Administrative Policy

Clinical Criteria

Policy Number: 3.201
Version Number: 14
Version Effective Date: 07/13/16

Product Applicability

<table>
<thead>
<tr>
<th>All Plan* Products</th>
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<tbody>
<tr>
<td>Well Sense Health Plan</td>
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<tr>
<td>- New Hampshire Medicaid</td>
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<tr>
<td>- NH Health Protection Program</td>
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<tr>
<td>Boston Medical Center HealthNet Plan</td>
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<td>- MassHealth</td>
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<td>- Qualified Health Plans/ConnectorCare/Employer Choice Direct</td>
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<tr>
<td>- Senior Care Options ◊</td>
</tr>
</tbody>
</table>

Notes:
+ Disclaimer and audit information is located at the end of this document.
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at www.SeniorsGetMore.org to determine coverage guidelines for Senior Care Options.

Purpose

The purpose of this policy is to ensure that when making utilization review decisions the Plan uses written clinical review criteria which are based on sound clinical evidence, and conducts all utilization review activities in accordance with applicable policies and procedures and the Plan’s Utilization Management (UM) Program. 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’s clinical coverage criteria and UM decision tools are applied equitably across the Plan’s membership.

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Review the Plan’s Prior Authorization/Notification Requirements matrix for a list of services that require prior authorization. The Plan’s prior authorization matrix, medical policies, and reimbursement policies are available at www.bmchp.org for BMC HealthNet Plan members (or www.SeniorsGetMore.org for members enrolled in Senior Care Options) and www.wellsense.org for Well Sense Health Plan members. See the product-specific definitions of cosmetic services and reconstructive surgery and procedures in the Plan policy, Cosmetic, Reconstructive, and Restorative Services, policy number OCA 3.69. Review the product-specific definition of experimental or investigational treatment in the Experimental and Investigational Treatment policy, policy number OCA 3.12. The product-specific definitions for medical necessary are listed in the Plan policy, Medically Necessary, policy number OCA 3.14. The Plan’s New Technology 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 Clinical Trials policy, policy number OCA 3.192, if applicable to the requested service.

Policy Statement

When the Plan conducts utilization review (UR), appropriate professional utilization management (UM) Plan staff shall consistently apply Plan-adopted written clinical review criteria that are objective, scientifically derived and evidence-based, developed with the input of participating practitioners, and consistent with applicable legal, regulatory, and national accreditation organization standards and Plan contracts. The Plan’s clinical coverage criteria and UM decision tools are applied equitably across the Plan’s membership. The Plan shall involve appropriate practitioners in developing, evaluating, adopting, and reviewing the clinical review criteria. On at least an annual basis, the Plan shall review all clinical review criteria and the procedures for applying the clinical review criteria and update as new treatments, applications, and technologies are adopted as generally accepted professional medical practice. Plan UM staff shall apply the clinical review criteria consistently, however, they shall also take into account individual member needs and circumstances and the local healthcare delivery system when determining the medical necessity of health care services.

The Plan makes its clinical review criteria available to its practitioners upon request and states in writing how practitioners can obtain the clinical review criteria. Internally developed criteria are posted on the Plan’s applicable website(s), www.bmchp.org and/or www.wellsense.org; copyrighted commercial criteria can be obtained by calling or faxing the Plan with a request for a copy of specific criteria. Directions for doing so are shared with practitioners/providers in writing (by mail) and in the Plan’s provider manual.

Delegated Management

Effective March 1, 2010, the Plan delegated management of behavioral health services to an NCQA-accredited managed behavioral health organization (MBHO), Beacon Health Strategies, LLC. The MBHO has its own clinical criteria policy which has been approved as part of delegation oversight.
Effective March 15, 2010, the Plan delegated the management of radiology services to an NCQA-accredited managed care vendor, eviCore healthcare (formerly known as MedSolutions, Inc.). eviCore develops and utilizes criteria to make utilization management decisions for requested radiology services, establishes policies for communicating those criteria to providers and members, and evaluates consistency in the application of those criteria through inter rater reliability testing when determining medical necessity for radiology services.

Effective April 1, 2011, the Plan delegated management of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) to a URAC-accredited DMEPOS vendor, Northwood, Inc. The Plan has retained the management of medical necessity denial decisions and notifications. The vendor has its own clinical criteria policy and procedure which has been approved as part of delegation oversight.

Effective October 1, 2013, EnvisionRx Options became the Plan’s pharmacy benefits administrator for all Plan products, and EnvisionRx Options adopts the Plan’s clinical criteria policy. In addition, EnvisionRx Options adheres to the Plan’s administrative UM policies. Policies delegated to EnvisionRx Options have been approved as part of delegation oversight. As of October 1, 2013, the Plan’s pharmacy mail order company for BMC HealthNet Plan products and Well Sense Health Plan products is Orchard Pharmaceutical Services.

Procedure

Application of the clinical review criteria are specified below in items 1 through 7:

1. The Plan’s Office of Clinical Affairs (OCA) and Pharmacy UM staff and Medical Directors/Physician Reviewers will consistently use applicable Plan clinical review criteria when determining the medical necessity of health care services. Along with the appropriate Plan clinical review criteria, UM staff considers the following factors for the member when applying the criteria to each request, as specified below in items a through f:

   a. Age; AND

   b. Co-morbidities; AND

   c. Complications; AND

   d. Progress of treatment; AND

   e. Psychosocial circumstances; AND

   f. Environmental factors.

When clinical review criteria are not met for a specified service such that medical necessity cannot be established, UM staff will engage in discussions with licensed Plan pharmacists, UM clinicians, and/or Plan Medical Directors/Physician Reviewers to determine if the clinical review criteria are appropriate for the member’s circumstances or local delivery system. If the clinical criteria

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review criteria are not appropriate, UM staff may make the utilization determination based on the member’s condition and other unique circumstances.

2. UM staff members consider the following characteristics of the healthcare delivery system when applying clinical review criteria to each request, as specified below in items a through c:

   a. Availability of acute and sub-acute care facilities, rehabilitation and skilled nursing facilities (SNF), and/or home care to support the member after hospital discharge; AND

   b. Covered benefits for acute and sub-acute care facilities, rehabilitation and SNF, and/or home care, if applicable; AND

   c. The ability of acute and sub-acute care facilities, rehabilitation and SNF, and/or home care services to provide all recommended services within the estimated length of stay.

3. An OCA staff member who is unable to authorize care by establishing medical necessity will forward the request and documentation to the appropriate Medical Director/Physician Reviewer or licensed Plan pharmacist for a determination.

4. The Medical Directors/Physician Reviewers and/or licensed Plan pharmacists consider alternate methods of determining medical necessity (as defined in the *Medically Necessary* policy, policy number OCA 3.14) if it cannot be established through existing clinical review criteria.

5. The Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC), Pharmacy and Therapeutics (P&T) Committee, Utilization Management Committee (UMC), Quality Improvement Committee (QIC), and other applicable committees meet annually or more frequently as needed to review and authorize all clinical review criteria used by the Plan along with the policies and procedures for application.

6. UM staff training and inter rater reliability (IRR) testing review shall be utilized to ensure the consistency of medical necessity determinations among the OCA and Pharmacy UM staff and the Medical Directors/Physician Reviewers. (See the Definitions section of this policy for the definition of IRR.)

7. The Plan shall make its clinical review criteria available to its practitioners upon request and shall state in writing in the Plan’s provider manual(s) and/or Plan’s web site(s) how practitioners can obtain the criteria.

**Responsibility and Accountability**

Responsibility and accountability are specified below in items 1 through 4:

1. The Utilization Management Committee (UMC), chaired by the Manager of UM Program Oversight and Member Appeals and Grievances, oversees and is accountable for the adoption,
development, review, update, and implementation of the Plan’s clinical review criteria. Generally, the Plan adopts nationally developed and accepted criteria (e.g., InterQual®). When national criteria are not available, Plan-specific criteria may be developed that are objective, scientifically derived, and evidence-based, with input from participating practitioners and consistent with applicable legal, regulatory, and national accreditation organization standards.

2. The Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) is responsible for developing medical policies, and the Pharmacy and Therapeutics (P&T) Committee is responsible for developing pharmaceutical coverage policies. In the case in which either committee develops policies and procedures that include clinical review criteria to be subsequently applied by Plan UM staff, the MPCTAC and the P&T Committee will submit such clinical review criteria through the appropriate review and approval bodies. The P&T Committee is an approval committee in its own right, but sends criteria through the QIC for review and feedback. The MPCTAC sends criteria to the QIC for approval.

3. The Director(s) of OCA, Director of Pharmacy, Chief Medical Officer, Plan Medical Directors/Physician Reviewers, and clinical staff shall use the Plan’s clinical review criteria in accordance with applicable Plan policies and procedures.

4. The Director(s) of OCA and Pharmacy Director or their designee(s) shall be responsible for ensuring UM staff training, evaluating, and monitoring. The Chief Medical Officer or designee(s) shall be responsible for ensuring Medical Director training, evaluation, and monitoring to ensure consistent application of clinical review criteria and medical necessity determinations.

Definitions:

Clinical Review Criteria (for BMC HealthNet Plan 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. See the Plan’s medical policy, Medically Necessary (policy number OCA 3.14), for the product-specific definition of medically necessary treatment.

Clinical Review Criteria (for Well Sense Health Plan Products): 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.

Inter Rater Reliability (IRR): A performance measurement tool used to compare and evaluate the level of consistency in healthcare determinations between two or more medical and behavioral health utilization management (UM) clinicians. The tool is used to minimize variation in the application of clinical review criteria and identify potentially avoidable utilization target areas that need improvement and evaluate the ability to identify quality of care issues.
**Practitioner (for the Qualified Health Plans, ConnectorCare, and Employer Choice Direct):** A professional who provides health care services. Practitioners are usually required to be licensed as defined by law.

**Utilization Review (UR):** A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, and/or retrospective review.

**References**


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 New Hampshire Department of Health and Human Services and Plan

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

<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date* and Version Number</th>
<th>Policy Owner</th>
<th>Approved by</th>
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| Regulatory Approval: 08/01/08  
MH Review: 02/19/10  
Internal Approval: 07/24/07 and 08/13/07 | 08/13/07 Version 1 | Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) and member of Quality Improvement Committee (QIC) | Utilization Management Committee (UMC) |

*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12  
*Effective Date for the Well Sense Health Plan New Hampshire Medicaid Product(s): 01/01/13  
*Effective Date for the Senior Care Options Product(s): 01/01/16

**Policy Revisions History**

*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 Well Sense Health Plan.*
<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date and Version Number</th>
<th>Approved by</th>
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<tbody>
<tr>
<td>04/22/08</td>
<td>Typos and formatting corrected. Removed bullet stating Chief Medical Officer conducts review on all criteria annually.</td>
<td>Version 2</td>
<td>04/22/08: UMC</td>
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<tr>
<td>05/07/08</td>
<td>Added authority for plan pharmacists to render pharmacy denials.</td>
<td>Version 3</td>
<td>05/20/08: UMC 06/19/08: QIC</td>
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<tr>
<td>08/20/09</td>
<td>Changed titles within Health Services, minor typos and formatting, updated references, changed definition for clinical criteria.</td>
<td>Version 4</td>
<td>09/22/09: UMC 09/23/09: QIC</td>
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<tr>
<td>07/21/10</td>
<td>Updated names, departments and references, extra definition for medically necessary was removed.</td>
<td>Version 5</td>
<td>07/21/10: MPCTAC 08/25/10: QIC</td>
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<tr>
<td>07/01/11</td>
<td>Added medically necessary definition and language for Commercial product.</td>
<td>Version 6</td>
<td>07/22/11: MPCTAC 08/24/11: QIC</td>
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<td>07/01/12</td>
<td>References updated, moved Purpose section of policy to the beginning of the document and added reference for the Plan’s Prior Authorization/Notification Requirements matrix. Referenced the Plan’s Medically Necessary policy for a definition of medically necessary for each member type and deleted medically necessary definitions from this policy. Added language regarding delegated management in Policy Statement section. Added reference to Physician Reviewers in policy. Changed definition title from “Clinical Criteria” to “Clinical Review Criteria.”</td>
<td>Version 7</td>
<td>07/18/12: MPCTAC 08/15/12: MPCTAC</td>
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<td>08/15/12</td>
<td>Off cycle review for Well Sense Health Plan, revised Purpose, Definitions, Policy Statement, reformatted Procedure, updated references for all Plan products.</td>
<td>Version 8</td>
<td>08/17/12: MPCTAC 09/13/12: QIC</td>
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<tr>
<td>09/01/12</td>
<td>Added language to clarify the Plan’s UR process that includes the evaluation of member’s circumstances and local delivery system, when clinically appropriate.</td>
<td>Version 9</td>
<td>09/19/12: MPCTAC 09/26/12: QIC</td>
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### Policy Revisions History

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<tr>
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<th>Effective Date</th>
<th>Version</th>
<th>Authorizing Entity</th>
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<tr>
<td>06/01/13</td>
<td>Review for effective date 07/18/13. Revised title of chair for the Utilization Management Committee.</td>
<td>07/18/13</td>
<td>10</td>
<td>06/19/13: MPCTAC 07/18/13: QIC</td>
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<tr>
<td>06/01/14</td>
<td>Review for effective date 10/01/14. Updated Purpose, Policy Statement, Delegated Management, Procedure, Responsibility and Accountability, Definitions, and References sections.</td>
<td>10/01/14</td>
<td>11</td>
<td>06/09/14: MPCTAC 07/09/14: QIC</td>
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<tr>
<td>06/01/15</td>
<td>Review for effective date 07/08/15. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available. Administrative changes made to Purpose, Policy Statement, Delegated Management, and Procedure sections.</td>
<td>07/08/15</td>
<td>12</td>
<td>06/17/15: MPCTAC 07/08/15: QIC</td>
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<tr>
<td>09/01/15</td>
<td>Review for effective date 10/14/15. Added reference to eviCare healthcare in the Delegated Management section. Updated list of applicable products, including the removal of Commonwealth Care, Commonwealth Choice, and Employer Choice because the products are no longer available.</td>
<td>10/14/15</td>
<td>13</td>
<td>09/16/15: MPCTAC 10/14/15: QIC</td>
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<tr>
<td>06/01/16</td>
<td>Review for effective date 07/13/16. Updated Delegated Management, References, and References to Applicable Laws and Regulations sections.</td>
<td>07/13/16</td>
<td>14</td>
<td>06/15/16: MPCTAC 07/13/16: QIC</td>
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### Last Review Date

06/01/16

### Next Review Date

06/01/17

### Authorizing Entity

QIC

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Other Applicable Policies

Administrative Policy – Inter Rater Reliability, policy number OCA 3.216
Administrative Policy – New Technology, 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
Medical Policy – Medically Necessary, policy number OCA 3.14
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

Reference to Applicable Laws and Regulations


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.

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