

**MEDICAL ASSOCIATES HEALTH PLANS**  
**HEALTH CARE SERVICES POLICY AND PROCEDURE MANUAL**  
**POLICY NUMBER: PP 64**

**POLICY TITLE:** Determining Coverage of Advancing Medical Technology

**POLICY STATEMENT:** Medical Associates Health Plans has established this policy to formalize the process by which the Plan evaluates the inclusion of new medical technologies and the new application of existing technologies, including medical procedures, pharmaceutical, behavioral health procedures, new vaccines and devices into the benefit package.

**POLICY:**

1. In order to meet criteria for coverage, a technology must meet the following:
  - a. The technology must have final approval from the appropriate government regulatory bodies.
  - b. The scientific evidence must permit conclusions concerning the effect of the technology in health outcomes.
  - c. The technology must improve the net health outcome.
  - d. The technology must be as beneficial as any established alternatives.
  - e. The improvement must be attainable outside the investigational setting.
2. Coverage by Medicare implies meeting established criteria.
3. Requests for certification of new medical technologies or new uses of existing technologies will be based upon:
  - a. scientific research
  - b. current medical literature and
  - c. in accordance with current community standards
4. Upon request by members, providers, or Plan practitioners, the requester shall be asked to supply literature that supports the therapy requested. The Chief Medical Officer/Utilization Management Committee will perform an in-depth review of literature provided by the requesting party, and perform additional literature search, as required. Professionals or specialists with expertise related to the technology shall be utilized to evaluate the information.
5. All new technology requests are reviewed using resources of other health plan payers, Apollo Medical Review Criteria or information obtained, as appropriate, from government regulatory bodies, as well as current published literature related to the technology.
6. Requests for certification of new medical technologies and/or new uses of existing technologies shall be reviewed by the Utilization Management and Quality Improvement Committees, with the ultimate decision resting with the Clinic Board of Directors.
7. In cases where the request will affect/delay active treatment of an enrollee, the request will be handled in an expedited process. Expedited procedures are available to all enrollees if health, life, or ability to repair maximum function may be jeopardized. The Chief Medical Officer will approve/deny such requests on an as needed basis. The request for medical technology will then be taken to the Utilization Management Committee and Quality Improvement Committee for review, with the ultimate decision resting with the Clinic Board of Directors.

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8. Should determination/findings support a change in policy for the Plan, the Chief Medical Officer or designee, with the assistance of professionals with expertise in the technology, shall create a formal policy and the criteria for its application. Policies shall be reviewed by the Utilization Management and Quality Improvement Committees. Final approval will be issued by the Clinic Board of Directors.
9. The policy change shall be communicated, as appropriate, to network physicians and enrollees.
10. Denials are communicated according to Policy #2 Health Care Services Denial.
11. The Chief Medical Officer or designee will have the responsibility to provide to the requesting party, evidence that supports coverage decisions when questioned in conjunction with a member or practitioner appeal.

All new policies created will be added to the Policy and Procedure Manual, as appropriate.

**PROCEDURE:**

1. Provider, Member or Plan Practitioner requests review of a new medical technology or new application of an existing technology.
2. Case Manager will forward petition with supporting documentation to the Chief Medical Officer or designee for evaluation.
3. The Chief Medical Officer or designee performs further current literature and governmental regulatory body search if insufficient documentation is provided by the requester.
4. The Chief Medical Officer or designee reviews the information supplied in conjunction with the criteria for evaluation and determines if a specialist review is necessary.
5. Chief Medical Officer forwards case and/or technology to be assessed to the Utilization Management Committee for review and recommendations. Decisions impacting potential changes to benefit coverage are referred to the Health Plans' Management Staff for analysis and implementation.
6. Once coverage determination has been ascertained, the recommendation by the Utilization Management Committee will be forwarded to the Quality Improvement Committee. The Quality Improvement Committee will provide recommendation to the Clinic Board of Directors for final approval.
7. These coverage changes will also be incorporated into established Hospital Utilization Review Criteria and authorization of Out-of-Plan Referral Criteria.
8. Decisions will be communicated verbally to the member and/or practitioner. Subscriber contract addendums are mailed as indicated, decisions affecting a larger population are

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communicated via provider/member newsletters and/or Provider Reference Guide. Denials are communicated according to Health Care Services Policy #2 Health Care Services Denial.

9. Once the medical technology has been given the final approval by the UMC, QIC and MAC BOD, the decision is communicated to the Senior Management of MAHP via email and/or at the next Management meeting.

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Date

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 Director of Health Care Services/Quality Improvement

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Date

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