Aetna Better Health of Louisiana			
Policy Name:	Process for Approving and Applying Medical Necessity Criteria	Page:	1 of 10
Department:	Medical Management	Policy Number:	7000.30
Subsection:	Utilization Management	Effective Date:	01/15/2009
Applies to:	■ Medicaid Health Plans ■		

PURPOSE:

The purpose of this policy is to provide guidelines for the oversight process related to medical necessity criteria.

STATEMENT OF OBJECTIVE:

The objectives of this policy are to:

- Establish accountabilities and requirements for the review and approval of clinical medical necessity criteria
- Define the process for, at a minimum, annual evaluation of adopted medical necessity criteria
- Maintain processes for ongoing monitoring of scientific evidence for internally developed and adopted medical necessity criteria
- Define the process for the application of medical necessity criteria

DEFINITIONS:

Aetna Clinical Policy Bulletins (CPBs)	Statements of Aetna's policy regarding the experimental and investigational status and medical necessity of medical technologies that may be eligible for coverage under Aetna medical plans. CPBs also state what medical technologies Aetna considers cosmetic. CPBs apply to all Aetna medical benefit plans and are used in conjunction with the terms of the member's benefit plan and other Aetna-recognized criteria to determine health care coverage for Aetna's members. Aetna's CPBs are based on evidence in the peer-reviewed published medical literature, technology assessments and structure evidence reviews, evidence-based consensus statements, expert opinions of health care providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and government public health agencies. The Aetna CPBs are available on Aetna.com http://www.aetna.com/healthcare-professionals/policies-guidelines/clinical_policy_bulletins.html.
Aetna Medicaid Administrators LLC (AMA)	A subsidiary of Aetna Inc. AMA was acquired by Aetna in 2007 and has become the company's national Medicaid subsidiary. AMA provides plan management and other administrative services for Aetna's Medicaid programs nationally.

American Society of Addiction Medicine (ASAM) Criteria, 3rd Edition	The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies®; 2013
Child and Adolescent Level of Care Utilization System (CALOCUS©), Version 20	A nationally recognized clinical guideline for making decisions regarding medical necessity for behavioral health treatment. CALOCUS was developed for children and adolescents by the American Association of Community Psychiatrists (AACP).
Evidence-Based Guidelines	Clinical practice guidelines, statements of recommendation, algorithms or materials created through an unbiased and transparent process of systematic review, appraisal and the best clinical findings to aid in the delivery of optimum clinical care. The guidelines are based on the best available scientific evidence; or on professional standards, in the absence of scientific evidence; or on expert opinion, in the absence of professional standards.
Level Of Care Utilization System© (LOCUS) Version 20	A nationally recognized clinical guideline for making decisions regarding medical necessity for behavioral health treatment. LOCUS was developed for adults by the American Association of Community Psychiatrists (AACP).
MCG®	MCG, including Chronic Care Guidelines, are evidence-based clinical guidelines that are updated annually. They support prospective, concurrent, and retrospective reviews; proactive care management; discharge planning; patient education, and quality initiatives.
Medical Necessity Criteria	Guidelines that provide a recommended guide to help practitioners make decisions about appropriate health care for specific clinical circumstances. Aetna Better Health uses only evidence-based clinical guidelines.
Medical Necessity Determination	A decision about coverage for a requested service based on whether the service is clinically appropriate and/or needed based on a member's circumstances. The National Committee for Quality Assurance (NCQA) requires a medical necessity review and appropriate practitioner review of "experimental" or "investigational" requests, unless the requested services or procedures are specifically excluded from the benefits plan.

Medically Necessary/Medical Necessity	This term refers to services or supplies for diagnosing, evaluating, treating or preventing an injury, illness, condition or disease, based on evidence-based clinical standards of care. Medically necessary services are accepted health care services and supplies provided by health care entities, appropriate to evaluation and treatment of a disease, condition, illness or injury and consistent with the applicable standard of care. Determination of medical necessity is based on specific criteria. **Note:** This NCQA definition is based on the Centers for Medicare & Medicaid Services (CMS) and American College of Medical Quality (ACMQ) definitions.
Utilization Management (UM) Steering Committee	An Aetna National Medicaid cross-functional committee that meets monthly and is responsible for overseeing UM activities, such as Concurrent Review and Prior Authorization activities (e.g., PA Grid modifications).

LEGAL/CONTRACT REFERENCE:

- National Committee for Quality Assurance (NCQA) Standards and Guidelines for the Accreditation of Health Plans
- 2020 Louisiana Medicaid Management Care Organization Statement of Work, Sections 8.1.2.1 – 8.1.2.4; 8.1.4; 8.1.5; 8.1.6.1 – 8.1.6.4; 8.1.3.1 – 8.1.3.4; 8.1.11
- 42 CFR 438.236

FOCUS/DISPOSITION:

-Aetna Better Health adopts and maintains medical necessity criteria for use in medical necessity determinations regarding members of affiliated health plans, specified by state contract or required by state and federal regulations and requirements. Medical necessity criteria must be established and approved according to the requirements stated in this policy.

-***Aetna Better Health Responsibilities***

-Aetna Better Health is responsible for review and approval of the utilization management criteria used for medical necessity determinations. Additionally, Aetna Better Health is responsible to confirm that medical necessity criteria are established in accordance with generally accepted standards of medical practice and are objective, based on medical evidence, and clinically appropriate for the member's condition and characteristics (such as age,

comorbidities, complications, progress of treatment, psychosocial situation, home environment) including the characteristics of the local delivery system such as:

- Availability of the inpatient outpatient and transitional facilities
- Availability of outpatient services in lieu of inpatient services such as Surgi-centers verses Inpatient Surgery.
- Availability of Highly specialized services such as transplant facilities or cancer centers
- Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge[1] [LK1]

Service authorization staff that make medical necessity determinations are trained on the criteria and the criteria are accepted and reviewed according to Aetna Better Health policies and procedures. Aetna Better Health will meet all NCQA standards and include medical management criteria and practice guidelines that are:

- Adopted in consultation with contracting health care professionals;
- Objective and based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
- Considerate of the needs of the members; and
- Reviewed annually and updated periodically as appropriate [2] [LK2]

Medical necessity criteria and practice guidelines, including physical health, dental, pharmaceutical services and behavioral health management criteria, are distributed to all practitioners/providers upon request[3] and, upon request, to members and potential members by contacting a Aetna Better Health medical management representative. Aetna Better Health distributes criteria by mail to practitioners and members who do not have fax, e-mail or internet access.[4]

Initial and annual review processes consist of an evaluation of existing criteria, determination of any recommendations or changes, and final acknowledgement or acceptance of criteria. The process involves appropriate practitioners to review, advise and comment on development or

[1] NCQA HP 2020/2021 UM2 A1-3
[2] 2020 Louisiana Medicaid Management Care Organization Statement of Work, 2014 Section 8.1.7

[3] [3] 2020 Louisiana Medicaid Management Care Organization Statement of Work, 2014 Section 8.1.5

[4] NCQA HP 2020/2021 UM2 B

adoption of UM criteria, and on the instructions for applying criteria. Annually, the UM Steering Committee reviews national criteria sets and the procedures for applying them against current clinical and medical evidence. The UM Steering Committee is comprised of senior and plan medical directors representing a broad range of specialties such as emergency medicine, behavioral health, pediatrics, surgery, family medicine and internal medicine. The Aetna Better Health QM/UM Committee membership includes local medical directors and community practitioners who review criteria sets in comparison to state requirements and current clinical and medical evidence to update and adopt final criteria sets as appropriate. Adopted criteria are submitted to the Aetna Better Health Quality Management Oversight Committee for review and adoption.[5] Aetna Better Health will coordinate the development of clinical practice guidelines with other Louisiana Department of Health (LDH) managed care organizations (MCOs) to avoid providers receiving conflicting practice guidelines from different MCOs. [6][LK3]

Aetna Better Health will take steps to require adoption of the clinical practice guidelines by subcontracted specialized behavioral healthcare providers, and to measure compliance with the guidelines, until such point that ninety percent (90%) or more of the providers consistently achieve eighty percent (80%) compliance, based on Aetna Better Health measurement findings.

Aetna Better Health will identify the source of the medical management criteria used for the review of service authorization requests, including but not limited to the:

- Vendor will be identified if the criteria was purchased;
- Association or society will be identified if the criteria are developed/recommended or endorsed by a national or state health care provider association or society;
- Guideline source will be identified if the criteria are based on national best practice guidelines; and
- Individuals who will make medical necessity determinations will be identified if the criteria are based on the medical training, qualifications, and experience of the MCO medical director or other qualified and trained professionals.[7]

Medical necessity criteria and practice guidelines, including physical health, dental and behavioral health management criteria, are distributed to all practitioners/providers upon request and, upon request, to members and potential members by contacting a Aetna Better Health

[5] NCQA HP 2020/2021 UM2 A4-5
[6] 2020 Louisiana Medicaid Management Care Organization Statement of Work, 2014 Section 8.1.4
[7] 2020 Louisiana Medicaid Management Care Organization Statement of Work, Sections 8.1.6.1 – 8.1.6.4

medical management representative. Aetna Better Health distributes criteria by mail to practitioners and members who do not have fax, e-mail or internet access.[8]

Medical necessity criteria and practice guidelines, including physical health, dental, pharmaceutical services and behavioral health management criteria, are distributed to all practitioners/providers upon request and, upon request, to members and potential members by contacting a Aetna Better Health medical management representative. Aetna Better Health distributes criteria by mail to practitioners and members who do not have fax, e-mail or internet access.[9]

Initial and annual review processes consist of an evaluation of existing criteria, determination of any recommendations or changes, and final acknowledgement or acceptance of criteria. The process involves appropriate practitioners to review, advise and comment on development or adoption of UM criteria, and on the instructions for applying criteria. Annually, the UM Steering Committee reviews national criteria sets and the procedures for applying them against current clinical and medical evidence. The UM Steering Committee is comprised of senior and plan medical directors representing a broad range of specialties such as emergency medicine, behavioral health, pediatrics, surgery, family medicine and internal medicine. The Aetna Better Health QM/UM Committee membership includes local medical directors and community practitioners who review criteria sets in comparison to state requirements and current clinical and medical evidence to update and adopt final criteria sets as appropriate. Adopted criteria are submitted to the Aetna Better Health Quality Management Oversight Committee for review and adoption.[10]

Quality Management Oversight Committee (QMOC)

Aetna Better Health is responsible for seeing that criteria are submitted annually and approved by the -Aetna Better Health Quality Management Oversight Committee (QMOC). Additional recommended changes in the established criteria are communicated to the Aetna Medicaid Medical Management (MM) Unit for review and input prior to submission to the Aetna Better Health QMOC for final determination and implementation.

[8] NCQA HP 2019 UM2 B
[9] NCQA HP 2018/2019 UM2 B
[10] NCQA HP 2018/2019 UM2 A4-5

After QMOC has approved the criteria submission, Aetna Better Health must provide any medical management documentation to support the QMOC approval decision to the director of Utilization Management of the Aetna Medicaid Medical Management Unit. This documentation can be in the form of meeting minutes and is required for tracking and monitoring purposes.

Clinical Criteria for UM Decisions[11]

Aetna Better Health adopts evidence-based clinical practice guidelines from nationally recognized sources. These guidelines are adopted to promote consistent application of evidence-based treatment methodologies, facilitate improvement of health care and reduce unnecessary variations in care.[12] Aetna Better Health will use LDH's medical necessity definition as defined in LAC 50:I.1101 (Louisiana Register, Volume 37, Number 1) for medical necessity determinations. The MCO shall make medical necessity determinations that are consistent with the State's definition. [13]The[LK4] determination of whether a service is medically necessary is made on a case-by-case basis, taking into account the individual needs of the member and allowing for consultation with requesting practitioners/providers when appropriate. Individual characteristics of the member to be considered include at least the following when applying criteria: age, comorbidities, complications, progress of treatment, psychosocial situation and home improvement, when applicable. Certain medical services, while being medically necessary, may exceed established coverage guidelines. In these circumstances, coverage determination is based on Aetna Better Health utilization management alternative procedures such as referral to a licensed physician with the appropriate clinical expertise for review.

Process for the Application of Medical Necessity Criteria[14]

Aetna Better Health uses the following criteria for physical health and behavioral health consulted in the order listed below; as applicable:

- Criteria required by applicable state or federal regulatory agency
- Aetna Medicaid Pharmacy Guidelines for pharmacy criteria
- MCG for physical and behavioral health criteria
- LOCUS, CALOCUS for behavioral health criteria
- ASAM

[11] NCQA HP 2020/2021 UM2 A2
[12] 2020 Louisiana Medicaid Management Care Organization Statement of Work, Sections 8.1.3.1
[13] 2020 Louisiana Medicaid Management Care Organization Statement of Work, Sections 8.1.11

[14] 2020 Louisiana Medicaid Management Care Organization Statement of Work, Sections 8.1.3.2

- Aetna Clinical Policy Bulletins (CPBs)
- Aetna Clinical Policy Council Review

If primary criteria are not clear enough to make a determination and the requested service is not addressed by the Aetna CPBs, the medical director may submit a request for a position determination to the Aetna Clinical Policy Council. The policy council researches literature applicable to the specific request and, when a determination is reached, responds to the medical director.

When criteria are present but unclear in relation to the situation, the reviewing medical director may contact the requester to discuss the case or may consult with a board-certified physician from an appropriate specialty area before making a determination of medical necessity.[15]

OPERATING PROTOCOL:

Systems

- Business operating systems

Measurement

- Not applicable

Reporting

- Aetna Better Health submits all criteria annually to the QM/UM Committee. Additional recommended changes in the established criteria are communicated to the Aetna Medicaid Medical Management Unit for review and input prior to submission to the QM/UM Committee for final determination and implementation.
- Aetna Better Health provides written communication (e.g., meeting minutes) to the director of Utilization Management of the Aetna Medicaid MM Unit for tracking and monitoring purposes

INTER-/INTRA-DEPENDENCIES:

Internal

- Aetna Better Health Quality Management Oversight Committee
- Aetna Better Health Quality Management/Utilization Management Committee

[15] NCQA HP 2020/2021 UM4 F1

- Aetna Clinical Policy Review Unit
- Aetna Medicaid Medical Management Unit
- Medical Management
- Medical directors
- Network Services
- Pharmacy
- Quality Management

External

- Ancillary services
- External information sources
- Practitioners/providers
- State agency or client

Aetna Better Health

Richard C. Born
Chief Executive Officer

Madelyn M. Meyn, MD
Chief Medical Officer

~~Reviewed and revised: 01/2009~~
~~Reviewed and revised: 02/2011~~
~~Reviewed and revised: 02/2012~~
~~Reviewed and revised: 01/2013~~
~~Reviewed and revised: 01/2014~~
~~Reviewed and revised: 01/2015~~
~~Reviewed and revised: 10/2015~~
~~Reviewed and revised: 07/2016~~
~~Reviewed and revised: 07/2017~~
~~Reviewed and revised: 12/2017~~
~~Reviewed and revised: 09/2018~~
~~Reviewed and revised: 06/2019~~
~~Reviewed and revised: 05/2020~~
~~Reviewed and revised: 01/2021~~

Review/Revision History	
03/2016	Added MCG to medical decision criteria for BH
02/2017	Added LDH Contract language and updated signatory lines
09/2017	Updated definitions, grammatical revisions, deleted 2016 NCQA, updated responsibilities and operating protocol including criteria
03/2018	Updated NCQA references
03/2019	Updated to template, updated signatory lines, updated signatory lines, added contract language
05/2019	Added additional contract language; updated signatory line for CMO; Updated revision date
04/2020	Reviewed, added additional contract language.
02/2021	Reviewed, added additional contract language and contract references