



Medical Necessity Criteria

What are Medical Necessity Criteria and when are they used?

Western Health Advantage (WHA) or your assigned medical group (group) requires prior authorization (pre-approval) for most care and services you receive, to make sure they are covered under your health plan benefits. When your primary care physician (PCP) decides you need to see a specialist or you require special procedures, services or equipment, the PCP will send a referral to the Medical Management department of your group for review and pre-approval when needed.

Eligibility is verified, the specialist's name on the referral is reviewed to make sure s/he is a participating WHA network provider, and the requested service is checked to see if it is a covered benefit. If the referral is for medical services, reviewers may evaluate your medical condition, diagnoses, clinical record and the requested service to make sure it is medically necessary and appropriate, based on your individual situation.

Who is responsible for the review process?

Experienced utilization management (UM) nurses are usually the review staff making initial decisions to approve referral requests. The UM nurses use pre-approved objective clinical criteria to evaluate each referral requiring pre-approval to determine medical necessity. Clinical criteria are evidence-based treatment guidelines developed by physicians and other medical experts. They are based on nationally recognized standards of care and medical practice. The criteria used by WHA and its group reviewers are objective and their use promotes consistency of decisions for patients with the same or similar conditions and health care needs.

Who makes the review decision?

By California law, only a physician can deny or modify a requested service that involves a medical necessity decision, including treatment requests involving new technology or that are considered experimental. If the nurse reviewer can verify that a requested service is medically necessary using clinical criteria, the nurse can approve the request (as long as all other conditions are met, such as verifying current eligibility and benefit coverage). If the nurse reviewer cannot establish medical necessity, the referral and all supporting documentation are forwarded to a qualified physician or physician review committee to make the final decision. Physician reviewers use appropriate criteria, benefit coverage guidelines and their own medical expertise and sound medical judgment to make medical necessity decisions on individual cases.

What is the basis for establishing the criteria used to make the decision?

Medical necessity criteria used by WHA and its contracted groups include Milliman Care Guidelines, InterQual/McKesson Treatment Criteria, CMS and St. Anthony's Medicare Benefit Guidelines, and Hayes, Inc. Treatment Guidelines for New Technology and Experimental Procedures. Some of WHA's

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contracted groups may also use their own internally developed and committee-approved care and treatment guidelines.

All criteria used by WHA and its contracted groups are developed and adopted for use with involvement from actively practicing physicians and other health care professionals with expertise relevant to the topics addressed in the criteria. These guidelines are consistent with sound clinical principles and treatment processes, and are evaluated, updated and approved for use at least annually by the Plan's Utilization Management and Quality Improvement Committees and Board of Directors. Results are then shared with our providers.

When a requested service is denied or modified and it involves a medical necessity decision, specific criteria used to make the decision are cited in notification letters, which are sent to the member and physicians involved in the referral. Other information in the letter explains how you or a representative may file an appeal with WHA, and whom you should contact with additional information that might change the decision.

Where can I find more information?

You can view our website at www.westernhealth.com for more information about WHA's services and member rights.

TDD/TTY service is available for the hearing or speech-impaired, Monday through Friday, 8:00 am to 5:00 pm in either English or Spanish, by calling: (888) 877-5378, or you can dial 711. Should you have need for a translator face-to-face or over the phone, contact the **WHA Member Services department**, Monday through Friday, 8:00 am to 5:00 pm, (888) 563-2250 toll free.

IMPORTANTE: ¿Puede leer este documento? Si no, nosotros le podemos ayudar a leerlo. Además, usted puede recibir el documento escrito en español. Para obtener ayuda gratuita, llame ahora mismo a Western Health Advantage al (888) 563-2250, de lunes a viernes de 8am a 5pm.

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