Policy

Approver Name: Rebecca Stokes, RN **Title**: AVP of Health Care Services **Signature**: 	**Policy No.**: TX HCS-365
	Policy Title: Clinical Criteria for Utilization Management (UM) Decision Making
	Department Name: Health Care Services – Utilization Mgmt (UM)
	Effective Date: 02/07/2019
Approver Name: David Valdez, MD **Title**: CMO **Signature**: 	**Reviewed and Revised Date**: 01/25/2019; 03/19/2019; 02/17/2020; 02/01/2021; 02/01/2022; 01/17/2023; 05/23/2023; 02/13/2024; 08/26/2024
	Review Only Date:
Approval Date: HCSC 02/07/2019 (QIC 11/25/2019); TDI 03/28/2019, HCSC 04/25/2019 (QIC 01/07/2020); TDI 07/16/2020, HCSC 07/30/2020 (QIC 08/07/2020); HCSC 04/01/2021 (QIC 04/09/2021); TDI 06/29/2021; ; HCSC 03/10/2022 (QIC 03/23/2022) TDI 03/30/2022; HCSC 02/22/2023 (QIC 02/21/2023) TDI 03/29/2023; TDI 08/01/2023; HCSC 08/24/2023 (QIC 08/31/2023) HCSC 02/21/2024 (QIHETC 02/28/2024) TDI 03/25/2024 HCSC 09/27/2024 (QIHETC 10/04/2024)	**Supersedes and replaces:** HCS-UM010 Clinical Criteria for HCS Decision Making; **Date**: 02/07/2019;

Entity:
☒MHT - Molina Healthcare of Texas, Inc.
☒MHTIC - Molina Healthcare of Texas Insurance Company

Line of Business:
☐All
☐Medicare-Medicaid Programs (MMP)
☐Medicare
☒STAR ☒ STAR+PLUS ☒ CHIP
☐Health Insurance Marketplace
☐Other: _____

I. PURPOSE

The purpose of this policy is to establish the appropriate review, use, availability, and application of objective evidence-based clinical criteria to determine medical necessity and appropriateness of requested services.

II. POLICY

Molina will use federal and state regulations, policies, and benefit guidance as well as nationally accepted evidence-based criteria guidelines for decision making. Clinical review criteria are based on sound medical evidence, updated regularly, reviewed and approved annually by the Healthcare Services (HCS) committee. Decision making criteria is purchased externally or developed internally with involvement of appropriate practitioners.

Molina Clinical Policies are shared on Molina's website for all participating and non-participating providers to access.

Molina HCS shall apply these criteria sets with special consideration regarding the healthcare needs of each individual member and characteristics of local delivery systems that are available for specific member populations.

Molina HCS shall review the criteria documents annually or when known updates are made and seek approval by Molina Healthcare, Inc. (MHI) and the Health Care Services Committee (HCSC).

III. SCOPE

Healthcare Services (HCS); Chief Medical Officer (CMO) Policy and Benefit; Molina Clinical Services (MCS); Clinical Management and Policy

IV. AREA(S) OF RESPONSIBILITY

Healthcare Services (HCS)

V. REFERENCE(S):

42 CFR 422.202 (b) (1-2) - Participation procedures/consultation
42 CFR 422.101 (b-c) - Requirements relating to basic benefits
42 CFR 438.236 - Practice guidelines
NCQA UM Standard 2: Clinical Criteria for UM Decisions
NCQA UM Standard 6: Clinical Information
Uniform Manage Care Contract (UMCC): 8.1.8 Utilization Management, 8.1.15 Behavioral Health (BH) Network
Texas Administrative Code: Title 28, Part 1, Chapter 3, Subchapter HH – Standards for Reasonable Cost Control and Utilization Review for Chemical Dependency Treatment Centers
Texas Insurance Code: Title 14; Chapter 4201 – Utilization Review Agents

Procedure

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I. PURPOSE

The purpose of this procedure is to establish the appropriate review, use, availability, and application of objective evidence based clinical criteria to determine medical necessity and appropriateness of requested services.

II. AREAS OF RESPONSIBILITY

Health Care Services (HCS)

III. SCOPE

Healthcare Services (HCS); Chief Medical Officer (CMO) Policy and Benefit; Molina Clinical Services (MCS); Clinical Management and Policy

IV. PROCEDURE

A. Clinicians review the clinical records and documentation to determine medical necessity of the requested services. Clinical records may include, but are not limited to:

1. Office and hospital records;
2. History of the presenting problem;
3. Clinical exam;
4. Diagnostic testing results;
5. Treatment plan and progress notes;
6. Patient psychosocial history;
7. Information and consultations with the treating practitioner;
8. Evaluations from other health care practitioners and providers;
9. Photographs;
10. Operative and pathological reports;
11. Rehabilitation evaluations;
12. Information regarding benefits for services or procedures;
13. Information regarding the local delivery system;
14. Patient characteristics and information; and
15. Information from responsible family members.

B. Clinicians consider the member's individual health care needs when reviewing for medical necessity:

1. Age;
2. Comorbidities;
3. Complications;
4. Progress of treatment;
5. Psychosocial situations and social determinants of health;
6. Home Environment, when applicable;
7. Local medical resources ability to provide all recommended services within the estimated scope of care;
8. Availability of inpatient, outpatient, and transitional care facilities;
9. Availability of any local delivery systems in Molina's service area as needed to support the patient after hospital discharge (e.g., skilled nursing facilities, sub-acute care facilities, and home care agencies);

10. Availability of highly specialized services, such as transplant facilities or cancer centers; and
11. Availability of outpatient services in lieu of inpatient services (e.g., surgical centers versus inpatient surgery).

C. When benefits are covered, clinicians follow the hierarchy of decision making:
   1. Applicable Federal Mandates/regulations.
   2. State of Texas regulations and state specific criteria guidelines:
      a. Texas Medicaid Provider Procedures Manual;
      b. Texas Resilience and Recovery Utilization Management Guidelines (TRRUMG);
      c. Texas Administrative Code;
      d. Uniform Managed Care Manual;
      e. Uniform Managed Care Contract.
   3. Delegated 3rd Party clinical criteria guidelines which were reviewed and approved for UM use in compliance with Molina policies.
   4. Licensed external decision making criteria including InterQual® Criteria or MCG.
   5. Corporate guidance documents and policies, including Molina Clinical Policy (MCP).
   6. American Society of Addiction Medicine (ASAM) Criteria.

D. Physician reviewers may also use the following as decision aids[1] for medical necessity determinations:

   1. National Comprehensive Cancer Network (NCCN).
      a. Level of evidence 2A or above may be considered for approval.
   2. Hayes Technology Assessments:
      a. Hayes Rating of B or better for the treatment/device may be considered for approval;
      b. Hayes Rating of C or below does not have proven benefit or sufficient evidence and would not be approved.
   3. UpToDate.
   4. State-mandated long-term care assessment tools which determine eligibility for and authorization of LTSS and waiver services.
   5. Technology assessments established by nationally accepted governmental agencies, physician specialty societies, associations or academies and published in peer reviewed medical literature.

[1] These **are not criteria**; while they may support a physician reviewer's medical judgment, they cannot be cited as criteria in denying or approving coverage. The determination is based on the physician's judgment, supported by scientific evidence as found in the appropriate decision aid.

6. Well controlled or prospective cohort/comparison studies published and referenced in medical or scientific literature with relevant clinical evidence supporting the assertion that the requested modality would provide benefit to the member and a clinical advantage over its competitors, two independent studies are preferred.
7. Specialty consultations by a third-party reviewer or an Independent Review Organization (IRO).
8. Level of Care Utilization Systems (LOCUS).
9. Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS-CASII).

E. When criteria does not appropriately address the individual member's needs or unique circumstances (e.g., age specific issues, physical or cognitive disabilities, etc.), the physician reviewer may use clinical judgement for approval or denial of services if there is relevant evidence to support this assertion.

F. The outcome of the criteria/guideline review for each authorization request is documented in the corresponding member case record within the designated computer authorization program.

G. When services are not authorized for a requested service due to termination of benefits, Molina staff will provide assistance and alternatives for care. A referral to Case Management, Service Coordination, applicable state agency worker, or an external support agency may be an appropriate alternative.

H. UM clinical rounds attended by HCS staff and physicians are conducted on a regular basis to discuss case-specific determinations and problematic cases to assist with appropriate decision making for all Molina members.

I. Review of current UM criteria as well as the development and adoption of new UM criteria involves participation of Molina Medical Directors, Chief Medical Officers, community physicians, pharmacists, or behavioral health professionals. Criteria is reviewed through the National Quality Improvement Committee, Healthcare Services Committee or the Pharmacy and Therapeutics Committee, annually or more frequently if necessary. When decision support criteria is not available, Medical Directors or contracted physicians may do one of the following:

1. For urgent requests contact the MHI Chief Medical Officer (CMO) Policy and Benefit department to request an ad hoc review of current literature.
2. For non-urgent requests complete a New or Revised MCP request form that details business need for policy development. The requests will be prioritized by the Molina Corporate Medical Director overseeing the MHI CMO Policy and Benefit Department and taken for review at the MCP or P&T Committees.
3. Either type of request must be submitted with two (2) peer reviewed, independent scientific, or medical documents with relevant clinical

evidence supporting the assertion that the requested treatment would provide benefit to the patient and be a clinical advantage over its competitors. These documents must be submitted by the requesting provider. Reliable evidence may be obtained from good quality randomized-control trials or minimally biased prospective cohort/ comparison studies. Case reports, retrospective studies, and abstracts are not sufficient. A technology may be considered if an established standard of medical practice that has published data with evidence supporting its effectiveness (e.g., transplantation with donor bank data supporting increased life expectancy).

J. Upon request, practitioners and members requesting authorization for procedures, equipment, or pharmaceuticals for medical, surgical, or behavioral health services will be provided the criteria used for making final coverage determinations.
    1. Practitioners are notified in writing of the availability of criteria via the Provider manual and through the Provider Newsletter. Molina's internal criteria are posted on the public website.
    2. Requests for criteria will be accepted in writing or via telephone contact.
    3. All requests are to be forwarded to a Medical Director or Clinical Director (e.g., UM, Pharmacy, Behavioral Health) prior to release to the requestor.
    4. Criteria specific to the request can be mailed, faxed, or provided verbally to the practitioner or member by a Medical Director, HCS Director or their designee(s).
    5. All non-approval letters shall include verbiage to inform practitioners and members about their ability to review UM criteria used in decision making.
    6. Molina provider manuals must have a statement regarding the availability of UM criteria for practitioners and/or members.

V. REFRENCE(S):

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