

<b>Approved by:</b> Optum Medical and Pharmacy Subcommittee	<b>Effective Date:</b> 06/10/26
<b>Clinical Policy Document:</b> Coverage Determination Guidelines	<b>Date Approved:</b> 06/10/26
<b>Reference #:</b> MC/C009	<b>Replaces Effective Clinical Policy Dated:</b> 09/10/25

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## PLANS IN SCOPE

Aspirus Health Plan

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## PURPOSE:

The intent of this policy is to provide guidelines to aid in coverage determinations within the organization’s Utilization Management and Quality Improvement governance framework, including committee oversight and periodic evaluation.

Please refer to the member’s benefit document for specific information. To the extent there is any inconsistency between this policy and the terms of the member’s benefit plan or certificate of coverage, the terms of the member’s benefit plan document will govern.

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## COVERAGE INDICATIONS:

New medical policies proceed to development only after approval under the organization’s policy creation governance process; this policy governs the development, approval, and maintenance phase. Medical policies undergo documented annual review, with each review resulting in one of the following outcomes: no change, revision, or retirement. The following criteria must apply:

- Benefits must be available for health care services.
- Health care services must be proven effective by reliable evidence.
- Health care services must be ordered by a provider, unless otherwise pre-empted by law.
- Health care services must be medically necessary, applicable conservative treatments must have been tried, the most cost-effective alternative must be requested for coverage consideration and not provided specifically for the convenience of the member or provider.

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- Services, drugs, or supplies must be rendered in the most cost-efficient setting or manner appropriate for the condition. Health care service must be based on medical standards and accepted practice parameters of the community and provided at a frequency that is accepted by the medical community as medically appropriate.
  - When standardized tests and measures are used, the most current edition/version of the testing instrument is employed.
  - For continuation of health care services, effectiveness or measurable improvement/progress must be documented and objectively quantified.

## Exclusions

The following exclusions apply:

- Absence of placement and/or availability at a lower level of care does not constitute medical necessity for continuation of care at the current level of care.
- Health care services designated by the CMS Medicare program as Coverage with Evidence Development (CED) are considered investigative and therefore not covered.
- Unnecessary tests and treatments are not covered, such as but not limited to the following:
  - Routine use of preoperative diagnostic testing and imaging in low-risk members for low-risk surgeries
  - Low-value medical procedures including diagnostic imaging and disease screening, including health care services that:
    - Are not supported by evidence
    - May be duplicative of other procedures
    - May provide harm
    - Are validated as unnecessary
  - Procedures determined by other review organizations (ex. Hayes New Technology Summaries, ECRI Health Technology Assessment Information Services, etc.) to be investigational.
- Refer to member's Certificate of Coverage or Summary Plan Description for additional exclusions

## Medical Records Documentation

Benefit coverage is determined by review of member specific benefit plan information and all applicable laws. Medical records documentation may be required to assess if the member meets criteria; however, provision of records does not guarantee coverage.

Documentation irregularities or inconsistencies regarding applicable condition(s) or health care service(s) in the medical record may result in non-coverage. Outcome measures and/or pre-determined goals that are specific, measurable, and relevant to treatment must be defined in the medical record. For continued services, documentation must provide evidence of lasting, sustainable progress with treatment and/or degree of change over time.

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## DEFINITIONS

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Definitions used in medical policies are maintained for consistency across utilization management and coverage policies and are reviewed as part of the annual policy review process.

**Health Care Service:** Medical or behavioral services including pharmaceuticals, drugs, devices, technologies, tests, treatments, therapies, supplies, procedures, hospitalizations, or provider visits.

**Investigative:** As determined by the Plan, a drug, device or medical treatment or procedure is investigative if reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes.

**Medically Necessary:** Any *health care services*, preventive health care services, and other preventive services that Optum and its' customers, in its discretion and on a case-by-case basis, determines are appropriate and necessary in terms of type, frequency, level, setting, and duration, for a diagnosis or condition; and the care must:

Be consistent with the medical standards and generally accepted practice parameters of providers in the same or similar general specialty as typically manages the condition, procedure or treatment at issue; and

Help restore or maintain health; or

Prevent deterioration of a condition; or

Prevent the reasonably likely onset of a health problem or detect an incipient problem.

**Provider:** A health care professional, physician, clinic or facility licensed, certified, or otherwise qualified under applicable state law to provide health care services

**Reliable evidence:** Medical findings based on high quality research and testing to evaluate treatment clinical efficacy and safety. For more information, please refer to policy MC/H001 Hierarchy of Evidence in the Evaluation of Healthcare Services.

**Specific, Measurable, and Functional Goals:** Clearly defined goals of treatment that allow measurement of the amount and/or degree of meaningful change over time. These goals are often determined by the use of functional outcome assessment tools.

**Standardized tests/measures current edition/version:** Standardized tests, scales and outcome measures must meet recognized standards for validity, reliability and precision. Providers must administer, score and interpret standardized tests, scales and outcome measures in accordance with test manuals and/or descriptions in the medical literature. The most current edition/version must be administered.

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## APPLICABLE CODES

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Not applicable

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## POLICY/REVISION HISTORY

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Date	Summary of Changes	Approval By
09/10/2025	Initial Policy Development	Optum Medical and Pharmacy Subcommittee
06/10/2026	Annual Policy Update: Strengthened documentation requirements; definition refinement; clarification of policy intent	Optum Medical and Pharmacy Subcommittee

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## REFERENCES:

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Centers for Medicare & Medicaid Services. (2024). Complying with Medical Record Documentation Requirements (MLN909160). Accessed April 7, 2026  
<https://www.cms.gov/files/document/certmedrecdoc10workgroup.pdf>

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<https://www.uspreventiveservicestaskforce.org/uspstf/about-uspstf/methods-and-processes>

# Nondiscrimination & Language Access Policy



Discrimination is Against the Law. Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation, gender identity and sex stereotypes), consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2). Aspirus Health Plan, Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aspirus Health Plan, Inc.:

Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters.
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Nondiscrimination Grievance Coordinator at the address, phone number, fax number, or email address below.

If you believe that Aspirus Health Plan, Inc. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a *grievance* with:

Nondiscrimination Grievance Coordinator  
Aspirus Health Plan, Inc.  
PO Box 1890  
Southampton, PA 18966-9998  
Phone: 1-866-631-5404 (TTY: 711)  
Fax: 763-847-4010  
Email: customerservice@aspirushealthplan.com

You can file a *grievance* in person or by mail, fax, or email. If you need help filing a *grievance*, the Nondiscrimination Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue, SW  
Room 509F, HHH Building  
Washington, D.C. 20201  
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>. This notice is available at Aspirus Health Plan, Inc.'s website: [https://aspirushealthplan.com/webdocs/70021-AHP-NonDiscrim\\_Lang-Assist-Notice.pdf](https://aspirushealthplan.com/webdocs/70021-AHP-NonDiscrim_Lang-Assist-Notice.pdf).

## Language Assistance Services

**Albanian:** KUJDES: Nëse flitmi shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-800-332-6501 (TTY: 711).

**Arabic:** تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن اعلى رقم الهاتف 1-800-332-6501 (رقم هاتف الصم والبك : 711)

**French:** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-332-6501 (ATS: 711).

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-332-6501 (TTY: 711).

**Hindi:** यान द : य द आप िहंदी बोलते ह तो आपके िलए मु त म भाषा सहायता सेवाएं उपल थ ह 1-800-332-6501 (TTY: 711) पर कॉल कर ।

**Hmong:** LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-332-6501 (TTY: 711).

**Korean:** 주의: 한국어를 사용하지는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-332-6501 (TTY: 711) 번으로 전화해 주십시오.

**Polish:** UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-332-6501 (TTY: 711).

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-332-6501 (телетайп: 711).

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-332-6501 (TTY: 711).

**Tagalog:** PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1-800-332-6501 (TTY: 711).

**Traditional Chinese:** 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-332-6501 (TTY: 711)

**Vietnamese:** CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-332-6501 (TTY: 711).

**Pennsylvania Dutch:** Wann du Deitsch (Pennsylvania German / Dutch) schwetzsch, kamscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-332-6501 (TTY: 711).

**Lao:** ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ໂດຍບໍ່ເສັຽຄ່າ, ຈະມີມື້ອມໃຫ້ທ່ານ. ໂທສ 1-800-332-6501 (TTY: 711).