Clinical Policy: Clinical Policy Committee

Reference Number: WNC.CP.297
Last Review Date: Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Note: When state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

NOTE: North Carolina Medicaid requires that Prepaid Health Plans (including WellCare of North Carolina) provide coverage for services that is no more restrictive than NC Medicaid Fee-For-Service in terms of scope, quantity or duration of service. Where NC Medicaid maintains a clinical coverage policy, WellCare of North Carolina ("WellCare") must utilize that policy as a coverage floor and typically adopts that policy for coverage. If NC Medicaid does not maintain a coverage policy for a particular service, then WellCare may utilize a Centene clinical coverage policy, developed according to the process outlined in this policy, which is then reviewed and approved by the WellCare Utilization Management Advisory Committee. If no Centene policy exists, then evidence-based clinical practice guidelines (e.g., InterQual) are utilized to inform coverage determinations. NC Medicaid also performs new technology review and maintains a specific list of "covered codes" for NC Managed Care plans. Except for members eligible for non-covered services under EPSDT, WellCare follows those NC Medicaid coverage determinations.

Description[1]

The Centene Clinical Policy Committee ensures that clinical policies provide a guide to medical necessity, are reviewed and approved by appropriately qualified physicians, and are available to all Centene Health Plans, including WellCare of North Carolina.

Clinical policies provide a guide to medical necessity. Benefit determinations should be based in all cases on the applicable contract provisions governing plan benefits ("Benefit Plan Contract") and applicable state and federal requirements, as well as applicable plan-level administrative policies and procedures. To the extent there are any conflicts between these policies and the Benefit Plan Contract provisions, the Benefit Plan Contract provisions will control.

Clinical policies reflect current scientific research and evidence-based clinical standards. Clinical policies are not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care and are solely responsible for the medical advice and treatment given to members. All clinical policies are available to providers in compliance with all federal, statutory, and regulatory requirements and upon request.

Policy/Criteria[1]

I. Purpose

A. The Centene Deputy Chief Health Officer (DCHO) or their designee is responsible for establishing and maintaining a Clinical Policy Committee (CPC) composed of physicians and other medical and operational representatives as appropriate from Corporate Population Health and Clinical Operations (PHCO)and each plan to assist in the identification of need, development, revision, and/or review of clinical policy. All corporate clinical policies require approval by the CPC. Physicians participating in the CPC shall be board-certified and shall be licensed in good standing in at least one state.

B. Clinical policies include medical and durable medical equipment and devices. These policies include but are not limited to:

1. New and emerging technologies;
2. New uses for existing technologies;
3. Coverage issues relating to new and existing technologies;
4. Clinical guidelines for the evaluation and treatment of specific conditions;
5. Clinical/medical criteria or information used in pre- or post-service review.

C. The DCHO or designee performs an annual review of all existing corporate clinical policies to determine continued applicability and appropriateness. In connection with this annual review, the DCHO or designee is responsible for identifying which policies require revisions. The DCHO or designee shall send any such policies to the CPC to oversee the revision process and for subsequent re-approval.

II. Membership

The DCHO or designee recruits and replaces, as needed, CPC members to maintain a committee that includes:

A. Voting members:

1. One Medical Director from each plan (at minimum)
2. Senior Corporate Medical Directors

B. Non-voting members:

1. PHCO staff representing each region
2. Corporate clinical policy leadership
3. Corporate PHCO staff

C. Ad hoc advisors

1. Representatives from Centene subsidiaries
2. Internal legal counsel
3. Plan compliance directors
4. Outside experts and/or relevant interested parties depending upon the specialty area or special needs of the clinical policy.

III. Committee Maintenance and Oversight

A. The DCHO or designee acts as the chairperson for meetings and activities performed by the CPC (Committee Chair). The Corporate Director of Clinical Policy reports committee activities to the Committee Chair.

B. The Corporate Director of Clinical Policy oversees the Clinical Policy Department which is tasked with the following responsibilities in connection with the development and approval of clinical policies:

1. Coordinating research and development of clinical policies, which includes:
    a. Prioritizing all inquiries for new corporate policies and maintaining an electronic log of all requests for research and new policies with the requestor and subject of review.
    Highest priority is given to inquires based on open medical management cases such as pending authorizaiton requests or appeals cases. Response to these requests typically occurs within 24 hours. Priority then continues based on requests originating from providers or members, needs identified through financial analysis, followed by inquiries by vendors and technologies identified through trade publications.
    b. Conducting prelimary review of topics as follows:
        i. A critical appraisal of the current published medical literature from peer-reviewed publications including systematic reviews, randomized controlled trials, cohort studies, case control studies, and diagnostic test studies with statistically sound methods.
        ii. Evidence-based guidelines developed by national organizations and recognized authorities.
        iii. Opinions and assessments by nationally recognized medical associations including physician specialty societies, consensus panels, or other nationally recognized research or technology assessment organizations such as Hayes, UpToDate, or ECRI.
        iv. Reports and publications of government agencies such as the Food and Drug, Administration (FDA), Centers for Disease Control (CDC), or National Institutes of Health (NIH).
        v. External review organization recommendations.
    c. Conveying the findings of the preliminary review to the requestor within the priority-based time frame. In cases of open medical management decisions, the requestor will use the information provided by the clinical policy staff and the specifics of the particular case to render a decision. Preliminary review findings are saved in an electronic file for future policy development.
    d. For topics identified through medical management needs, if two requests for the same topic are submitted, a formal medical policy may be developed. Requests identified through financial analysis will follow this policy development process.
        i. The clinical policy staff utilizes the preliminary research to draft a policy. Relevant CPT, HCPCS and ICD-10 codes are identified and included in the policy. A review of historical handling and/or payment of the policy topic is also conducted to share with the CPC as appropriate.

ii. Opinions from external physicians are solicited as appropriate, including behavioral health physicians. The policy is sent for CPC review and approval.
iii. Subsequent to each new policy approval, the clinical policy staff sends a notice to all medical directors and PHCO leadership to inform them of new policies that have been approved by the CPC.
iv. The completed policies are reviewed annually or updated more frequently as dictated by current medical literature, medical director or other relevant staff requests and appeals analysis.
v. Completed policies are posted on CNet and in Adobe Experience Manager for access by internal staff and for linking to plan websites for providers.

e. Communication of these policies to provider networks is arranged by the plan marketing or provider network department.

2. Coordinating activities of the CPC including, but not limited to, the review, revision, approval, and maintenance processes of all corporate clinical policies. This includes scheduling meetings, sending necessary agendas and attachments, documenting meeting minutes, clinical policy reference number assignment, and the maintenance of such documents in electronic files and within the organizational internal database.
3. Generating reports reflecting CPC activity on a quarterly basis, or more frequently as needed, for the Committee Chair.
4. Notifying all relevant persons/departments and health plans regarding approved policies and related materials through email, including:
   a. Claim support service teams for dissemination to IS and claims. The clinical policy team offers direction/coordination for any system needs to support the clinical policy.
   b. Corporate VPs of PHCO and Corporate medical auditing and training teams for dissemination and auditing.
   c. CPC members, PHCO VPs and directors, and other health plan contacts for dissemination to their plan UM personnel. This includes notification to plan respresentatives for inclusion in the plan UM or QI committee responsible for plan level policy approval. Marketing and/or provider relations are included for appropriate provider notification of policy changes.
5. Facilitating training, as needed, with the corporate PHCO Training Department.

IV. Meeting Frequency

A. CPC meetings are held, at minimum, on a quarterly basis. Frequency is dependent upon clinical policy revision cycles and/or clinical policy need (as determined by the DCHO or designee).

B. Meetings may be held in a physical location or through the use of alternative media as determined by the participation of members from remote locations or by the urgency of the clinical policy. Such media include video, telephonic conference call, or email.

V. Committee Member Activities and Responsibilities:

A. Identification of new subjects to consider for clinical policy development can occur in the following ways:

1. Through UM authorization requests;
2. New technologies identified through trade publications;
3. Inquiries from providers and vendors;
4. Review of appeals cases;
5. Suggestion of the Medical and Payment Policy Governance Committee;

B. Review of clinical policies which includes:

1. New clinical policy drafts;
2. Policies due for scheduled review;
3. Updates or revisions to existing policies outside of the scheduled review due to advances or changes in standards of care, new information, missing information or content error;
4. Updates regarding the status of any policies under review;
5. Policy and prioritization requests for new clinical policies;

C. Electronic approval of clinical policies

Policies will be reviewed and approved through an electronic web poll process.

1. All draft clinical policies are loaded into the Qualtrics survey tool.
2. An email notification is sent to each of the CPC members with a link for the current survey with policies due for review as well as the required completion date for review. Standard surveys allow one week for review of clinical policies.
3. The survey directs CPC members to indicate if the policy meets their approval with a vote stating either (a) "yes," (b) "yes, with comments," (c) "no," or (d) "abstain." "Yes, with comments" and "no" votes require feedback to be supplied before the reviewer can complete the survey.
4. The Committee Chair determines, based on voting feedback, whether an issue identified during the voting process will be included on the agenda for discussion at the following CPC meeting. If so, the feedback will be distributed with the agenda for consideration prior to the meeting.
5. In the context of the electronic approval process, CPC actions are determined by a majority vote of the voting members responding. A majority of the voting committee members must respond to the review request to be considered a quorum. If a quorum does not respond, a follow-up email is sent to request additional members to respond.
6. Survey results are maintained electronically in the folder dated with the survey fielded date, along with all the policies that were submitted for approval at that time.

D. Attendance and Participation

1. Committee members are expected to attend all scheduled meetings and participate in the review of documents forwarded electronically for review and consensus.
2. The Committee Chair has the right to replace a committee member who does not participate in two or more consecutive committee meetings.

3. In the context of CPC meetings, CPC actions are determined by a majority vote of the voting members present. A majority of the voting committee members must be present to constitute a quorum.
4. A corporate designee will document meeting minutes. Meeting minutes include the agenda topic, pertinent discussion, proposed changes submitted/discussed, and any action taken, or consensus reached with respect to the proposed changes.

E. Approvals

The DCHO or designee approves all clinical policies. The Committee Chair is authorized to act as the DCHO designee for the purpose of approving clinical policies.

1. Within 14 business days of the survey poll close date or CPC meeting date, the Corporate Clinical Policy team incorporates any agreed changes and loads the approved policy into the clinical policy SharePoint site.
2. The DCHO designee locks the policy in an approved status in the policy management system and distributes all policies by email to the health plans for review and plan level approval.

Reviews, Revisions, and Approvals	Reviewed Date	Approval Date
Policy adopted by WellCare of North Carolina with "Note" describing NC Medicaid requirements, policy hierarchy and purpose for adoption.		

References

1. Centene Corporation Clinical Policy Clinical Coverage Policy No: CP.CPC.01Clinical Policy Committee. Centene Corporation Clinical Policies Dashboard. Published January 1, 2024. Accessed June 4, 2024.

North Carolina Guidance

Eligibility Requirements

1. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
2. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
3. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age

- 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or

procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product or procedure:

I. that is unsafe, ineffective, or experimental or investigational.
II. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT and Prior Approval Requirements

- If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
- **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:

NCTracks Provider Claims and Billing Assistance Guide:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
EPSDT provider page: https://medicaid.ncdhhs.gov/

Provider(s) Eligible to Bill for the Procedure, Product, or Service
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

i. meet Medicaid qualifications for participation;
ii. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
iii. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

Compliance
Provider(s) shall comply with the following in effect at the time the service is rendered:

A. All applicable agreements, federal, state and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
B. All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

Claims-Related Information
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

- Claim Type - as applicable to the service provided:
  Professional (CMS-1500/837P transaction)
  Institutional (UB-04/837I transaction)
  Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
- International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10 edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.
- Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
  Unlisted Procedure or Service

CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service

- Modifiers - Providers shall follow applicable modifier guidelines.
- Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
- Co-payments -
  For Medicaid refer to Medicaid State Plan:
  https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan

- Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.