Policy Name	Texas Clinical Criteria for Utilization Management Decision Making
Policy Number	456A.02
Department	Utilization Management
Subcategory	Operations
Original Issue Date	03/18/2018
Committee Approval Date	1/20/2021
Effective Date	04/23/2019

Company Entities Supported (Select All that Apply):
_X_ Superior Vision Benefit Management
_X_ Superior Vision Services
___ Superior Vision of New Jersey, Inc.
_X_ Block Vision of Texas, Inc. d/b/a Superior Vision of Texas
_X_ Davis Vision
(Collectively referred to as 'Versant Health' or 'the Company')

DEFINITIONS:	
Term	**Definition**
CMS	Centers for Medicare and Medicaid
Medical Policy Council	The company's functional committee charged with the responsibility to review, edit and approve clinical criteria coverage policies. The committee is chaired by the Chief Medical Officer. The participants of the Committee are board certified Optometrists and Ophthalmologists holding active license to practice.

PURPOSE:

To ensure the Company applies objective and evidence-based criteria and takes individual circumstances and the local delivery system into account when determining the medical appropriateness of health care services.

SCOPE:

Medicare, Medicaid, Commercial and Exchange Plan lines of business

POLICY:

The Company's Chief Medical Officer, in conjunction with the Company's Medical Policy Council is responsible for the review, revision and development of policies containing clinical criteria for decision making related to covered health care services.

The Company maintains a current and complete library of Coverage Policies specific to the Medical Optometry and vision related Medical Services that the Company is responsible for rendering medical necessity determinations.

1. **Access to Policies**

   The Company's Clinical Coverage policies, including clinical criteria, are available to network providers/ practitioners via the Company's provider/practitioner portal, as well as by request to Provider Relations. Requests can be made in person, by telephone or email. Requested policies will be supplied to the requesting practitioner via fax, email or US mail.

   In addition, recorded videos are available for some of the most common clinical coverage policies. These are also available on the Company website, and are intended to be educational to the practitioner(s). Annually newsletters are emailed to providers/practitioners with a reminder that clinical criteria are available on the provider/practitioner portal via the Company's Website or by request to Provider Relations. All policies available to external resources are to be posted and delivered in PDF format.

2. **Development and Maintenance of Policies**

   All policies are developed with reference to standards of care, industry evidenced based medical publications, and CMS coverage guidelines. Policies are appropriately referenced with sources utilized to determine clinical criteria contained within said policy. Evidence from the American Association of Ophthalmologists or American Association of Optometry are frequently used to establish clinical criteria.

   External consultants and industry and specialty experts are engaged to ensure that clinical criteria policies remain current and are referenced with the most up to date evidenced based sources.

   All clinical coverage policies are reviewed and updated, at a minimum, annually by the members of the Medical Policy Council.

   The Medical Policy Council meets quarterly, and ad-hoc as needed to ensure clinical coverage policies stay current with standards or care and industry trends.

   Policies for consideration are circulated to Medical Policy Council members 2-4 weeks prior to the scheduled Council meeting for input and comments. Policies are reviewed formally at the Council meeting, with quorum voting to approve policies. All policies for review at each meeting of the Medical Policy Council are evidenced in the meeting minutes and materials.

3. Application of Clinical Criteria in Decision Making

The application of clinical coverage policies will be consistent with the CMS defined hierarchy of criteria, as well as the individual member's needs and the availability of service in their local delivery systems.

a. CMS requires the use of published Medicare criteria or Plan criteria, in the following order of preference:

   i. Plan Eligibility and Coverage
   ii. CMS Criteria
   iii. National Coverage Determination (NCD)
   iv. Local Coverage Determination (LCD)
   v. Local Coverage Medical Policy Article
   vi. Medicare Benefit Policy Manual
   vii. State specific requirements
   viii. Health Plan criteria (e.g. Coverage Summary, Medical Policy)
   ix. Evidence based criteria such as MCG and InterQual
   x. Other evidence-based resources such as Hayes or evidence based literature

b. Member's needs and individual characteristics are considered when rendering clinical based decisions:

   i. Age.
   ii. Comorbidities.
   iii. Complications.
   iv. Progress of treatment.
   v. Psychosocial situation.
   vi. Home environment, when applicable.

c. All screening criteria used in the state of Texas are

   I. Objective;
   II. Clinically valid;
   III. Compatible with established principles of health care; and
   IV. flexible enough to a deviation from the norm when justified on a case-by case basis. Special circumstances include, but are not limited to an individual who has a disability, acute condition, or life-threating illness.

d. Screening criteria is only used to determine whether to approve the requested treatment. A denial of requested treatment is referred to a physician or other health care provider to determine medical necessity.

e. Local delivery system, and geo-access considerations are often defined by the health plan, and are part of the decision making process when appropriate.

If the presence of evidenced based criteria is not available for a particular health care service being requested, generally accepted standards of medical practice in the medical community will be used to support medical necessity decisions.

DISCLAIMER, LIMITATIONS AND EXCLUSIONS:

None

RELATED POLICIES AND PROCEDURES	
Policy Number	**Policy Name**

Document History:		
Date	***Revision***	***Version***
4/22/2019	Updated into current format, assigned new ID and version number, previous Audit Control Number: 406.00	.01
11/25/2020	Updated to reflect Texas UM statutes and regulations. In addition, updated to the 2020 NCQA standards.	.02

Compliance Source(s):

NCQA Standards UM 2 (2020)

Texas Insurance Code

Tex. Ins. Code § 4201.153(LexisNexis)

Texas Administration Code

28 Tex. Admin. Code § 19.705(b-c)(LexisNexis).