COVERAGE DETERMINATIONS:

Farm Bureau HEALTH PLANS Tennessee®

Medicare Advantage (MA) and Medicare Prescription Drug (Part D) Plans

FBHP's policy is to ensure sound clinical evidence for Utilization Management (UM) decisions, to provide consistent application of evidence, and to consider member circumstances when conducting reviews. Our UM program uses evidence-based, clinical review criteria to support clinical review decisions. Cases requiring clinical review are forwarded to nurses or physicians for review. Medical directors offer peer-to-peer conversations with ordering physicians and mid-level providers as needed if determinations are adverse or whenever requested by ordering physicians or mid-level providers. The Medical Management Committee is responsible for overseeing the implementation and evaluation of the UM program.

FBHP maintains a list of procedures and supplies that the Plan has determined require Prior Authorization (PA). This list is publicly available on the plan's website and all contracted providers are educated on the process to request a PA.

Decision criteria are available to providers and members upon request. Application of criteria is reviewed in context of the member's age, co-morbidities, medical history, extenuating circumstances, complications, and/or response to treatment to determine reasonable and necessary coverage for the Medicare beneficiary. Providers and members may contact the Utilization Management (UM) Department to request access to clinical review criteria.

The UM Department can be reached toll-free at 1-800-608-2667.

The utilization review clinical team uses the following hierarchy, in the order listed, to review for medical necessity.

1. Health Plan eligibility and coverage-benefit plan packages:

a. The enrollee must be eligible for benefit coverage at the time the service is provided. Without benefit coverage on the date of service, the service is NOT covered, even if supported by scientific evidence. The requested service or supply must be covered by the member's plan as evidenced by a Certificate of Coverage (COC), Evidence of Coverage (EOC), Coverage of Benefits (COB) or Summary Plan Description (SPD)

b. Where no applicable federal, state, or contractual requirements exists the coverage/benefit document take precedence over medical policy.

c. Services that are explicitly included or excluded from coverage in the benefit document take precedence over medical policy.

d. In the event of a conflict between the benefit document and medical policy, the enrollee's specific benefit document takes precedence over medical policy.

2. Federal, State or Contractual Requirements for Coverage:

a. CMS National Coverage Determination (NCD); AND/OR,

b. Medicare Benefit Policy Manuals/ CMS Issued Statutes/Section 1862 of the Social Security Act (e.g. Medicare Policy Benefit Manual, Medicare Managed Care Manual, Medicare Claims Processing Manual, and the Medicare Learning Network); AND/OR

c. Local Coverage Determination (LCD) of Local Coverage Articles (LCA) applicable to plan's jurisdiction.

3. Health plan criteria when no other criteria applicable

a. Local Coverage Determinations outside of the plan's jurisdiction may be considered at the discretion of the plan Medical Director completing the review; OR

b. Medical Policies; OR

c. Drug Policies – Medication determinations; OR

d. Transplant Review Guidelines for transplant determinations; OR

e. InterQual a clinical decision, support criteria tool used for determining Level of Care, length of stay (LOS) and predetermination supported by evidence-based resources; OR

f. In the absence of applicable InterQual or medical policies mentioned above, other established evidence and/or guidelines may be used.

This may include:

i. Evidence-based guidelines (e.g., NCCN Clinical Practice Guidelines in Oncology) that have been approved by the appropriate line of service and standing committee;

ii. Studies from government agencies (e.g., the FDA);

iii. Evaluations performed by independent technology assessment groups (e.g., BCBSA); and/or

iv. Well-designed controlled clinical studies that have appeared in peer review journals.

Information to support UM decision making process may include:

- Pertinent patient history related to the requested service.
- Physical examination that addresses the area of request
- Laboratory and/or x-ray results to support the request.
- PCP and/or specialist progress or consultation notes.
- Any other relevant information or date specific to the request.

Characteristics of the local delivery system that are available for the Member are also taken into consideration. This includes:

- Availability of inpatient, outpatient, and transitional facilities
- Availability of outpatient services in lieu of inpatient services such as surgicenters vs. inpatient surgery
- Availability of highly specialized services, such as transplant facilities or cancer centers
- Availability of alternate level of care facilities or home care in FBHP's service area to support the member after hospital discharge
- Availability of skilled nursing facilities, sub-acute care facilities or home care where needed
- Ability of local hospitals to provide all recommended services within the recommended length of stay.