PreferredOne®

Department of Origin: Integrated Healthcare Services	**Effective Date:** 06/23/23
Approved by: Chief Medical Officer	**Date Approved:** 06/23/23
Clinical Policy Document: Coverage Determination Guidelines	**Replaces Effective Clinical Policy Dated:** 07/26/22
Reference #: MP/C009	**Page:** 1 of 3

PURPOSE:
The intent of this clinical policy is to provide guidelines to aid in coverage determinations.

Please refer to the member's benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the member's benefit plan or certificate of coverage, the terms of the member's benefit plan document will govern.

POLICY:
I. Benefits must be available for *health care services.*
II. *Health care services* must be proven effective by *reliable evidence.*
III. *Health care services* designated by the CMS Medicare program as Coverage with Evidence Development (CED) are considered *investigative*.
IV. *Health care services* must be ordered by a *provider*, unless otherwise pre-empted by law.
V. *Health care services* must be *medically necessary*, applicable conservative treatments must have been tried, the most cost-effective alternative must be requested for coverage consideration, and not provided specifically for the convenience of the member or provider.
VI. Services, drugs, or supplies must be rendered in the most cost-efficient setting or manner appropriate for the condition.
VII. *Health care service* must be based on medical standards and accepted practice parameters of the community and provided at a frequency that is accepted by the medical community as medically appropriate. Based on this, unnecessary tests and treatments are not-covered, such as but not limited to the following:
    A. Routine use of preoperative diagnostic testing and imaging in low-risk members for low-risk surgeries
    B. Low-value medical procedures including diagnostic imaging and disease screening, including health care services that:
        1. Are not supported by evidence
        2. May be duplicative of other procedures
        3. May provide harm
        4. Are truly unnecessary
VIII. Where applicable, *outcome measures* and/or pre-determined treatment goals that are *specific, measurable, and/or functional* must be employed and clearly defined in the medical record, including the degree of change over time. The documentation must also provide evidence of lasting, sustainable, progress with treatment.
IX. When *standardized tests and measures* are used, the most *current edition/version* of the testing instrument is employed.
X. For continuation of *health care services,* effectiveness or measurable improvement/progress must be documented and objectively quantified. Absence of placement and/or availability at a lower level of care does not constitute medical necessity for continuation of care at the current level of care.
XI. There are no documentation irregularities or inconsistencies regarding such condition or *health care service* in the medical record.

EXCLUSIONS (not limited to):
Refer to member's Certificate of Coverage or Summary Plan Description

DEFINITIONS:

Activities of Daily Living (ADL):
Activities related to personal self-care and independent living, which include eating, bathing, dressing, transferring, walking/mobility, and toileting/continence

Cosmetic:
Services, medications and procedures that improve physical appearance but do not correct or improve a physiological function, or are not medically necessary

Health Care Service:
Medical or behavioral services including pharmaceuticals, drugs, devices, technologies, tests, treatments, therapies, supplies, procedures, hospitalizations, or provider visits.

Investigative:
As determined by the Plan, a drug, device or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes.

Medically Necessary:
Any *health care services*, preventive health care services, and other preventive services that the Plan, in its discretion and on a case by case basis, determines are appropriate and necessary in terms of type, frequency, level, setting, and duration, for a diagnosis or condition; and the care must:

1. Be consistent with the medical standards and generally accepted practice parameters of providers in the same or similar general specialty as typically manages the condition, procedure or treatment at issue; and
2. Help restore or maintain health; or
3. Prevent deterioration of a condition; or
4. Prevent the reasonably likely onset of a health problem or detect an incipient problem.

Outcome Measures:
Objective, measurable, assessments to determine progress with treatment. The use of standardized tests and measures at the onset of care establishes the baseline status of the member, providing a means to quantify change in the patient's functioning. Outcome measures, along with other standardized tests and measures used throughout the episode of care, as part of periodic reexamination, provide information about whether predicted outcomes are being realized.

Provider:
A health care professional, physician, clinic or facility licensed, certified, or otherwise qualified under applicable state law to provide health care services

Reconstructive:
Refer to member's plan document for applicable reconstructive definition

Reliable evidence:

The Plan considers the following categories of reliable evidence, none of which shall be determinative by itself:

1. Whether there is a final approval from the appropriate government regulatory agency, if required. This includes whether a drug or device can be lawfully marketed for its proposed use by the FDA; or if the drug, device or medical treatment or procedure is under study or if further studies are

needed to determine its maximum tolerated dose, toxicity, safety or efficacy as compared to standard means of treatment or diagnosis; and

2. Whether there are consensus opinions or recommendations in relevant scientific and medical literature, peer-reviewed journals, or reports of clinical trial committees and other technology assessment bodies. This includes consideration of whether an oncology treatment is included in the applicable National Comprehensive Cancer Network (NCCN) guideline, as appropriate for its proposed use, or whether a drug is included in any *authoritative compendia* as identified by the Medicare program such as, the National Comprehensive Cancer Network Drugs and Biologics Compendium, as appropriate for its proposed use; and
3. Whether there are consensus opinions of national and local health care providers in the applicable specialty as determined by a sampling of providers, including whether there are protocols used by the treating facility or another facility, studying the same drug, device, medical treatment or procedure.

Specific, Measurable, and Functional Goals:
Clearly defined goals of treatment that allow measurement of the amount and/or degree of meaningful change over time. These goals are often determined by the use of functional outcome assessment tools.

Standardized tests/measures current edition/version:
Editions/version should be updated within 1-2 years following publication of the new edition. The most recent version incorporates best practices in assessment, current research and norms based on a sample that matches the most recent demographic characteristics of the population.

REFERENCES:

1. Integrated Healthcare Services Process Manual: UR015 Use of Medical Policy and Criteria
2. Clinical Policy: Clinical Policy Application, Development, Oversight, and Distribution MP/C014
3. Clinical Policy: Investigative Services MP/I001
4. Clinical Policy: Levels of Evidence and the Evaluation of Health Care Services MP/L004
5. 2023 NCQA Standards and Guidelines for the Accreditation of Health Plans
6. American Physical Therapy Association. Outcome Measurement. Last Updated 6/15/2017. Retrieved from: http://www.apta.org/OutcomeMeasures/. Accessed 06-12-23.

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PCHP:
Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact a Grievance Specialist.

If you believe that PCHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance Specialist
PreferredOne Community Health Plan
PO Box 59052
Minneapolis, MN 55459-0052
Phone: 1.800.940.5049 (TTY: 763.847.4013)
Fax: 763.847.4010
customerservice@preferredone.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, a Grievance Specialist is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1.800.940.5049 (TTY: 763.847.4013).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1.800.940.5049 (TTY: 763.847.4013).

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If you believe that PIC has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Grievance Specialist
PreferredOne Insurance Company
PO Box 59212
Minneapolis, MN 55459-0212
Phone: 1.800.940.5049 (TTY: 763.847.4013)
Fax: 763.847.4010
customerservice@preferredone.com

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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