UM Hierarchy clinical decision-making Criteria for Medicare Advantage

Imperial Health Plan of California (HMO) (HMO SNP) uses a specific hierarchy for making medical necessity decisions. We follow Traditional Medicare coverage guidelines, including Medicare statutes, regulations, NCDs, and LCDs. For supplemental benefits, we use a predefined objective set of criteria.

For D-SNP, we first follow the Medicare Advantage (MA) hierarchy. If a request doesn't meet MA criteria, we then review using available Medi-Cal criteria for UM or claims. This process is conducted after verifying eligibility, benefits, and the Aid code approved by DHCS through automated verification of Medi-Cal benefits for that month.

The MA Hierarchy Criteria Order of Use is as follows:

- Benefits and Eligibility as defined in Evidence of Coverage (plan document)
- Federal Mandates and any applicable State Requirements
- **Any** CMS/HHS overriding document (Like HCFA Rulings, DAB rulings etc)
- CMS National Coverage Determinations (NCD)
- **Any** available but applicable local Coverage Determinations (LCD)
- **Any** available but applicable local Coverage Articles (LCA) (Active/Retired)
- **Any** applicable Medicare Manual guidance
- MCG Health latest edition
- Any authoritative Peer reviewed physician specialty society (e.g. NCCN) or federal govt.agency publication (e.g. NIH, AHRQ, FDA, CDC)

Providers can contact Imperial Health Plan at (626) 838-5100 to obtain criteria used to make a final determination.

National Coverage Determinations

Local Coverage Determinations

Local Coverage Analysis

Medicare Claims Processing Manual

Medicare Benefit Policy Manual

Medicare Managed Care Manual

Medicare Program Integrity Manual

MCG Health

Final Hierarchy Overview for Supplemental Benefits

Hierarchy Level	Source	Purpose
1	Evidence of Coverage (EOC) and Summary of Benefits (SB)	Defines covered supplemental benefits and member entitlements.
2	CMS Medicare Managed Care Manual, Chapter 4	Establishes CMS rules for allowable supplemental benefits.
3	Plan-Specific Policies and Guidelines	Provides plan-level details on benefit administration and provider access.
4	Contractual Agreements with Vendors	Outlines vendor-specific benefit details and reimbursement policies.
5	State-Specific Regulations	Ensures compliance with state laws affecting supplemental benefits.
6	Medicare Marketing Materials (ANOC, SB)	Clarifies benefits for members and serves as a reference for plan communications.

For IHPSW or IIC entities operating in the Exchanges of UT, TX, AZ, or NV, the Hierarchy Criteria Order of Use is as follows:

1. Benefits and Eligibility as defined in the Evidence of Coverage (plan document)
2. Federal Mandates and any applicable State Requirements
3. Any CMS/HHS overriding document (e.g., HCFA Rulings, DAB Rulings)
4. MCG Health, latest edition
5. Any authoritative, peer-reviewed physician specialty society guidelines (e.g., NCCN) or federal government agency publications (e.g., NIH, AHRQ, FDA, CDC)

For any other contract where IHHMG or any medical group under the oversight of IMAS (such as Health Cosmos, Lone Star, etc.) is delegated for UM (for any line of business):

• IHHMG and the entities under IMAS, including these IPAs/medical groups, will adhere to the hierarchy of the delegating entity (plan) as confirmed by their delegation oversight. This should align with the guidelines provided in the Provider Manual of the plan.