaid-official-publications/ or the Utah Medicaid code Look-Up tool

CPT/HCPCS codes covered by Utah State Medicaid may still require further evaluation to determine medical necessity for coverage.

Clinical Rationale

Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member's benefit document, and in coordination with the Member's physician(s) on a case-by-case basis considering the individual Member's health care needs.

Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Medical Necessity Guidelines are revised annually or more frequently if new evidence becomes available that suggests needed revisions. Medical Necessity Guidelines apply to the fully insured Commercial and Medicaid products on which U of U Health Plans conducts utilization review unless otherwise noted.

McKesson InterQual® Criteria are nationally recognized medical necessity criteria developed by a clinical research staff, which includes physicians, registered nurses, and other health care professionals. The clinical content of the criteria is annually reviewed, updated, and validated by a national panel of clinicians and medical experts, including those in community and academic practice settings, as well as within the managed care industry throughout the United States.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern. Applicable state or federal mandates or other requirements will take precedence.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.

Applicable Coding

No applicable coding