5101:3-1-01 **Medicaid: medical necessity.**

(A) "Medical necessity" is a fundamental concept underlying the medicaid program. Physicians, dentists, and limited practitioners render, authorize, or prescribe medical services within the scope of their licensure and based on their professional ~~judgement~~ judgment regarding medical services needed by an individual. Unless a more specific definition regarding medical necessity for a particular category of service is included within division-level designation 5101:3 of the Administrative Code, "medically necessary services" are defined as services ~~which~~ that are necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. A medically necessary service must:

(1) Meet generally accepted standards of medical practice;

(2) Be appropriate to the illness or injury for which it is performed as to type of service and expected outcome;

(3) Be appropriate to the intensity of service and level of setting;

(4) Provide unique, essential, and appropriate information when used for diagnostic purposes;

(5) Be the lowest cost alternative that effectively addresses and treats the medical problem; and

(6) Meet general principles regarding reimbursement for medicaid covered services found in rule 5101:3-1-02 of the Administrative Code.

(B) Preventive health care, though not customarily thought of as a "medically necessary" service, is available through the department's early periodic screening, diagnosis and treatment (EPSDT, also known as HealthChek) program or through managed care plans (MCPs) ~~which~~ that have contracted with the department.

Effective:

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Certification

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Date

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