MEDICAL POLICY

POLICY TITLE	MEDICAL NECESSITY
POLICY NUMBER	MP- 4.003

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Effective Date:	**11/1/2020**

I. POLICY

Specific medical policies document the circumstances and conditions under which care and services are determined to be appropriate and necessary. Capital BlueCross defines "medical necessity or medically necessary" to mean the following:

- Services or supplies that a physician exercising prudent clinical judgment would provide to a plan member for the diagnosis and/or the direct care and treatment of the plan member's medical condition, disease, illness, or injury that are necessary; **and**
- In accordance with accepted standards of good medical practice; **and**
- Clinically appropriate for the plan member's condition, disease, illness or injury; **and**
- Not primarily for the convenience of the plan member and/or plan member's family, physician, or other health care provider; **and**
- Not more costly than alternative services or supplies at least as likely to produce equivalent results for the plan member's condition, disease, illness or injury.

For these purposes, "generally accepted standards of good medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other clinically relevant factors. The fact that a provider may prescribe, recommend, order, or approve a service or supply does not of itself determine medical necessity or make such a service or supply a covered benefit.

Exception: When a member's contract provides for benefits contrary to the medical necessity provision, Capital BlueCross will cover services to the extent provided in the contract.

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Medical Necessity for Out of Network Services

Note: Requests for non-emergency care from non-participating practitioners or providers require prior authorization and medical review.

Non-covered health plan services are not covered out-of-network or out-of-area.

Services from non-contracted healthcare providers are considered **medically necessary** for the following situations:

- There are no contracted providers with appropriate training and experience to provide the services that are being requested (i.e. specialized surgery, specialty care for a rare condition, etc.).
- Covered services are not accessible and available from contracted healthcare providers who are closer than non-contracted providers or within reasonable distances. Travel distances of up to 30 miles are considered reasonable for primary care and general hospital care, and distances up to 75 miles are considered reasonable for specialty care, specialty hospitals, and single healthcare service plan physicians or providers. These services may include providers of durable medical equipment (DME).
- The member is at or beyond the 24th week of pregnancy and one of the following situations:
  - Her contracted obstetrical provider terminates with Capital BlueCross (Exception Provider terminates due to Fraud)
  - The obstetrical provider of a newly-enrolled member is a non-contracted provider (see definitions)

  Note: Case Management support is available for members requesting transition of care.

- Emergent services for which the closest provider/facility is non-contracted. See definitions.
- A member is in an active course of treatment* with an out of network provider. Continued out of network services are reasonable while transiting to a contracted provider, and one of the following is met:
  - Contracted provider terminates with Capital BlueCross (Exception Provider terminates due to Fraud)
  - Newly-enrolled member's treating provider is a non-contracted provider Capital BlueCross

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Note: In most cases, only one (1) visit should be approved to an out of network specialist while transitioning is arranged (i.e. post-op emergent surgery, fracture). Determination may be approved up to 90 days from the provider's termination date or from the member's enrollment date until service(s) are no longer medical necessary and while transitioning is arranged. Case Management can help the member transition.

*Members in an active course of treatment are receiving active treatment for an acute condition in which provider continuity may prevent a recurrence of worsening of the condition under treatment and interfere with anticipated outcomes. Treatment typically involves regular visits with a practitioner to monitor the status of an illness or disorder, provider direct treatment, prescribe medication or other treatment or modify treatment protocol.

Examples of a qualifying condition:

- Treatment for an acute exacerbation of chronic asthma requiring ongoing treatment whereas monitoring for chronic asthma may not meet the above definition.
- Post-operative post-treatment or having a staged cycle of surgical procedures (e.g. cleft palate repair).
- Engaged in an ongoing course of treatment (e.g. radiation therapy or chemotherapy). Determinations may be approved through the current course of treatment, generally 6-12 months.

Covered services from non-contracted healthcare providers are **not medically necessary** for the following situations:

- Services are available within the member's Capital BlueCross network.
- There is no continuity of care or network gap.
- Primary care physicians (PCPs):
  - Members enrolled in a Capital BlueCross plan that require a PCP are expected to select a participating PCP at the time of enrollment.

In addition to the Capital BlueCross Medical Policies, Capital BlueCross utilizes InterQual criteria, which is an industry standard set of objective, evidence-based, utilization management criteria to assist in evaluating the medical necessity and appropriateness of medical care delivered to Members. InterQual criteria is evaluated yearly for updates and changes.

II. PRODUCT VARIATIONS TOP

This policy is only applicable to certain programs and products administered by Capital BlueCross please see additional information below, and subject to benefit variations as discussed in Section VI below.

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FEP PPO - All benefits are subject to the definitions, limitations, and exclusions in the Blue Cross and Blue Shield Service Benefit Plan brochure and are payable only when we determine that the criteria for medical necessity are met. Medical necessity shall mean health care services that a physician, hospital, or other covered professional or facility provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice in the United States; and
- Clinically appropriate, in terms of type, frequency, extent, site, and duration; and considered effective for the patient's illness, injury, disease, or its symptoms; and
- Not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury, or disease, or its symptoms; and
- Not part of or associated with scholastic education or vocational training of the patient; and
- In the case of inpatient care, only provided safely in the acute inpatient hospital setting.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and physician specialty society recommendations.

III. DESCRIPTION/BACKGROUND

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This policy describes the circumstances under which a service is considered medically necessary.

IV. DEFINITIONS

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A **Participating Provider** is a pharmacy, prescriber, professional provider, facility provider, or any other eligible healthcare provider or practitioner that is approved by Capital and, where licensure is required, is licensed in the applicable state and provides covered services and has entered into a provider agreement with or is otherwise engaged by Capital to provide benefits to members and who satisfies Capital's credentialing and privileging criteria. The status of a provider as a participating provider may change from time to time. It is the member's responsibility to verify the current status of a provider.

An **Emergency Service** is any health care service provided to a member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe

pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in and of the following:

- Placing the health of the *member*, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Other serious medical consequences; or
- Transportation, treatment, and related *emergency services* provided by a licensed *emergency medical services agency* if the condition is as described in this definition.

(Examples of conditions requiring *emergency services* are: excessive bleeding; broken bones; serious burns; sudden onset of severe chest pain; sudden onset of acute abdominal pains; poisoning; unconsciousness; convulsions; and choking. In these circumstances, 911 services are appropriate and do not require *Preauthorization.)*

Out of Area Services: Capital BlueCross has a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." Whenever members access healthcare services outside of Capital BlueCross' service area, the claims for these services may be processed through one of these Inter-Plan Arrangements. When a member receives care outside of Capital BlueCross' service area, members will receive it from one of two kinds of providers. Most providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some providers ("nonparticipating providers") do not contract with the Host Blue.

A **Non-Participating Provider** is a provider who is not under contract with Capital BlueCross or a provider who is not a BlueCard participating provider. Services provided by non-participating providers may require higher cost-sharing amounts or may not be covered benefits. If such services are covered, benefits will be reimbursed at a percentage of the allowable amount applicable to this coverage with Capital BlueCross. Information on whether benefits are provided when performed by a nonparticipating provider and the applicable level of payment for such benefits is noted in the Summary of Cost-Sharing and Benefits section of the member's Certificate of Coverage.

V. BENEFIT VARIATIONS TOP

The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are

excluded, which are subject to benefit limits and which require preauthorization. There are different benefit plan designs in each product administered by Capital BlueCross. Members and providers should consult the member's health benefit plan for information or contact Capital BlueCross for benefit information.

VI. DISCLAIMER

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Capital BlueCross's medical policies are developed to assist in administering a member's benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital BlueCross' Provider Services or Member Services. Capital BlueCross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

- ***Specific procedure coding does not apply to this policy.***

VIII. POLICY HISTORY

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MP-4.003	**CAC 10/28/02**
	CAC 4/27/04
	CAC 9/28/04
	CAC 9/27/05
	CAC 9/26/06
	CAC 9/25/07
	CAC 7/29/08
	CAC 9/29/09 Consensus review. Policy statement unchanged, references updated.
	CAC 11/30/10 Consensus review.
	CAC 11/22/11 Consensus review. New medical necessity definition required for FEP effective 1/1/12 added to the policy.
	7/19/13 Administrative update. Coding review complete.
	CAC 9/24/13 Consensus review. Policy statements unchanged.

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	CAC 9/30/14 Consensus review. Policy statements unchanged.
	CAC 9/29/15 Consensus review. Policy statements unchanged.
	CAC 11/29/16 Consensus review. Changed Medicare variation definition of medically necessary to match the glossary listing in Medicare.gov. Variation reformatting.
	3/1/17 Administrative update. Added information for OON services.
	1/1/18 Admin Update: Medicare variations removed from Commercial Policies.
	12/29/17 Consensus review. Policy statements unchanged. Utilization of InterQual statement added to the Policy section.
	11/27/18 Consensus review. No change to statements.
	9/30/19 Consensus review. No change to statements.
	8/24/2020 Consensus review. No change to policy statement. Definitions updated to match COC.

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