

Medicare Advantage Medical Policy



Medicare Advantage Coverage Determination Hierarchy

PURPOSE

The purpose of this policy is to outline the process for applying coverage determination guidance in accordance with Centers for Medicare and Medicaid Services (CMS) regulations, ensuring compliance and consistency in decision-making for Medicare Advantage plan members while promoting clinically appropriate outcomes.

SCOPE

This policy applies to all Medicare Advantage products offered by Blue Cross Blue Shield of Michigan (BCBSM)/Blue Care Network (BCN), including Medicare Plus Blue PPO and Blue Care Network Advantage.

POLICY

BCBSM/BCN is responsible for adhering to Centers for Medicare and Medicaid Services (CMS) regulations, as outlined in § 422.101(c), when determining whether a service or item is "reasonable and necessary" for coverage. According to the Social Security Act, § 1862(a)(1)(A), a service or item is considered "reasonable and necessary" if it is essential for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member. FDA approval or the assignment of a CPT code does not automatically render a procedure medically reasonable and necessary. Similarly, the inclusion of a procedure or device code in the Medicare fee schedule does not guarantee coverage. If a service is deemed not reasonable and necessary due to concerns about safety, efficacy, or investigational in nature, it is considered non-covered.

As a Medicare Advantage (MA) plan, BCBSM/BCN is required to provide the same medical benefits as Original Medicare. Consistent with Original Medicare guidelines, we will cover items and services that meet one of the following criteria: (1) classified as an Original Medicare benefit, (2) covered by CMS National Coverage Determinations (NCDs), or (3) authorized by written Local Coverage Decisions (LCDs) or Local Coverage Articles (LCAs) issued by Medicare Administrative Contractors (MACs).

When Medicare statutes, regulations, NCDs, or LCDs do not provide comprehensive coverage criteria, the CMS permits MA plans, such as BCBSM/BCN, to develop and utilize internal coverage criteria policies. These policies must be grounded in current evidence-based practice, as supported by widely recognized treatment guidelines or clinical literature and be made publicly available as outlined in § 422.101(b)(6).

BCBSM/BCN will utilize an internal coverage policy for a specific medical condition only in the absence of a fully established Medicare statutes, regulations, NCD, LCD, or LCA. Medicare statutes, regulations, NCD, or LCD is considered not fully established when one or more of the following conditions are met as outlined in § 422.101(6)(i):

1. Additional, unspecified criteria are needed to interpret or supplement general provisions in order to determine medical necessity consistently. The MA organization must demonstrate that the additional

criteria provide clinical benefits that are highly likely to outweigh any clinical harms, including from delayed or decreased access to items or services; or

2. NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD; or
3. There is an absence of any applicable Medicare statutes, regulations, NCDs or LCDs setting forth coverage criteria.

Medicare Advantage medical coverage policies will indicate the criteria to be used to determine when medical service or item is considered “reasonable and necessary”.

The MA Plan may consider some services to be investigational and thus, not reasonable and necessary. 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).

POLICY GUIDELINES

BCBSM/BCN applies the following defined hierarchy for policy coverage determinations:

1. Eligibility
2. Evidence of Coverage
3. CMS
 - a. The Law, Regulations, and Medicare Manuals
 - b. NCD
 - c. LCD/LCA within BSBSM/BCN geographical service area when NCD is considered not fully established
4. Medicare Advantage Medical Policy references to internal non-CMS sourced guidance when CMS is considered not fully established, which may include:
 - a. BCBSM/BCN internal coverage criteria established in medical policies
 - b. Third party set of evidence-based clinical care guidelines (e.g., Change Healthcare InterQual® Criteria)
 - c. LCD outside of BCBSM/BCN geographical service area when no applicable LCD within BCBSM/BCN geographical service area exists
5. Independent medical research, which may be found in generally accepted research sites when no CMS or Medicare Advantage Medical Policy guidance is available (e.g., Hayes)

DEFINITIONS

NCDs are developed by the CMS and applied to all claims on a nationwide basis. An NCD indicates whether specific medical items, services, treatment procedures or technologies can be paid for under Medicare. Decisions that an item or service is not covered are generally based on “not reasonable and necessary,” or other statutory authority (Federal Register, national CMS guidelines, etc.). CMS can publish revisions and updates on a quarterly basis. NCDs

are binding on all Medicare carriers, fiscal intermediaries, quality improvement organizations, health maintenance organization, competitive medical plans, and health care payment plans. Under 42 CFR 422.256(b), an NCD that expands coverage is also binding on an MA organization.

LCDs are decision by a local MAC and are applicable only within the issuing MAC's jurisdiction(s). LCDs generally describe the criteria and coverage limitations that apply to medical items, procedures, or services for coverage and payment purposes that were not articulated in an NCD. LCDs for a jurisdiction will often provide additional guidance. LCDs can vary by region and revisions and updates can occur anytime. LCDs are binding only on the Medicare Contractor that issued the LCD.

LCAs are typically published by a local MAC to provide coding/billing guidelines or other provider education that is complementary to an existing NCD or LCD. In some cases, LCAs may be issued by MACs as independent policies. Like LCDs, LCAs apply only to the MAC that issued the article.

BACKGROUND

Medicare Advantage policies are developed as needed and are subject to a minimum of an annual review, update, and approval by a Utilization Management (UM) Committee. The committee ensures that guidelines are based on the highest level of evidence currently available in clinical literature, widely accepted professional guidelines, clinical effectiveness data, and community physicians.

REFERENCE

1. Social Security Administration (SSA). Section 1862(a)(1)(A). Accessed 06/05/2025 https://www.ssa.gov/OP_Home/ssact/title18/1862.htm
2. Pub. 110-04, Medicare Claims Processing Manual, Chapter 23 Fee Schedule Administration and Coding Requirements, § 30 Services Paid Under the Medicare Physician's Fee Schedule, A. Physician's Services. Accessed 06/05/2025 <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c23.pdf#page=30>
3. 42 CFR § 422.101 – Requirements Relating to Basic Benefits.
4. 45 CFR § 146.136 – Mental Health Parity and Substance Use Disorder Benefits
5. 42 CFR § 422.109 – Effect of National Coverage Determinations (NCDs) and Legislative Changes in Benefits
6. 42 CFR § 422.137 - Medicare Advantage Utilization Management Committee
7. 42 CFR § 422.562 – General Provisions
8. Title 18 Social Security Act, Sec. 1862 – Exclusions from Medicare as Secondary Payer

Revision History

Rev #	UMC Approval Date	Change Description
1.0	07/31/2025	New Policy - utilization management requirements in the 2024 Medicare Advantage (MA) final rule