BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Medical Policy

Medically Necessary

Policy Number: OCA 3.14
Version Number: 27
Version Effective Date: 12/01/21

Product Applicability	☒ **All Plan+ Products**
WellSense Health Plan ☒ NH Medicaid ☒ NH Medicare Advantage	**Boston Medical Center HealthNet Plan** ☒ MassHealth – ACO ☒ MassHealth – MCO ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☒ Senior Care Options

+ Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan will provide coverage for services that are considered medically necessary as outlined in the member's benefit documents. The Plan complies with coverage guidelines for all applicable state-mandated benefits and federally-mandated benefits that are medically necessary for the member's condition. All Plan policies are developed in accordance with state, federal and accrediting organization guidelines and requirements, including National Committee for Quality Assurance (NCQA). The Plan and the Plan's delegated clinical vendors conducting utilization management do NOT discriminate, arbitrarily deny, and/or impose stricter requirements by reducing the amount, duration, and/or scope of required and medically necessary services for ANY Plan member based on the member's diagnosis, type of illness, health status or condition, sex, gender identity/gender dysphoria, and/or sexual orientation.

The Plan's *Prior Authorization/Notification Requirements Matrix* includes a list of services that require prior authorization. Review the Plan's *Prior Authorization CPT Code Look-up Tool* and *Prior*

+ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name WellSense Health Plan.

Authorization HCPCS Code Look-up Tool for the prior authorization guidelines for each of the service's applicable, industry-standard billing code(s). The Plan's prior authorization matrix, CPT/HCPCS code look-up tools, medical policies, and reimbursement policies are available at www.bmchp.org for BMC HealthNet Plan members (including Senior Care Options member) and posted at www.wellsense.org for WellSense Health Plan members.

It will be determined during the Plan's prior authorization process if a service is considered medically necessary for the requested indication. The Plan's clinical review criteria used to determine medical necessity are applied equitably across the Plan's membership. However, the Plan's Office of Clinical Affairs (OCA) Utilization Management staff (or the delegated clinical vendor's professional staff when the management of services is delegated to the vendor) will take into account the member's individual needs, circumstances, and healthcare services requested and/or currently provided to the member to integrate healthcare for continuity, coordination, and collaboration of services, as well as assessing the local healthcare delivery system's ability to meet the member's healthcare needs, when determining the medical necessity of services. Plan authorizations, as well as authorizations by each of the Plan's delegated clinical vendors conducting utilization management, are based on a comprehensive and individualized needs assessment that addresses all member needs, including but not limited to social determinants of health and a subsequent person-centered planning process. Plan prior authorization requirements (and those of each of the Plan's delegated clinical vendors) comply with parity in mental health and substance use disorders.

The Plan will submit substantive revisions to its medical necessity review process and/or medical necessity guidelines, including clinical review criteria and related utilization management protocols, to the Massachusetts Office of Patient Protection, Massachusetts Executive Office of Health and Human Services (EOHHS), New Hampshire Department of Health and Human Services (DHHS), and the Centers for Medicare & Medicaid Services at least **60 calendar days** before the effective date of these substantive revisions (or another timeframe specified by the organization) when these changes may impact services provided to the organization's enrollees. A designated contact person must be provided in writing to the Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) by the organization or its designee.

The Plan's *Experimental and Investigational Treatment* medical policy, policy number OCA 3.12, specifies the product-specific definitions of experimental or investigational treatment. Review the product-specific definitions of cosmetic services and reconstructive surgery and procedures in the Plan's *Cosmetic, Reconstructive, and Restorative Services* medical policy, policy number OCA 3.69. The Plan's *Clinical Review Criteria* administrative policy, policy number OCA 3.201, includes product-specific definitions of clinical review criteria, a summary of the Plan's procedure for applying clinical review criteria to services that require prior authorization, and specifies which entities are responsible for the development, implementation, and monitoring of the Plan's clinical review criteria. The Plan's *Clinical Technology Evaluation* administrative policy, policy number OCA 3.13, includes definitions for evidence-based medicine and medical technology assessment, and the policy outlines the process for evaluating new technology and the new application of existing technology. Review the Plan's applicable *Clinical Trials* reimbursement policy if the requested service is related to a clinical trial:

reimbursement policy number 4.134 for BMC HealthNet Plan members, reimbursement policy number SCO 4.134 for Senior Care Options members, or reimbursement policy number WS 4.12 for Well Sense Health Plan members.

Clinical Criteria

The Plan will provide coverage for services that are considered medically necessary and are covered services for the member (as outlined in the member's applicable benefit documents) when BOTH of the following criteria in item 1 and item 2 are met:

1. **Criteria for All Plan Products:**

   Referencing the appropriate definition of medically necessary (as specified in the Definitions section of this policy) and any relevant internal medical policies, an appropriately licensed clinician at the Plan will evaluate whether a service, treatment, procedure, supply, device, biological product, or drug is medically necessary by consideration of ALL of the criteria in items a through f:

   a. The treatment must have final approval from the appropriate governmental regulatory body(ies) to market the technology (e.g., the U.S. Food and Drug Administration or other federal governmental body with authority to regulate the technology); AND

   b. The authoritative evidence must support conclusions concerning the effect of the treatment on health outcomes; AND

   c. The treatment must improve the net health outcome and should outweigh any harmful effect; AND

   d. The treatment must be as beneficial as any established alternative; AND

   e. The outcomes must be attainable outside the investigational or experimental settings; AND

   f. The definition of medically necessary is applied in a manner outlined in the *Clinical Review Criteria* administrative policy, policy number OCA 3.201, that considers ALL of the following member-specific factors (that include the member's individual health care needs) when applying the applicable clinical review criteria to determine whether a requested service. The service may include a treatment, procedure, supply, device, biological product, or drug and will be used to prevent, diagnose, stabilize, and/or treat a disease, condition, and/or disorder that results in health impairment and/or disability, and/or the service allows the member to attain, maintain, or regain functional capacity. Individual consideration includes an assessment of ALL of the member-specific factors listed in items (1) through (16):

      (1) Member's condition; AND

(2) Member's comorbidities (including the assessment of ongoing and/or chronic conditions with services authorized in a manner that reflects the member's ongoing need for such services and supports for stabilization of one or more ongoing and/or chronic conditions); AND

(3) Member's age (i.e., neonates, infants, children, adolescents, adults, or older adults) including the assessment of age-appropriate growth, development, and competencies, as well as evaluation of age-related healthcare needs and issues; AND

(4) Relevant past medical/surgical/behavioral health/dental/pharmacotherapy history; AND

(5) Complications experienced by the member; AND

(6) Progression of the member's condition, illness, or injury; AND

(7) Diagnostic test results, when applicable; AND

(8) Progress with treatment; AND

(9) Available treatment options for the member's condition; AND

(10) Psychosocial circumstances; AND

(11) Home and environmental factors impacting the member's clinical condition (e.g., homelessness, employment status, poverty, neighborhood); AND

(12) Other healthcare services requested and/or currently provided to the member to integrate healthcare for continuity, coordination, and collaboration of services; AND

(13) Local healthcare delivery system's ability to meet the healthcare needs of the member's specific condition; AND

(14) Member's reasonable accessibility to a qualified provider with appropriate credentials, licensure, clinical expertise and/or resources in the applicable clinical area necessary to adequately manage the member's condition (including but not limited to pharmacotherapy, behavioral health services, dental services, radiology services, and/or durable medical equipment, prosthetics, orthotics and supplies); AND

(15) Other factors related to the member's plan of care and/or health outcomes; AND

(16) If applicable, verification that the requested device, system, biological product, or drug is being prescribed/requested and will be utilized according to its FDA-approved

clearance and guideline information, including intended use for the member's age and medical condition; AND

2. **Additional Product-Specific Criteria:**

   ONE (1) of the criteria in item a or item b is met when it is applicable for the Plan member:

   a. **Criterion Only for BMC HealthNet Plan Members Enrolled in a MassHealth Product:**

      Utilizing providers in the Plan's provider network, the Plan will provide or refer all MassHealth enrollees under age 21 (i.e., until the member's 21st birthday) for medically necessary treatment services in accordance with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements included in their benefit package.

   b. **Criterion Only for Plan Members Enrolled in a Well Sense Health Plan Product:**

      For a Well Sense Health Plan member under age 21 (i.e., until the member's 21st birthday), the Plan will provide coverage for medically necessary services that are covered by federal Medicaid law, including services not specifically included in the covered service list in the member's benefit documents when no other equally effective course of treatment is available or suitable for the member in accordance with the definition of Early and Periodic Screening, Diagnosis and Treatment (EPSDT). This coverage includes ALL services listed in items (1) through (3):

      (1) Healthcare services; AND

      (2) Diagnostic services; AND

      (3) Treatment and other measures needed to correct or improve deficits and physical or behavior health illnesses and conditions.

Member benefit documents are available at the following websites: www.bmchp.org for BMC HealthNet Plan members, www.SeniorsGetMore.org for Senior Care Options members, www.wellsense.org for WellSense New Hampshire Medicaid members, and www.WellSense.org/Medicare for WellSense Medicare Advantage HMO members.

Limitations and Exclusions

Not applicable.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and WellSense Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. Verify CMS guidelines in effect on the date of the prior authorization request that are appropriate for the service and indication for treatment. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Contract Definitions of Medically Necessary or Medical Necessity

MassHealth ACO and MassHealth MCO Contract Definition of Medically Necessary or Medical Necessity: Consistent with guidelines specified in 42 CFR §438.210(a)(5) and in accordance with 130 CMR 450.204, medically necessary services are those services:

1. Which are reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the Enrollee that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a disability, or result in illness or infirmity AND

2. For which there is no other medical service or site of service, comparable in effect, available, and suitable for the Enrollee requesting the service, that is more conservative or less costly. Medically necessary services must be of a quality that meets professionally recognized standards of health care, and must be substantiated by records including evidence of such medical necessity and quality.

Per the MassHealth ACO contract and MassHealth MCO contract, the Plan's definition of what constitutes medically necessary services and the medical necessity guidelines established by the Plan will NOT be more restrictive than the above definition of "medically necessary" or "medical necessity." The Plan shall authorize provides and in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to members under MassHealth fee-for-service. The Plan may place appropriate limits on covered service on the basis of medical necessity, or for the purpose of utilization control, provided that the furnished services can reasonably be expected to achieve their purpose. The Plan will NOT deny authorization for a Plan covered service demonstrated to be medically necessary by a health care professional who has the clinical expertise in treating the member's medical condition or in performing the procedure or providing treatment, whether or not there is a non-Plan covered service that might also meet the member's medical needs.

If there is a substantive change in the Plan's medical necessity guidelines, program specifications, and/or services components, the Plan will notify the Massachusetts Executive Office of Health and Human Services (EOHHS) no less than **60 calendar days** before the effective date of these substantive

revisions (or another timeframe specified by EOHHS) when these changes may impact services provided to enrollees, as specified in the *Clinical Review Criteria* administrative policy, OCA 3.201. The Plan's definition of what constitutes medically necessary services includes ALL of the following types of Plan covered services: services necessary for the prevention, diagnosis, and/or treatment of health impairments; services that allow the member to achieve age-appropriate growth and development; and/or services necessary for the member to attain, maintain, or regain functional capacity. Review the member's applicable benefit document at www.bmchp.org to determine benefit coverage of medically necessary Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for a BMC HealthNet Plan member under the age of 21 on the date of service.

Qualified Health Plans/ConnectorCare/Employer Choice Direct Definition of Medically Necessary or Medical Necessity: In accordance with 211 CMR 52.02, medically necessary services are: Health care services that are consistent with generally accepted principles of professional medical practice as determined by whether: (a) the service is the most appropriate available supply or level of service for the member in question considering the potential benefits and harms to the member; (b) the service is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or (c) for services and interventions not in widespread use, the service is based on scientific evidence. If there is a substantive change in the Plan's medical necessity guidelines, program specifications, and/or services components, the Plan will notify the Massachusetts Office of Patient Protection (OPP) no less than **60 calendar days** before the effective date of these substantive revisions (or another timeframe specified by OPP) when these changes may impact services provided to these members, as specified in the *Clinical Review Criteria* administrative policy, OCA 3.201.

New Hampshire Medicaid Care Management Program Contract Definitions of Medically Necessary (for the Well Sense Health Plan Products):

1. For Well Sense Health Plan members 21 years of age and older:

   In accordance with He-W 530.01(e), "medically necessary" means services that a licensed provider, exercising prudent clinical judgment, would provide, in accordance with generally accepted standards of medical practice to a member for the purpose of evaluating, diagnosing, preventing, or treating an acute or chronic illness, injury, disease, or its symptoms. Medically necessary health care services for members ages 21 years and older must be:

   a. Clinically appropriate in terms of type, frequency of use, extent, site, and duration; AND

   b. Consistent with the established diagnosis or treatment of the member's illness, injury, disease, or its symptoms; AND

   c. Not primarily for the convenience of the member or the member's family, caregiver, or health care provider; AND

d. No more costly than other items or services which would produce equivalent diagnostic, therapeutic, or treatment results as related to the member's illness, injury, disease, or its symptoms; AND

e. Not experimental, investigative, cosmetic, or duplicative in nature.

2. For Well Sense Health Plan members under age 21 (i.e., until the member's 21st birthday):

"Medically necessary" means ANY of the criteria in item a or item b is met for the service:

a. The course of treatment meets BOTH of the criteria in items (1) and (2) to be considered medically necessary:

(1) Is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions that meet ANY of the criteria in items i through v:

i. Endanger life; OR

ii. Cause pain; OR

iii. Result in illness or infirmity; OR

iv. Threaten to cause or aggravate a handicap; OR

v. Cause physical deformity or malfunction; AND

(2) No other equally effective course of treatment is available or suitable for the member; AND/OR

b. Per Early and Periodic Screening, Diagnostic and Treatment 2.1.74.1 (EPSDT) for Members under 21 years of age, "Medically Necessary" means any service that is included within the categories of mandatory and optional services listed in Section 1905(a) of the Social Security Act, regardless of whether such service is covered under the Medicaid State Plan, if that service is necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

The Plan's definition of what constitutes medically necessary services and the medical necessity guidelines established by the Plan for all Well Sense Health Plan members (including adult members and members under the age of 21) will NOT be more restrictive than the above definition of "medically necessary" according to the Plan's contract with the New Hampshire Department of Health and Human Services (DHHS). The Plan ensures that each service is furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same service(s) provided under fee-for-service Medicaid. Services provided to adult and pediatric Plan members are no more restrictive than

the New Hampshire DHHS fee-for-service Medicaid program, including quantitative and non-quantitative treatment limits, and are in compliance with applicable New Hampshire State laws and regulations, the Medicaid State Plan, and New Hampshire State policies and procedures. If there is a substantive change in the Plan's medical necessity review process, the Plan will notify the New Hampshire DHHS no less than **60 calendar days** before the effective date of these substantive revisions (or another timeframe specified by DHHS) when these changes may impact services provided to enrollees, as specified in the *Clinical Review Criteria* administrative policy, OCA 3.201. The Plan's definition of what constitutes medically necessary services includes ALL of the following types of covered services for all Well Sense Health Plan members: services necessary for the prevention, diagnosis, and/or treatment of health impairments; services that allow the member to achieve age-appropriate growth and development; and services necessary for the member to attain, maintain, or regain functional capacity. Review the member's applicable benefit document at www.wellsense.org to determine benefit coverage of medically necessary EPSDT services for a Well Sense Health Plan member under the age of 21 on the date of service.

Product-Specific Definitions

Clinical Review Criteria (Definition for MassHealth and Senior Care Options Products): Criteria used to determine the most clinically appropriate and necessary level of care and intensity of services to ensure the provision of medically necessary services. The Plan's clinical review criteria include internally developed criteria specified in the Plan's medical policies, InterQual® criteria, and/or clinical guidelines established by delegated management partners. The Plan's *Clinical Review Criteria* administrative policy, policy number OCA 3.201, includes product-specific definitions of clinical review criteria, a summary of the Plan's procedure for applying clinical review criteria to services that require prior authorization, and specifies which entities are responsible for the development, implementation, and monitoring of the Plan's clinical review criteria. See the Contract Definitions section of this policy for the product-specific definition of medically necessary treatment. For the MassHealth ACO and MassHealth MCO products, medical necessity guidelines established by the Plan will be no more restrictive than the contractual definition of "medically necessary" or "medical necessity."

Clinical Review Criteria (Definition for Qualified Health Plans/ConnectorCare/Employer Choice Direct Definition Products): In accordance with 958 CMR 3.020, clinical review criteria are the written screening procedures, decisions, abstracts, clinical protocols and practice guidelines used by the Plan to determine the medical necessity and appropriateness of health care services. Utilization review criteria shall be up to date and applied consistently by the Plan or the Plan's partner clinical vendor and made easily accessible to members, providers, and the general public on the Plan's website; or, in the alternative, on the Plan's partner clinical vendor's website so long as the Plan provides a link on its website to the vendor's website; provided, however, that the Plan shall not be required to disclose licensed, proprietary criteria purchased by the Plan or partner clinical vendor on its website, but must disclose such criteria to a provider or subscriber upon request. Any new or amended pre-authorization requirement or restriction shall not be implemented unless the Plan's and/or partner clinical vendor's respective website has been updated to clearly reflect the new or amended requirement or restriction. Review the Plan's *Clinical Review Criteria* administrative policy, OCA 3.201, for a complete description

of the Plan's process to establish guidelines for medical necessity consistent with 958 CMR 3.000 and 211 CMR 52.05.

Clinical Review Criteria (Definition for WellSense New Hampshire Medicaid Product): A set of medical decision standards employed in the utilization review process in order to ensure members receive appropriate care, at an appropriate time, in an appropriate setting by an appropriate provider and at an appropriate level of care. Criteria are consistent with an efficient and effective utilization of resources available to recipients. The Plan's clinical review criteria include internally developed criteria specified in Plan medical policies, InterQual® criteria, and/or clinical guidelines established by delegated management partners. The Plan's *Clinical Review Criteria* administrative policy, policy number OCA 3.201, includes product-specific definitions of clinical review criteria, a summary of the Plan's procedure for applying clinical review criteria to services that require prior authorization, and specifies which entities are responsible for the development, implementation, and monitoring of the Plan's clinical review criteria. See the Contract Definitions section of this policy for the product-specific definition of medically necessary treatment; the medical necessity guidelines established by the Plan for Well Sense Health Plan members will not be more restrictive than the product-specific definition of "medically necessary" according to the Plan's contract with the New Hampshire Department of Health and Human Services.

References

Centers for Medicare & Medicaid Services (CMS). EPSDT - A Guide for States: Coverage in the Medicaid Benefit for Children and Adolescents. 2014 Jun.

Centers for Medicare & Medicaid Services (CMS). Manuals. Publication # 100-02. Medicare Benefit Policy Manual.

Centers for Medicare & Medicaid Services (CMS). Manuals. Publication # 100-03. Medicare National Coverage Determinations (NCD) Manual.

Centers for Medicare & Medicaid Services (CMS). Medicaid. Early and Periodic Screening, Diagnosis, and Treatment. Medicaid.gov.

Centers for Medicare & Medicaid Services (CMS). Medicare Coverage Database (MCD).

Centers for Medicare & Medicaid Services (CMS). Medicare Managed Care Manual. Chapter 4 - Benefits and Beneficiary Protections. 90.5 – Creating New Guidance. Rev 120. Issued 01-16-15, Effective 01-01-15, Implementation 01-01-15.

Centers for Medicare & Medicaid Services (CMS). Transmittals.

Change Healthcare. InterQual® Criteria.

Commonwealth of Massachusetts. Division of Insurance (DOI) Bulletins.

Commonwealth of Massachusetts. Division of Insurance (DOI) Bulletin 2021-06. Required Coverage for Treatment of PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections and PANS (Pediatric Acute-Onset Neuropsychiatric Syndrome). 2021 April 27.

Commonwealth of Massachusetts. MassHealth Provider Bulletins.

Commonwealth of Massachusetts. MassHealth Provider Manuals.

Commonwealth of Massachusetts. MassHealth Transmittal Letters.

Commonwealth of Massachusetts. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) and Pediatric Health Care Screening and Diagnosis (PPHSD) Information and Resources. Mass.gov.

Contract between the Commonwealth Health Insurance Connector Authority and Plan.

Contract between the Massachusetts Executive Office of Health and Human Services (EOHHS) and Plan.

Contract between the Executive Office of Health and Human Services (EOHHS) and the Plan to Serve as an Accountable Care Partnership Plan for the Accountable Care Organization Program.

Contract between the New Hampshire Department of Health and Human Services and Plan.

Hayes, a Tract Manager Company.

Massachusetts Health Quality Partners (MHQP). 2021 Adult Preventive Care Guidelines.

Massachusetts Health Quality Partners (MHQP). 2021 Pediatric Preventive Care Guidelines.

Medicaid.gov. Early and Periodic Screening, Diagnostic, and Treatment. Centers for Medicare & Medicaid Services.

New Hampshire Department of Health and Human Services. Billing Manuals.

New Hampshire Department of Health and Human Services. NH Medicaid Program.

New Hampshire Department of Health and Human Services. Provider Notices

Senior Care Options Contract between the Massachusetts Executive Office of Health and Human Services (EOHHS) and Plan and Medicare Advantage Special Needs Plan Contract between the Centers for Medicare & Medicaid Services (CMS) and the Plan.

Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: 08/01/08 Internal Approval: 07/05/05	07/05/05 Version 1	Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	Quality and Clinical Management Committee (Q&CMC)

*Effective Date for the BMC HealthNet Plan Commercial Product: 01/01/12
*Effective Date for the WellSense New Hampshire Medicaid Product: 01/01/13
*Effective Date for the Senior Care Options Product: 01/01/16
*Effective Date for the WellSense Medicare Advantage HMO Product: 01/01/22

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
11/07/06	No changes.	Version 2	
02/27/07	Updated policy and procedure sections, added Commonwealth Care language and definitions, added references.	Version 3	02/27/07: Utilization Management Committee (UMC) 04/04/07: Quality Improvement Committee (QIC) 05/01/07: Q&CMC
04/22/08	Changed the responsibility section to indicate that licensed pharmacists can determine if the service requests are medically necessary and added a statement that records must be made available to MassHealth upon request.	Version 4	04/22/08: UMC
06/19/08	Added statement that records must be made available to MassHealth upon request.	Version 5	06/19/08: QIC
08/22/09	Updated references, changed the term member to enrollee, added under 21 language for MassHealth enrollees.	Version 6	09/22/09: MPCTAC 09/23/09: QIC
08/01/10	Policy Statement was revised to read: The Plan will provide coverage for services that are considered medically necessary "and a	Version 7	07/21/10: MPCTAC 08/25/10: QIC

Policy Revisions History			
	covered service as outlined in the members benefit documents". The references were updated and the policy was formatted into criteria template.		
07/01/11	Added medically necessary definition and language for Commonwealth Choice and updated references.	Version 8	07/22/11: MPCTAC 08/24/11: QIC
07/01/12	Added reference to the Plan's Prior Authorization/ Notification Requirements matrix, and updated reference list.	Version 9	07/18/12: MPCTAC 08/22/12: QIC
08/01/12	Off cycle review for Well Sense Health Plan and BMC HealthNet Plan products. Revised Description of Service/Item, revised and reformatted Definitions, deleted Clinical Guidelines Statement, added Coverage Determination Statement, revised references.	Version 10	08/17/12: MPCTAC 09/06/12: QIC
05/01/13	Review for effective date 07/01/13. Revised Description of Item or Service and language in Applicable Coding sections without changing criteria.	07/01/13 Version 11	05/15/13: MPCTAC 06/20/13: QIC
06/01/14	Review for effective date 08/01/14. Revised Summary section and language in the Applicable Coding section. Clarified text in Medical Policy Statement section without changing criteria and removed MassHealth product names. Updated references. Deleted definition of 'medically necessary' for Commercial members and added definition of 'medically necessary' for Commonwealth Choice/Employer Choice and Qualified Health Plans/ConnectorCare/Employer Choice Direct in the Definitions section.	08/01/14 Version 12	06/18/14: MPCTAC 07/09/14: QIC
06/01/15	Review for effective date 08/01/15. Updated references. Removed references to the Commonwealth Care, Commonwealth Choice, and Employer Choice products from the list of applicable products, the Medical Policy Statement section, and the Definitions section because the products are no longer available.	08/01/15 Version 13	06/17/15: MPCTAC 07/08/15: QIC
11/01/15	Review for effective date 01/01/16.	01/01/16	11/18/15: MPCTAC

Policy Revisions History			
	Updated template with list of applicable products and notes. Updated Summary and References sections. Updated Medical Policy Statement section for the Senior Care Options products.	Version 14	12/09/15: QIC
06/01/15	Review for effective date 08/01/16. No revisions.	08/01/16 Version 15	06/15/16: MPCTAC 07/13/16: QIC
07/01/17	Review for effective date 08/01/17. Administrative changes made to the Policy Summary and Other Applicable Policies sections.	08/01/17 Version 16	07/19/17: MPCTAC
08/22/17	Review for effective date 08/26/17. Revised language in the Medical Policy Statement section for Plan Members Enrolled in a Well Sense Health Plan Product (only) to be consistent with the Definitions section (for New Hampshire Medicaid Care Management Program Contract Definitions of Medically Necessary for the Well Sense Health Plan Products).	08/26/17 Version 17	08/25/17: MPCTAC (electronic vote)
08/31/17	Updated the MassHealth ACO and MassHealth MCO contract definition of Medically Necessary or Medical Necessity to include requirements for the medical necessity guidelines applicable for the Accountable Care Organization (ACO). Updated Product Applicability and References sections to incorporate ACO.	08/31/17 Version 18	08/31/17: MPCTAC (electronic vote)
10/01/17	Review for effective date 01/01/18. Revised definitions of medically necessary for Well Sense Health Plan members to be consistent with updated contract definitions. Administrative change made to the Medical Policy Statement section.	01/01/18 Version 19	10/18/17: MPCTAC
06/01/18	Review for effective date 07/01/18. Administrative changes made to the Policy Summary, References, and Other Applicable Policies sections.	07/01/18 Version 20	06/20/18: MPCTAC
10/01/18	Review for effective date 11/01/18. Renamed the "Definitions" section the "Contract Definitions of Medically Necessary or Medical Necessity" section. Administrative changes made to clarify the current guidelines and notification process	11/01/18 Version 21	10/17/18: MPCTAC

Policy Revisions History			
	without changing the contract definitions of medically necessary and/or medical necessity. Added "Other Definitions" section and included additional definitions not related to the Plan's contract definitions of medically necessary and/or medical necessity. Additional administrative changes made to the References, Other Applicable Policies, and References to Applicable Laws and Regulations sections.		
06/01/19	Review for effective date 09/01/19. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections. Revised the Well Sense Health Plan definition of Medically Necessary for a member under the age of 21.	09/01/19 Version 22	06/19/19: MPCTAC
12/01/19	Review for effective date 01/01/20. Clarified the Plan's existing process for determining medical necessity in the Medical Policy Statement section.	01/01/20 Version 23	12/18/19: MPCTAC
06/01/20	Review for effective date 07/01/20. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections.	07/01/20 Version 24	06/17/20: MPCTAC
06/01/21	Review for effective date 07/01/21. Clarified current guidelines in the Policy Summary, Medical Policy Statement, and Contract Definitions of Medically Necessary or Medical Necessity sections. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections.	07/01/21 Version 25	06/16/21: MPCTAC
08/01/21	Review for effective date 09/01/21. Administrative changes made to the Policy Summary, Contract Definitions of Medically Necessary or Medical Necessity, Other Definitions, References, and Reference to Applicable Laws and Regulations sections to clarify current guidelines.	09/01/21 Version 26	08/13/21: MPCTAC (electronic vote)
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, the	12/01/21 Version 27	11/17/21: MPCTAC

Policy Revisions History			
	Medical Policy Statement section renamed the Clinical Criteria section, and the Limitations section renamed the Limitations and Exclusions section. Added WellSense Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Product-Specific Definitions, and References sections. Removed the Applicable Coding section.		

Next Review Date

06/01/22

Authorizing Entity

MPCTAC

Other Applicable Policies

Administrative Policy - *Clinical Review Criteria*, policy number OCA 3.201
Administrative Policy - *Clinical Technology Evaluation*, policy number OCA 3.13
Medical Policy - *Clinical Trials*, policy number OCA 3.192
Medical Policy - *Cosmetic, Reconstructive, and Restorative Services*, policy number OCA 3.69
Medical Policy - *Experimental and Investigational*, policy number OCA 3.12
Reimbursement Policy - *Clinical Trials*, policy number 4.134
Reimbursement Policy - *Clinical Trials*, policy number SCO 4.134
Reimbursement Policy - *Clinical Trials*, policy number WS 4.12
Reimbursement Policy - *Early Intervention*, policy number 4.3
Reimbursement Policy - *Early and Periodic Screening, Diagnosis and Treatment (EPSDT)*, policy number WS 4.15
Reimbursement Policy - *General Billing and Coding Guidelines*, policy number 4.31
Reimbursement Policy - *General Billing and Coding Guidelines*, policy number SCO 4.31
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Reimbursement Policy - *Hospital*, policy number WS 4.21
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Reimbursement Policy - *Non-Participating Provider*, policy number WS 4.5
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Reimbursement Policy - *Non-Reimbursed Codes*, policy number WS 4.38
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Reimbursement Policy - *Physician and Non-Physician Practitioner Services*, policy number 4.608
Reimbursement Policy - *Physician and Non-Physician Practitioner Services*, policy number SCO 4.608
Reimbursement Policy - *Physician and Non-Physician Practitioner Services*, policy number WS 4.28
Reimbursement Policy - *Provider Preventable Conditions and Serious Reportable Events*, policy number 4.610
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42 CFR 422.205. Code of Federal Regulations. Public Health. Centers for Medicare & Medicaid Services. Medicare Advantage Program. Provider Antidiscrimination Rules.

42 CFR 438.100. Code of Federal Regulations. Public Health. Centers for Medicare & Medicaid Services. Managed Care. Enrollee Rights and Protections. Enroll Rights.

42 CFR 438.210. Code of Federal Regulations. Public Health. Centers for Medicare & Medicaid Services. Medical Assistance Programs. Managed Care. Coverage and Authorization of Services.

42 CFR 440.210. Code of Federal Regulations. Public Health. Centers for Medicare & Medicaid Services. Medical Assistance Programs. Medical Assistance Programs. Required Services for the Categorically Needy.

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130 CMR 410.00. Code of Massachusetts Regulations. Division of Medical Assistance. Outpatient Hospital Services.

130 CMR 415.000. Code of Massachusetts Regulations. Division of Medical Assistance. Acute Inpatient Hospital Services.

130 CMR 433.00. Code of Massachusetts Regulations. Division of Medical Assistance. Physician Services.

130 CMR 440.00. Code of Massachusetts Regulations. Division of Medical Assistance. Early Intervention Program Services.

130 CMR 450.000. Code of Massachusetts Regulations. Division of Medical Assistance. Administrative and Billing Regulations.

130 CMR 450.117(J). Code of Massachusetts Regulations. Division of Medical Assistance. Administrative and Billing Regulations. Managed Care Participation. Compliance with Mental Health Parity Law.

130 CMR 450.140-150. Code of Massachusetts Regulations. Division of Medical Assistance. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services and Preventive Pediatric Health Care Screening and Diagnosis (PPHSD).

130 CMR 450.204. Code of Massachusetts Regulations. Division of Medical Assistance. Administrative and Billing Regulations. Medically Necessary.

130 CMR 505. Code of Massachusetts Regulations. Division of Medical Assistance. MassHealth Coverage Types.

211 CMR 52.00. Code of Massachusetts Regulations. Division of Insurance. Managed Care Consumer Protections and Accreditation of Carriers.

211 CMR 52.02. Code of Massachusetts Regulations. Division of Insurance. Managed Care Consumer Protections and Accreditation of Carriers. Definitions. Medical Necessity or Medically Necessary.

211 CMR 52.02. Code of Massachusetts Regulations. Division of Insurance. Managed Care Consumer Protections and Accreditation of Carriers. Definitions. Utilization Review.

958 CMR 3.020. Code of Massachusetts Regulations. Health Insurance Consumer Protection. Definitions. Clinical Review Criteria.

958 CMR 3.020. Code of Massachusetts Regulations. Health Insurance Consumer Protection. Definitions. Utilization Review.

958 CMR 3.020. Code of Massachusetts Regulations. Health Insurance Consumer Protection. Definitions. Medical Necessity or Medically Necessary.

958 CMR 3.020. Code of Massachusetts Regulations. Health Insurance Consumer Protection. Definitions. Utilization Review.

958 CMR 3.101. Code of Massachusetts Regulations. Health Insurance Consumer Protection. Definitions. Carrier's Medical Necessity Guidelines.

958 CMR 3.400. Code of Massachusetts Regulations. Health Insurance Consumer Protection. External Review.

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He-W 531.01(a). New Hampshire Code of Administrative Rules. Medical Assistance. Physician Services. Cosmetic Purpose.

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RSA 417-D:2-b. New Hampshire Revised Statutes Annotated. Women's Health Care. Reconstructive Surgery.

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Social Security Act. Title XIX. 1902(a)(43), 1905(a)(4)(B), 1905(r). Grants to States for Medical Assistance Programs. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

Social Security Act. Title XXI. State Children's Health Insurance Program.

U.S. Women's Health and Cancer Right Act of 1998.

Disclaimer Information: [+]

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name WellSense Health Plan.