Authorizations and medical necessity reminder

Requests for authorization for coverage of medical services are reviewed for medical necessity. Amerigroup Community Care utilizes federal and state regulations, Anthem Medical Policies, vendor guidelines approved by the organization, McKesson InterQual ®, and specialty society guidelines or results of clinical studies published in peer-reviewed literature to determine medical necessity as specified for each request (i.e., inpatient requests are reviewed against McKesson InterQual ®).

According to TennCare Rules Chapter 1200-13-16, in order for a medical item or service to be medically necessary, it must satisfy each of the following criteria:

1. It must be recommended by a licensed physician who is treating the enrollee or other licensed health care provider practicing within the scope of his or her license who is treating the enrollee;
2. It must be required in order to diagnose or treat an enrollee's medical condition;
3. It must be safe and effective;
4. It must not be experimental or investigational; and
5. It must be the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition.

Additionally, a cost-effective alternative service is a service that is not covered but is approved by TennCare and provided solely at our discretion. TennCare enrollees are not entitled to receive these services. Cost-effective, alternative services may be provided because they are either (1) alternatives to covered Medicaid services that, in our judgment, are cost-effective or (2) preventive in nature and offered to avoid the development of conditions that, in our judgment, would require more costly treatment in the future. Cost-effective, alternative services need not be determined medically necessary except to the extent that they are provided as an alternative to covered Medicaid services. (TennCare policy BEN08-001.)

Please note that Medicaid members **must not** be billed for rendered services that are within scope of TennCare benefits, even if your claim is denied.

What does this mean to you?

The following examples are provided in order to illustrate how this applies to specific authorization requests.

Example 1: A physician orders home health services, specifically a home health aide, for 35 hours, seven days a week, for nine weeks to assist with activities of daily living due to functional limitations. Upon further review of the clinical documentation submitted to support medical necessity and an assessment of functional need completed by an Amerigroup clinician, the Amerigroup Medical Director determines the member only needs two hours a day, five days a week to adequately meet his/her needs. Authorization for coverage of the original order is denied but an alternate level of care is approved as the least costly alternative for treatment that is adequate for the enrollee's medical and/or functional condition(s).

Example 2: A physician orders skilled nursing facility admission for a member to receive physical and occupational therapy after the member has been diagnosed with a severe cerebral vascular accident with subsequent one-sided paralysis. Upon further review of the clinical documentation submitted, the Amerigroup Medical Director determines that the nursing facility level of care is appropriate as a cost-effective alternative in order to stabilize the member's condition and support long-term services and completion of a preadmission evaluation (PAE) and the member's eventual return to the community.

Example 3: A physician orders skilled nursing facility admission in order for a member to receive physical therapy after the member has had a total knee replacement. Upon further review of the clinical documentation submitted, the Amerigroup Medical Director determines that the nursing facility level of care is not appropriate as a cost-effective alternative. This is because home health services are a covered benefit, and will be the least costly alternative course of treatment that is adequate for the enrollee's medical condition.

Example 4: A physician orders inpatient admission for a member who is discharged home within two days. Submitted clinical documentation meets criteria for observation level of care. The Medical Director determines the acute inpatient level of care would not be considered the least costly alternative course of diagnosis or treatment that is adequate for the enrollee's medical condition, as the needs could have been met with an observation level of care. The request for coverage of inpatient admission is denied as not medically necessary.

What if I need assistance?

If you have questions about this communication, received this fax in error, or need assistance with any other item, please contact your local Provider Relations representative or call Provider Services toll free at 1-800-454-3730.