Neighborhood Health Plan OF RHODE ISLAND™

Clinical Medical Policy

Use of Evidence Based Medicine - #075

Last reviewed: 04/08/26

Application

Application of this Medical Policy applies to:
RIte Care (MED), Rhody Health Partners (RHP), Rhody Health Expansion (RHE), Children with Special Health Care Needs (CSN), Substitute Care (SUB), Extended Family Planning (EFP), Commercial (HBE), INTEGRITY for Duals (FIDE), Duals CONNECT (CO-DSNP)
Application Excluded for:
None

Medicare Distinction

For INTEGRITY for Duals (FIDE) and Duals CONNECT (CO-DSNP) members: Neighborhood Health Plan of Rhode Island (Neighborhood) uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations, including medical necessity. Coverage determinations are based on applicable National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs), and other Medicare guidelines.

For FIDE Members: In the absence of an applicable or incomplete NCD, LCD, or other Medicare guidelines OR if available Medicare coverage guidance is not met, then Neighborhood will apply coverage guidance from the Rhode Island Executive Office of Health & Human Services (EOHHS), or other widely used treatment guidelines with peer-reviewed scientific evidence, such as InterQual® and/or internal Clinical Medical Policies as a means of secondary coverage through the member's Medicaid benefit.

For CO-DSNP Members: In the absence of an applicable or incomplete NCD, LCD, or other Medicare guidelines, then Neighborhood will apply coverage guidance from other widely used treatment guidelines with peer-reviewed scientific evidence, such as InterQual® and/or internal Clinical Medical Policies.

Description

Neighborhood Health Plan of Rhode Island's (Neighborhood) Clinical Medical Policies (CMPs) define when a conditional benefit is medically necessary. Neighborhood's CMPs are developed and/or revised following review of current medical literature and standards of practice. To the extent possible, Neighborhood's CMPs are developed according to evidence-based outcomes as well as the unique needs of Neighborhood's member population. Board-certified specialty physician

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advisors are consulted for their expertise and recommendations in the development of CMPs, as necessary.

The purpose of this policy is to address those conditional benefits which do not have a specific clinical medical policy or clinical criteria available. With the ever-increasing medical technology, Neighborhood desires to offer the benefit of evidence-based medicine to all our members in accordance with benefit packages.

While Neighborhood Health Plan of Rhode Island goes to great lengths to utilize existing coverage guidelines for the majority of review scenarios, requests are submitted that are not addressed by established criteria. In the event that a request cannot be adequately evaluated using established medical criteria (for example, Centers for Medicare/Medicaid Services National Coverage Determinations, Local Coverage Determinations, InterQual®, or existing Clinical Medical Policies), the request will be forwarded to a medical doctor reviewer who will review the request using current evidence-based medicine.

The physician reviewer may utilize one or more of the following resources in formulating a decision on whether a requested service/item is evidence-based, and reflects the current standard of care:

- Cochrane Reviews
- PubMed
- ICER
- Hayes
- UpToDate
- Current society guidelines
- Centers for Medicare and Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Centers for Disease Control (CDC)
- Other applicable third-party payer policies
- External expert specialty review opinion
- Critical Developments in Health Technology Assessment and/or other Scientific journals/publications/Internet websites

Definitions

Medically Necessary or Medical Necessity or Medically Necessary Service(s)	Medical, surgical, or other services required for the prevention, diagnosis, cure, or treatment of an injury, health related condition, disease or its symptoms. For Medicaid members under the age of 21, the term also includes the EPSDT services described in Section 1905(r) of the Social Security Act, including services necessary to correct or ameliorate a defect or physical or mental illness or condition discovered through EPSDT screenings. A service is considered Medically Necessary if it is rendered for any of the following situations: (1) Is provided in response to a life-threatening condition or pain; (2) To treat an injury, illness or infection;

(3) To achieve a level of physical or mental function consistent with prevailing community standards for the diagnosis or condition;
(4) To provide care for a mother and child through the maternity period;
(5) To prevent the onset of a serious disease or illness;
(6) To treat a condition that could result in physical or behavioral health impairment; or,
(7) To achieve age-appropriate growth and development or to attain, maintain, or regain functional capacity.

Experimental Treatment or Investigational Treatment

Reliable evidence shows that the consensus of opinion among experts regarding the healthcare service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or reliable evidence shows that the dental service (e.g., procedure, treatment, supply, device, equipment, drug, biological product) does not improve net health outcome, is not as beneficial as any established alternatives, or does not produce improvement outside.

Coverage Determination

Requests for Evidence Based Services are covered **ONLY** when physician review (described above) shows that **ALL** of the following criteria are met:

- ☐ The requested service or item is safe and effective.
- ☐ The requested service or item is not experimental or investigational.
- ☐ The requested service or item is within accepted standards of medical practice.
- ☐ The requested service or item is appropriate to the medical needs and condition of the member in the current clinical scenario.
- ☐ The available evidence and clinical documentation must support the conclusion that the item/treatment/procedure improves net health outcomes.
- ☐ The available evidence and clinical documentation must support the conclusion that the item/treatment/procedure is:
  - a. as beneficial as any established alternative, or
  - b. more beneficial than existing alternatives for an identifiable subgroup of individuals
- ☐ The available evidence and clinical documentation must support the conclusion that the item/treatment/procedure is:
  - a. as safe as existing alternatives, or

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b. If the item/treatment/procedure is less safe than existing alternatives but is efficacious for patients who are not adequately treated with existing alternatives, approval may be recommended provided that all other criteria, including the above, are met.

- ☐ The requested service or item is not specifically excluded by another Clinical Medical Policy or treatment guideline.
  AND
- ☐ The requested service or item is ordered and furnished by qualified personnel.

Exclusions and Limitations

- Neighborhood does not cover experimental items, procedures, or treatments, except as otherwise required by law. Also refer to Neighborhood Clinical Medical Policy "Experimental or Investigational Services."

Authorization Request Forms

Access prior authorization request forms by visiting Neighborhood's website at www.nhpri.org.

1. Click on Providers
2. Click on Provider Resources
3. Click on Forms
4. Click on "Click here for a list of prior authorization request forms" – forms are listed alphabetically.

A phone messaging system is in place for requests/inquiries both during and outside of business hours. Providers can call 1-800-963-1001 for assistance.

Covered Codes: For information on coding, please reference the Authorization Quick Reference Guide.

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CMP Cross Reference:	**This policy is an updated combination of the No Criteria and Non-Standard Requests Policies**
Created:	June 2022
Annual Review Month:	April
Review Dates:	6/15/22, 6/7/23, 4/10/24, 4/9/25, 4/8/26
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Medical Director Approval Dates:	6/15/22, 6/7/23, 4/10/24, 4/9/25, 4/8/26
Effective Dates:	6/15/22, 6/7/23, 4/10/24, 4/9/25, 4/8/26

Neighborhood reviews clinical medical policies on an annual basis.

Disclaimer:

Neighborhood has developed medical policies to assist us in administering health benefits. This medical policy is made available to you for informational purposes only and does not constitute medical advice. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Members should always consult their physician before making any decisions about medical care. Treating providers are solely responsible for medical advice and treatment of members. Benefits and eligibility are determined by the member's coverage plan; a member's coverage plan will supersede the provisions of this medical policy. For information on member-specific benefits, call member services. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to review and revise this policy for any reason and at any time, with or without notice.