

Medical Coverage Policy 01: General Medical Necessity Criteria

South Country Health Alliance

Medicare	X
Medicaid	X

Policy & Procedure

Policy Name	General Medical Necessity Criteria
Policy Number	MCP 01
Regulatory Requirement(s)	Minnesota Administrative Rules, Part 9505.0175, Subpart 25 Minnesota Administrative Rules, Part 9505.0355, Subpart 2 Minnesota Statute 256B.0625 Minnesota Statute 256B.04, subd. 13 Minnesota Administrative Rules, Part 9505.5005, Subpart 9 Minnesota Administrative Rules, Part 9505.0210 Minnesota Administrative Rules, 4685.0700, subpart 4, item F Minnesota Administrative Rules, 4685.0100, subpart 6a 42 CFR 422.101
Original Effective Date	October 19, 2018
Version Effective Date	April 15, 2024
Policy Owner(s)	Medical Director, Director of Health Services
Cross Reference(s)	

Purpose

The General Medical Necessity Criteria may be used by the South Country Health Alliance (SCHA) Medical Director, or designated physician reviewer, when there are no item-specific nor service-specific DHS (in the case of Medicaid only requests), CMS (in the case of Medicare or dual eligible requests), InterQual, nor SCHA Medical Coverage Policy criteria applicable to a given prior authorization or claim appeal request. The SCHA Medical Director and Utilization Management Medical Coverage Policy Committee may develop item-specific or service-specific criteria that may be used for prior authorization or claim appeal request determination.

Definitions**Medical Necessity – Medicaid**

"Medically necessary" or "medical necessity" means a health service that is consistent with the recipient's diagnosis or condition **AND**:

A. is recognized as the prevailing standard or current practice by the provider's peer group; **and**

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B. is rendered in response to a life-threatening condition or pain; or to treat an injury, illness, or infection; or to treat a condition that could result in physical or mental disability; or to care for the mother and child through the maternity period; or to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition; **or**

C. is a preventive health service under Minnesota Rule part [9505.0355 Subpart 2](#).

Medical Necessity - Medicare

South Country will make Medicare medical necessity determinations based on all the following:

- A. Coverage and benefit criteria as specified at 42 CFR § 422.101(b) and (c). South Country will apply coverage criteria established in applicable Medicare statutes, regulations, NCDs or LCDs. If such coverage criteria are not fully established, South Country will only apply internal coverage criteria if it is created and made publicly accessible as required in 42 CFR § 422.101(b)(6).
- B. Whether the provision of items or services is reasonable and necessary under section 1862(a)(1) of the Act.
- C. The enrollee's medical history (for example, diagnoses, conditions, functional status), physician recommendations, and clinical notes.
- D. Where appropriate, involvement of the organization's medical director as required at 42 CFR § 422.562(a)(4).

Experimental or Investigative [from DHS Contract]

Experimental or Investigative Service means a drug, device, medical treatment, diagnostic procedure, technology, or procedure for which reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. [Minnesota Rules, Parts 4685.0100, subpart 6a and 4685.0700, subpart 4, item F]

Standards

All criteria must be met for the service to be considered medically necessary.

1. The services are prescribed by a licensed health care practitioner practicing within the scope of his/her license in the context of his/her treatment of the individual; **AND**
2. The services are safe, effective, and recognized as the prevailing standard or current practice by the provider's peer group; **AND**
3. The services are not experimental or investigational (see Minnesota Administrative Rules, Part 9505.5005, Subpart 9); **AND**

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4. The services are not considered cosmetic. Reference from the DHS Provider manual, “Medicaid or MinnesotaCare does not cover surgery primarily for cosmetic purposes”. Reference from the 2021 DHS contracts: “Cosmetic procedures or treatment are not covered, except that the following services are not considered cosmetic and therefore must be covered: services necessary as the result of injury, illness or disease, or for the treatment or repair of birth anomalies.” **AND**
5. The services are individualized, specific, and consistent with the individual’s signs, symptoms, history, diagnosis or condition; **AND**
6. The health service rendered (consistent with current DHS contracts) is:
 - 6.1 in response to a life-threatening condition or pain; **or**
 - 6.2 to treat an injury, illness or infection; **or**
 - 6.3 to treat a condition that could result in physical or mental disability; **or**
 - 6.4 to care for the mother and unborn child through the maternity period; **or**
 - 6.5 to achieve a level of physical or mental function consistent with prevailing community standards for diagnosis or condition; **or**
 - 6.6 a preventive health service defined under Minnesota Rules, Part 9505.0355 Subpart 2. **AND**
7. The health service must be determined by prevailing community standards or customary practice and usage to be appropriate and effective for the medical needs of the of the patient and represent an effective and appropriate use of program funds; **AND**
8. The services are not primarily for the convenience of the individual, practitioner, caregiver, family, or another party; **AND**
9. The services are not predominantly domiciliary or custodial; **AND**
10. No exclusionary criteria apply to the situation.


Procedure

During the Utilization Management authorization process, the clinical reviewer staff will review established authorization criteria, as defined in “Purpose” above, for possible approval of the medical service as medically necessary. In the circumstance where there are no item-specific or service-specific criteria applicable for authorization of services, or these specific criteria are not met, the authorization request will be sent for secondary medical review by the Medical Director, or designated physician reviewer, for determination based on medical necessity. This secondary review process may include consideration of any relevant, specific clinical factors that may uniquely apply to the request, as well as the medical necessity principles noted above, and other sources, including, but not necessarily limited to, peer reviewed medical literature, UpToDate, Professional Practice Guidelines, clinical judgement, and standards of medical care, but at no

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time will South Country utilize coverage criteria that does not meet the requirements stated above.

Signatures:

Signature Approval:  _____ Date: 4/16/2024
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Medical Director

Signature Approval:  _____ Date: 4/16/2024
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Director of Health Services