Medicare Advantage Medical Policy Management

Medicare Advantage Medical Policy #MA-089
Original Effective Date: 03/01/2025
Current Effective Date: 03/01/2025

Applies to all products administered or underwritten by the Health Plan, unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Policy Hierarchy

The Medicare Advantage (MA) Plan uses guidance from the Centers for Medicare and Medicaid Services (CMS) for coverage determinations. The MA Plan's medical policies follow Medicare Advantage Policy Guidelines to comply with the CMS Policy, National Coverage Determinations (NCDs) and /or Local Coverage Determinations (LCDs). When coverage criteria are not fully established by Medicare statutes, NCDs or LCDs we develop medical necessity guidelines that provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services.

Per CMS requirements, MA Medical Policy will be determined using the following hierarchy:

1. **National Coverage Determinations (NCDs)**
2. **Local Coverage Determinations (LCDs) Novitas Solutions Inc.**
3. **Internal Medical Policy**
4. **InterQual®**
5. **LCDs from Other Medicare Administrator Contractors**

Policy Guidelines

Medicare Advantage Administrative Guidelines
To access CMS NCDs and LCDs, click Medicare Coverage Database to begin your search.

National Coverage Determinations (NCDs)
For some services, procedures, and technologies, CMS has published an NCD, which is to be applied on a national basis for all Medicare beneficiaries. NCDs are binding for all Medicare Advantage plans.

To review the specific NCDs, please click "accept" on the CMS licensing agreement at the bottom of the CMS webpage when prompted. Click MCD Search Results to see the NCDs alphabetical index.

Local Coverage Determinations (LCD)
When there is no NCD or other coverage provision outlining medical necessity criteria within a Medicare manual, or when there is a need to further define an NCD, then the MAC for a service area may develop a local coverage determination (LCD) or article.

For services, procedures, and technologies, the MA Plan will utilize LCDs appropriate for this region as approved by CMS. Novitas Solutions Inc. is the primary designated MAC to follow for

this MA Plan's service region. When there is not a Novitas LCD available, other approved regional LCDs, specifically CGS Administrators, LLC and Wisconsin Physicians Service Government Health Administrators (WPS), will be utilized.

Novitas Solutions Inc. is available at https://www.novitas-solutions.com/webcenter/portal/NovitasSolutions.

To review the specific Novitas Solutions LCDs, please click "accept" on the Novitas Solutions licensing agreement on the home page when prompted. Click to see the LCDs alphabetical index.

In addition, this MA Plan has implemented the guidelines published by Palmetto GBA under the Molecular Diagnostic (MolDX®) Program for this service area, which address genetic and molecular diagnostic testing.

LCDs included in the MolDX® program are available at Palmetto GBA MolDX LCDs.

MA Plan Medical Policies
In the absence of a national or local Medicare coverage guidance regarding medical treatments, procedures, drugs, devices or biological products, then CMS guidelines allow for the MA Plan to make its own coverage determination. However, it must use an objective, evidence-based process based on authoritative evidence. In these situations, the MA Plan may apply Medical Policy criteria to the services under review. The MA Plan's medical policies are developed following an objective, evidence-based process based on scientific evidence, generally accepted and current standards of medical practice, and authoritative clinical practice guidelines.

The MA Plan may consider some services to be investigational. *When a procedure or device is deemed "investigational" by the MA Plan, the term "investigational" is* ***not*** *meant to imply the procedure or device has not received approval by the Food and Drug Administration (FDA). Rather, the use of this term simply means the procedure or device does not meet the health plan's objective, evidence-based technology assessment based on authoritative evidence*.

In addition, most services related to or required as a result of non-covered services are also non-covered under Medicare. Thus, services directly associated with the investigational procedure or technology may also be denied as not medically necessary. As previously stated, the issuance of a procedure code (CPT or HCPCS) or FDA approval is not sufficient for a procedure to be considered medically reasonable and necessary. While the FDA reviews data from studies and clinical trials to determine safety and effectiveness prior to approval, it does not establish medical necessity of that device or drug. Medicare may adopt FDA determinations regarding safety and effectiveness, but Original Medicare, Medicare contractors, and Medicare Advantage Organizations evaluate whether or not the drug or device is reasonable and necessary for the Medicare population under §1862(a)(1)(A).

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InterQual®

If no policy criteria are available within an NCD, LCD, coverage manual, article, or existing medical policy for the services in question, Interqual® criteria may be applied when available.

The MA Plan is allowed to use LCD guidance from the following MACs that are cited within Medicare InterQual® criteria:

- CGS Administrators, LLC; available at https://www.cgsmedicare.com/
- Palmetto GBA; available at https://www.palmettogba.com/
- Noridian Healthcare Solutions; available at https://www.noridianmedicareportal.com/
- Wisconsin Physician Service Government Health Administrators (WPS); available at https://www.wpsgha.com/
- First Coast Service Options, Inc.; available at https://www.fcso.com/

InterQual® can be accessed by providers and members through the Interqual® Transparency Tool. Click Sign In – One Healthcare ID to register and access the InterQual® tool.

Use of LCDs from Other Medicare Administrator Contractors

If no policy criteria are available within an NCD, LCD, coverage manual, article, or existing medical policy for the services in question, the MA Plan may reference the LCDs below from other MACs.

LCD Number	Title	MAC	Last Reviewed Date
L34049	LCD - Outpatient Physical and Occupational Therapy Services (L34049)	CGS Administrators	02/18/2025
L37641	LCD - Continuous Peripheral Nerve Blocks (CPNB) (L37641)	Palmetto GBA	02/18/2025
L34032	LCD - Debridement Services (L34032)	CGS Administrators	02/18/2025
L37379	LCD - Echocardiography (L37379)	Palmetto GBA	02/18/2025
L34636	LCD - Electrocardiographic (EKG or ECG) Monitoring (Holter or Real-Time Monitoring) (L34636)	WPS	02/18/2025
L33818	LCD - Excision of Malignant Skin Lesions (L33818)	First Coast Service Options	02/18/2025
L37632	LCD - Spinal Cord Stimulators for Chronic Pain (L37632)	Palmetto GBA	02/18/2025

L39420	LCD - Thermal Destruction of the Intraosseous Basivertebral Nerve (BVN) for Vertebrogenic Lower Back Pain (L39420)	Palmetto GBA	02/18/2025
L34417	LCD - CT of the Head (L34417)	Palmetto GBA	02/18/2025
L33950	LCD - Breast Imaging Mammography/Breast Echography (Sonography)/Breast MRI/Ductography (L33950)	CGS Administrators	02/18/2025
L33960	LCD - Cardiovascular Nuclear Medicine (L33960)	CGS Administrators	02/18/2025
L33457	LCD - Cardiac Radionuclide Imaging (L33457)	Palmetto GBA	02/18/2025
L38769	LCD - Computed Tomography Cerebral Perfusion Analysis (CTP) (L38769)	Palmetto GBA	02/18/2025
L33459	LCD - Computerized Axial Tomography (CT), Thorax (L33459)	Palmetto GBA	02/18/2025
L34008	LCD - Computerized Corneal Topography (L34008)	CGS Administrators	02/18/2025
L34415	LCD - CT of the Abdomen and Pelvis (L34415)	Palmetto GBA	02/18/2025
L34425	LCD - Magnetic Resonance Imaging of the Head and Neck (L34425)	Palmetto GBA	02/18/2025
L34045	LCD - Non-Invasive Vascular Studies (L34045)	CGS Administrators	02/18/2025
L33667	LCD - Duplex Scan Of Lower Extremity Arteries (L33667)	First Coast Service Options	02/18/2025
L33449	LCD - Swallowing Studies for Dysphagia (L33449)	Palmetto GBA	02/18/2025
L33977	LCD - Transcranial Doppler Studies (L33977)	First Coast Service Options	02/18/2025
L39851	LCD - Artificial Intelligence Enabled CT Based Quantitative Coronary Topography (AI-QCT)/Coronary Plaque Analysis (AI-CPA) (L39851)	Palmetto GBA	02/18/2025

Background/Overview

Medicare Advantage Policy Guidelines are developed as needed and are subject to a minimum of an annual review, update and approval by a Utilization Management (UM) Committee. When there is not clear CMS guidance, NCDs or LCDs, an established process exists within the Health Plan. The extensive review of the medical policies ensures guidelines are based on the highest level of evidence currently available in clinical literature, widely accepted professional guidelines, clinical effectiveness data, community physicians and rigorous new technology assessment reports. The committee makes final recommendations for approval and implementation and reports out to the UM Committee.

The medical policies are provided as information only for the purpose of transparency of the criteria or medical necessity guidelines used in determining coverage for payment purposes. The existence of the medical policy is not an authorization, certification, explanation of benefits, or a contract for the services, devices, or drugs that is referenced in the medical policy. Medical policies do not constitute medical advice and do not guarantee any results or outcomes. Medical policy is not intended to replace independent medical judgment for treatment of individuals. Treating physicians and health care providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to individual plan documents.

References

1. Title XVIII of the Social Security Act, §1862(a)(1)(A)
2. Medicare Claims Processing Manual, Pub. #100-04, Chapter 23 - Fee Schedule Administration and Coding Requirements, §30 - Services Paid Under the Medicare Physician's Fee Schedule, A. Physician's Services
3. Medicare Managed Care Manual, Pub. #100-16, Chapter 4 - Benefits and Beneficiary Protections, §90.1 – Overview
4. Medicare Managed Care Manual, Pub. #100-16, Chapter 4 - Benefits and Beneficiary Protections, §90.6 – Sources for Obtaining Information
5. Medicare Managed Care Manual, Pub. #100-16, Chapter 4 - Benefits and Beneficiary Protections, §90.3 – General Rules for NCDs
6. Medicare Managed Care Manual, Pub. #100-16, Chapter 4 - Benefits and Beneficiary Protections, §90.4.1 – MACS with Exclusive Jurisdiction over a Medicare Item or Service
7. Molecular Diagnostics (MolDX) Program General Webpage
8. Medicare Managed Care Manual, Pub. #100-16, Chapter 4 - Benefits and Beneficiary Protections, §90.5 - Creating New Guidance
9. Medicare Benefit Policy Manual, Pub. #100-02, Chapter 16 - General Exclusions From Coverage, §180 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare

Policy History

Original Effective Date: 03/01/2025
Current Effective Date: 03/01/2025
02/18/2025 Utilization Management Committee review and approval. New Policy.
Next Scheduled Review Date: 03/2026

**Medically Necessary (or "Medical Necessity") - Health care services, treatment, procedures, equipment, drugs, devices, items or supplies that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

A. In accordance with nationally accepted standards of medical practice;
B. Clinically appropriate, in terms of type, frequency, extent, level of care, site and duration, and considered effective for the patient's illness, injury or disease; and
C. Not primarily for the personal comfort or convenience of the patient, physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient's health insurance contract contains language that differs from the Health Plan's Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Health Plan recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

Medicare Advantage Members

Established coverage criteria for Medicare Advantage members can be found in Medicare coverage guidelines in statutes, regulations, National Coverage Determinations (NCD)s, and Local Coverage Determinations (LCD)s. To determine if a National or Local Coverage Determination addresses coverage for a specific service, refer to the Medicare Coverage Database at the following link: https://www.cms.gov/medicare-coverage-database/search.aspx. You may wish to review the Guide to the MCD Search here: https://www.cms.gov/medicare-coverage-database/help/mcd-benehelp.aspx.

When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, internal coverage criteria may be developed. This policy is to serve as the summary of evidence, a list of resources and an explanation of the rationale that supports the adoption of this internal coverage criteria.

InterQual®
Interqual® is utilized as a source of medical evidence to support medical necessity and level of care decisions. InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider. InterQual® criteria are clinically based on best practice, clinical data, and medical literature. The criteria are updated continually and released annually. InterQual® criteria are a first-level screening tool to assist in determining if the proposed services are clinically indicated and provided in the appropriate level or whether further evaluation is required. The utilization review staff does the first-level screening. If the criteria are met, the case is approved; if the criteria are not met, the case is referred to the medical director.