Medical Necessity

Policy Number: BIP096.L
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Instructions for Use

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Related Policies
None

Federal/State Mandated Regulations

Article 5. Standards [1367 - 1374.195]

(Article 5 added by Stats. 1975, Ch. 941.)

1367.015 Health and Safety Code – HSC Division 2. Licensing Provisions

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1367.015&lawCode=HSC

In addition to complying with subdivision (h) of Section 1367.01, in determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, based in whole or in part on medically necessity, a health care service plan subject to Section 1367.01 shall not base decisions to deny requests by providers for authorization for mental health services or to deny claim reimbursement for mental health services on either of the following:

(a) Whether admission was voluntary or involuntary.
(b) The method of transportation to the health facility.

Chapter 2.2. Health Care Service Plans (1340 - 1399.874)

(Chapter 2.2 Added By Stats. 1975, Ch. 941.)

Article 5.6. Point-of-Service Health Care Service Plan Contracts (1374.60 - 1374.76)

(Article 5.6 added by Stats. 1993, Ch. 987, Sec. 3.)

1374.721

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?sectionNum=1374.721.&lawCode=HSC

(a) A health care service plan that provides hospital, medical, or surgical coverage shall base any medical necessity determination or the utilization review criteria that the plan, and any entity acting on the plan's behalf, applies to determine the medical necessity of health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders on current generally accepted standards of mental health and substance use disorder care.
(b) In conducting utilization review of all covered health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders in children, adolescents, and adults, a health care service plan shall apply the criteria and guidelines set forth in the most recent versions of treatment criteria developed by the nonprofit professional association for the relevant clinical specialty.

(c) In conducting utilization review involving level of care placement decisions or any other patient care decisions that are within the scope of the sources specified in subdivision (b), a health care service plan shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit a health care service plan from applying utilization review criteria to health care services and benefits for mental health and substance use disorders that meet either of the following criteria:
  (1) Are outside the scope of the criteria and guidelines set forth in the sources specified in subdivision (b), provided the utilization review criteria were developed in accordance with subdivision (a).
  (2) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in subdivision (b), provided that the utilization review criteria were developed in accordance with subdivision (a).

(d) If a health care service plan purchases or licenses utilization review criteria pursuant to paragraph (1) or (2) of subdivision (c), the plan shall verify and document before use that the criteria were developed in accordance with subdivision (a).

(e) To ensure the proper use of the criteria described in subdivision (b), every health care service plan shall do all of the following:
  (1) Sponsor a formal education program by nonprofit clinical specialty associations to educate the health care service plan's staff, including any third parties contracted with the health care service plan to review claims, conduct utilization reviews, or make medical necessity determinations about the clinical review criteria.
  (2) Make the education program available to other stakeholders, including the health care service plan's participating providers and covered lives. Participating providers shall not be required to participate in the education program.
  (3) Provide, at no cost, the clinical review criteria and any training material or resources to providers and health care service plan enrollees.
  (4) Track, identify, and analyze how the clinical review criteria are used to certify care, deny care, and support the appeals process.
  (5) Conduct interrater reliability testing to ensure consistency in utilization review decision making covering how medical necessity decisions are made. This assessment shall cover all aspects of utilization review as defined in paragraph (3) of subdivision (f).
  (6) Run interrater reliability reports about how the clinical guidelines are used in conjunction with the utilization management process and parity compliance activities.
  (7) Achieve interrater reliability pass rates of at least 90 percent and, if this threshold is not met, immediately provide for the remediation of poor interrater reliability and interrater reliability testing for all new staff before they can conduct utilization review without supervision.

(f) The following definitions apply for purposes of this section:
  (1) "Generally accepted standards of mental health and substance use disorder care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties such as psychiatry, psychology, clinical sociology, addiction medicine and counseling, and behavioral health treatment pursuant to Section 1374.73. Valid, evidence-based sources establishing generally accepted standards of mental health and substance use disorder care include peer-reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.
  (2) "Mental health and substance use disorders" has the same meaning as defined in paragraph (2) of subdivision (a) of Section 1374.72.
  (3) "Utilization review" means either of the following:
    (A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, enrollees, or their authorized representatives for coverage of health care services prior to, retrospectively or concurrent with the provision of health care services to enrollees.
    (B) Evaluating the medical necessity, appropriateness, level of care, service intensity, efficacy, or efficiency of health care services, benefits, procedures, or settings, under any circumstances, to determine whether a health care service or benefit subject to a medical necessity coverage requirement in a health care service plan contract is covered as medically necessary for an enrollee.
  (4) "Utilization review criteria" means any criteria, standards, protocols, or guidelines used by a health care service plan to conduct utilization review.

(g) This section applies to all health care services and benefits for the diagnosis, prevention, and treatment of mental health and substance use disorders covered by a health care service plan contract, including prescription drugs.

(h) This section applies to a health care service plan that conducts utilization review as defined in this section, and any entity or contracting provider that performs utilization review or utilization management functions on behalf of a health care service plan.
(i) The director may assess administrative penalties for violations of this section as provided for in Section 1368.04, in addition to any other remedies permitted by law.
(j) A health care service plan shall not adopt, impose, or enforce terms in its plan contracts or provider agreements, in writing or in operation, that undermine, alter, or conflict with the requirements of this section.
(k) This section does not apply to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code, between the State Department of Health Care Services and a health care service plan for enrolled Medi-Cal beneficiaries.

(Added by Stats. 2020, Ch. 151, Sec. 5. (SB 855) Effective January 1, 2021.)

State Market Plan Enhancements

None

Covered Benefits

Important Note: Covered benefits are listed in *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits* sections. Always refer to the *Federal/State Mandated Regulations* and *State Market Plan Enhancements* sections for additional covered services/benefits not listed in this section.

A service or item will be covered under the UnitedHealthcare Health Plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded, if it is medically necessary or otherwise required to be covered under the law or as described in the member's combined evidence of coverage.

An Intervention may be medically indicated yet not be a covered benefit if it is not medically necessary or otherwise required to be covered under the law or otherwise set forth in the member's combined evidence of coverage.

An Intervention is medically necessary if, as recommended by the treating physician and determined by the medical director of UnitedHealthcare or the network medical group, it is **(all of the following):**
a. A health intervention for the purpose of treating a medical condition;
b. The most appropriate supply or level of service, considering potential benefits and harms to the member;
c. Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and
d. If more than one health intervention meets the requirements of a, b and c above, furnished in the most cost-effective manner that may be provided safely and effectively to the member. "Cost-effective" does not necessarily mean lowest price.

Note: Refer to the member's EOC for information regarding timely access to medically necessary care.

Not Covered

None

Policy History/Revision Information

Date	Summary of Changes
12/01/2023	**Federal/State Mandated Regulations** • Updated reference link to *California Health and Safety Code Section 1367.015* **Covered Benefits** • Replaced language indicating:

Date	Summary of Changes
	○ "An *intervention* will be covered under the UnitedHealthcare health plan if it is an otherwise covered category of service, not specifically excluded, and medically necessary" with "a *service or item* will be covered under the UnitedHealthcare health plan if it is an *intervention that is* an otherwise covered category of service *or item*, not specifically excluded, *if it is* medically necessary *or otherwise required to be covered under the law or as described in the member's combined evidence of coverage*" ○ "An intervention may be medically indicated yet not be a covered benefit *or meet the definition of* medical necessity" with "an intervention may be medically indicated yet not be a covered benefit *if it is not* medically necessary *or otherwise required to be covered under the law or otherwise set forth in the member's combined evidence of coverage (EOC)*" **Supporting Information** • Removed *Definitions* section • Archived previous policy version BIP096.K

Instructions for Use

Covered benefits are listed in three (3) sections: *Federal/State Mandated Regulations*, *State Market Plan Enhancements*, and *Covered Benefits*. All services must be medically necessary. Each benefit plan contains its own specific provisions for coverage, limitations, and exclusions as stated in the member's Evidence of Coverage (EOC)/Schedule of Benefits (SOB). If there is a discrepancy between this policy and the member's EOC/SOB, the member's EOC/SOB provision will govern.