



Medical Necessity Determination

I. Policy

University Health Alliance's (UHA) Health Care Services Department (HCS) is engaged in decisions of medical necessity and propriety. UHA has studied and embraces the four principles of medical ethics (Beneficence, Nonmaleficence, Justice, and Autonomy), the Institute of Medicine's six imperatives for medical care (Safe, Effective, Efficient, Timely, Personalized, and Equitable) and the Institute for Healthcare Improvement's triple aim (Better Health, Better Care, Better Value).

It is understood that some of these principles can be in opposition to each other (e.g., autonomy and justice or value). Effort will be extended to understand and balance these contrarities. Health Care Services will exercise rational and educated judgment in determination of medical necessity.

The Medical Necessity Determination policy of UHA is, and will remain, in compliance with the definition of Medical Necessity as stated in the [Hawaii Revised Statutes §432E-1.4](#) Medical necessity. HRS Definition can be found in this policy reference section.

II. Criteria/Guidelines

- A. UHA defines medical necessity as health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease or its symptoms in a manner that is:
 1. In accordance with generally accepted standards of medical practice
 - a. Underlying most medical necessity determinations is the question of which standards will be used to judge whether a service is effective or appropriate. It is useful to have strong scientific evidence documenting that a particular treatment has a particular outcome for a particular group. In these situations, UHA will utilize Milliman Care Guidelines, NCCN Compendia and Guidelines, InterQual, UpToDate, and other current resources of evidence-based care for medical necessity determinations. For many medical treatments, however, a strong scientific base is unavailable—even for widely used interventions. In these instances, practice guidelines and consensus statements from UHA's Physician Advisory Panel and physician peers who have obtained Board Certification in the area of medicine in dispute are used as the standard.
 2. Clinically appropriate in terms of type, frequency, extent, site, and duration
 - a. In instances where outcomes of a treatment are generally known and the pertinent research foundation is strong, standard protocols are appropriate and should be used for efficiency. In instances where a person has a rare or particularly complex condition, questions about treatment effects may arise and research data may be sparse. Standard protocols should not and will not be substituted for carefully reasoned judgments based on discussions with the individual, family members, and physicians or other clinicians with demonstrated experience.
 3. Not primarily for the economic benefit of UHA or the health plan purchasers or for the convenience of the patient, treating physician, or other health care provider.
- B. The "prudent physician" standard of medical necessity ensures that physicians are able to use their expertise and exercise discretion, consistent with good medical care, in determining the medical necessity for care to be provided each individual patient.

1. Unless the contrary is specified by UHA policy, the term “medical necessity” entails a general determination of what works in the ordinary case. Where UHA presents sufficient evidence to show that a treatment is not medically necessary in the usual case, the burden lies on the patient and his or her physician to show that an individual patient is different from the usual in ways that make the treatment medically necessary within the presenting circumstances.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member’s individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

III. Limitations/Exclusions

- A. The Medical Necessity Determination policy of UHA is, and will remain, in compliance with the definition of Medical Necessity as stated in the Hawaii Revised Statutes §432E-1.4 Medical necessity. The statutory definition is attached to this document.
- B. UHA’s Chief Medical Officer (CMO) and Medical Director(s) have the final responsibility for making decisions about medical necessity. Decisions about coverage are made within clinically accepted standards of medical practice and UHA’s decision will be final only when the decision rests on valid and reliable evidence.
 1. In medical necessity decisions where the determination may be modified by additional medical evidence, there exists an opportunity for the treating physician to provide such evidence by providing clinical documentation and opening a dialog with UHA’s CMO or Medical Director. When UHA has denied coverage for reasons of medical necessity, UHA will facilitate the expeditious handling of physician requests for peer-to-peer clinical reviews and appeals of such denials within the UHA appeals process.
- C. Defining Medical Necessity under the Affordable Care Act
 1. There exist hazy contours around the definition of medical necessity in a variety of legal and policy contexts and the significance of that definition for future debates surrounding the Affordable Care Act (ACA). The ACA essentially has deferred the task of defining medical necessity to private insurers, while emphasizing the values of individualizing care, ensuring, value, and having medical necessity decisions strongly rooted in evidence. UHA is committed to determining medical necessity within the parameters of the ACA, while refining and adjusting policy decisions as newer and more specific determinations of the ACA definition evolve.
 2. UHA uses CMS directives where they exist and Local Coverage Determinations in the same way that it uses other references for the determination of necessity. Issues of reasonableness, effectiveness, safety, and necessity must rest upon sufficient data to establish utility.

IV. Administrative Guidelines

- A. Medical necessity is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management (E/M) service when a lower level of service is warranted. Documentation should support the level of service reported.
- B. UHA's determination of medical necessity is separate from its determination that the E/M service was rendered as billed. (See UHA's "Office Visits and Consultations" (E&M) payment policy.)
 - 1. UHA determines E/M services largely through the experience and judgment of clinician coders along with the limited tools provided in CPT and by CMS.
 - 2. During an audit, UHA will deny or adjust E/M services that, in its judgment, exceed the patient's documented needs.
 - 3. The volume of documentation should not be the influence upon which a specific level of service is billed. Cloned and prepopulated verbiage within clinical notes that does not provide pertinent real-time information does not contribute to medical necessity determination.
- C. Medical necessity should not be confused with medical decision making. Review UHA's payment policies and document accordingly. If not documented, the rationale for diagnostics and ancillary services should be easily inferred.
 - 1. Diagnosis documentation alone is often insufficient to document medical necessity.
- D. This Medical Necessity Determination Policy applies to all non-administrative health benefit coverage, including but not limited to behavioral health, including substance abuse, medical procedures, genetic testing, all evaluation and management (E & M) visits, and prescription medications.

V. Policy History

Policy Number: MPP-0102-130701

Current Effective Date: 08/10/2021

Original Document Effective Date: 07/01/2013

Previous Revision Dates: 09/19/2018, 10/18/19

PAC Approved Date: 07/01/2013

Previous Policy Title: Medical Necessity Decision

References:

- E. http://www.capitol.hawaii.gov/hrscurrent/Vol09_Ch0431-0435E/HRS0432E/HRS_0432E-0001_0004.htm
- F. Hill, Jessie B. What is the meaning of Health? Constitutional Implications of Defining "Medical Necessity" and "Essential Health Benefits" Under the Affordable Care Act. Case research in Legal Studies May 2012 American Journal of Law & Medicine, 38 (2012): 445-470
- G. Case Legal Studies Research Paper No. 2012-21
- H. <http://www.cga.ct.gov/2007/rpt/2007-r-0055.htm>
- I. <http://www.jhsph.edu/research/centers-and-institutes/womens-and-childrens-health-policy-center/publications/cshcn-MedicalNecessity.pdf>
- J. <http://www.hhs.gov/oig>
- K. <http://www.law.uh.edu/healthlaw/perspectives/Managed/001129Difficulties.html>
- J. <http://static.aapc.com/a3c7c3fe-6fa1-4d67-8534-a3c9c8315fa0/cfa2b133-ce13-47e1-90c1-4907eba70dbd/6b9dc000-0897-4c24-9f4a-519e1f3ab372.pdf>

ACA § 1302(b)(1); see also id. § 1301(a)(1)(b) (defining a “qualified health plan” as one that provides “essential health benefits”); id. § 2707 (requiring insurers on the small group and individual markets to provide “essential health benefits” as defined in the ACA). The ten required categories of coverage under the ACA are “[a]mbulatory patient services,” “[e]mergency services,” “[h]ospitalization,” “[m]aternity and newborn care,” “[m]ental health and substance use disorder services, including behavioral health treatment,” “[p]rescription drugs,” “[r]ehabilitative and rehabilitative services and devices,” “[l]aboratory services,” “[p]reventive and wellness services and chronic disease management,” and “[p]ediatric services, including oral and vision care.” Id. § 1302(b)(1)(A)-(J).

K. State of Hawaii Definition:

- a. §432E-1.4 Medical necessity. (a) For contractual purposes, a health intervention shall be covered if it is an otherwise covered category of service, not specifically excluded, recommended by the treating licensed health care provider, and determined by the health plan's medical director to be medically necessary as defined in subsection (b). A health intervention may be medically indicated and not qualify as a covered benefit or meet the definition of medical necessity. A managed care plan may choose to cover health interventions that do not meet the definition of medical necessity.
- b. A health intervention is medically necessary if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is:
 1. For the purpose of treating a medical condition;
 2. The most appropriate delivery or level of service, considering potential benefits and harms to the patient;
 3. Known to be effective in improving health outcomes; provided that:
 - A. Effectiveness is determined first by scientific evidence;
 - B. If no scientific evidence exists, then by professional standards of care; and
 - C. If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and
 4. Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.
- c. When the treating licensed health care provider and the health plan's medical director or physician designee do not agree on whether a health intervention is medically necessary, a reviewing body, whether internal to the plan or external, shall consider, but shall not be bound by, the recommendations of the treating licensed health care provider and the health plan's medical director or physician designee.
- d. For the purposes of this section:

"Cost-effective" means a health intervention where the benefits and harms relative to the costs represent an economically efficient use of resources for patients with the medical condition being treated through the health intervention; provided that the characteristics of the individual patient shall be determinative when applying this criterion to an individual case.

"Effective" means a health intervention that may reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

"Health intervention" means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied. New interventions for which clinical trials have not been conducted and effectiveness has not been scientifically established shall be evaluated on the basis of professional standards of care or expert opinion. For existing interventions, scientific evidence shall be considered first and, to the greatest extent possible, shall be the basis for determinations of medical necessity. If no scientific evidence is available, professional standards of care shall be considered. If professional standards of care do not exist or are outdated or contradictory, decisions about existing interventions shall be based on expert opinion. Giving priority to scientific evidence shall not mean that coverage of existing interventions shall be denied in the absence of conclusive scientific evidence. Existing interventions may meet the definition of medical necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care, or in the absence of such standards, convincing expert opinion.

"Health outcomes" mean outcomes that affect health status as measured by the length or quality of a patient's life, primarily as perceived by the patient.

"Medical condition" means a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation.

"Physician designee" means a physician or other health care practitioner designated to assist in the decision making process who has training and credentials at least equal to the treating licensed health care provider.

"Scientific evidence" means controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and the health outcomes may be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases. Scientific evidence may be found in the following and similar sources:

1. Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
2. Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institutes of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline, and MEDLARS database Health Services Technology Assessment Research (HSTAR);
3. Medical journals recognized by the Secretary of Health and Human Services under section 1861(t)(2) of the Social Security Act, as amended;
4. Standard reference compendia including the American Hospital Formulary Service-Drug Information, American Medical Association Drug Evaluation, American Dental Association Accepted Dental Therapeutics, and United States Pharmacopoeia-Drug Information;
5. Findings, studies, or research conducted by or under the auspices of federal agencies and nationally recognized federal research institutes including but not limited to the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, Centers for Medicare and Medicaid Services, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; and
6. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

"Treat" means to prevent, diagnose, detect, provide medical care, or palliate.

"Treating licensed health care provider" means a licensed health care provider who has personally evaluated the patient. [L 2000, c 250, §8; am L 2011, c 43, §18]