Policy

DEPARTMENT: Utilization Management	**POLICY #:** UM.040
TITLE: Coverage Determinations	**VERSION:** 4
REVIEW APPROVED BY: UM Committee	**REVIEW APPROVAL DATE:** 3/24/2024, Rev 12/18/2024, Rev 6/5/2025, 12/12/2025
	POLICY COMMITEE APPROVAL DATE: 1/12/26
RELATED DEPARTMENTS:	
DEPENDENCIES: N/A	

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Purpose

This policy outlines Longevity Health Plan's coverage determination process for beneficiaries including the development, selection, and application of coverage criteria.

Definitions, Abbreviations, and Acronyms

Acronym	Meaning
Plan	Longevity Health Plan
CMS	Centers for Medicare and Medicare Services
LCD	Local Coverage Determinations
NCD	National Coverage Determinations
UM	Utilization Management

Policy

The Plan follows CMS guidance as it relates to the determination of coverage and appropriateness of services for the Plan membership. This policy broadly outlines the process for determination of service coverage.

Medicare Allowable Services

The Plan will abide by the parameters set by CMS regarding Medicare covered services. The services may be subject to prior authorization and/or referral. The Plan will not cover services not covered by Medicare unless specifically stipulated as a covered benefit in the supplemental benefits package or overall plan design. The Plan reviews its Utilization Management (UM) criteria and procedures against current clinical and medical evidence, and updates them, when appropriate. If new scientific evidence is not available, the UM committee may determine if further review of a criterion is necessary.

Providers Rendering Care

For services requiring medical necessity review and prior authorization, the Plan reserves the right to recommend providers to render the care at the Plan's discretion.

Medical Necessity Decisions

The Plan requires prior authorization for some services. The list of services for which prior authorization is required can be found on the Plan website: www.longevityhealthplan.com. The Plan considers at least the following characteristics when applying criteria to each individual: age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment (when applicable). The Plan's UM policies and procedures consider the availability of services in the local delivery system and their ability to meet the member's specific health care needs, when UM criteria are applied.

The determination for medical necessity is based on the below criteria hierarchy to be followed in utilization management (UM) decisions, in accordance with guideline requirements. The organization reviews its UM criteria and procedures against current clinical and medical evidence, and updates them, when appropriate. If new scientific evidence is not available, the UM committee may determine if further review of a criterion is necessary.

1. **CMS Coverage Policies:**

   - UM decisions must align with CMS coverage policies and guidelines. These policies serve as the primary source for determining the medical necessity and appropriateness of services.

2. National Coverage Determinations (NCDs):

   - NCDs issued by CMS define whether a particular service or item is covered nationally under Medicare. UM decisions should adhere to NCDs when applicable.

3. Local Coverage Determinations (LCDs):

   - LCDs provide guidance on Medicare coverage at the regional level. UM decisions should comply with LCDs specific to the geographic area where the service is being provided.

4. Medicare Benefit Policy Manual:

   - The Medicare Benefit Policy Manual outlines the general principles for determining coverage and payment policies for Medicare services. UM decisions should be consistent with the provisions outlined in this manual.

5. Utilization Review Criteria and Plan Specific Policies:

   - Utilization review criteria, such as InterQual or Milliman guidelines, provide evidence-based criteria for determining the medical necessity and appropriateness of services. UM decisions should align with these criteria when making coverage determinations.
   - Plan-specific policies and guidelines established by the health plan should also be considered in UM decisions if CMS Coverage Policies, NCDs, LCDs, or guidance from the Medicare Benefit Policy Manual are not applicable to the service being requested. These policies may include additional criteria or requirements beyond CMS guidelines.

Part B Pharmaceuticals

The Plan will abide by the parameters set by CMS regarding Medicare covered services. These services may require prior authorization to determine medical necessity. The Plan will utilize CMS coverage policies, NCDs, and LCDs to make coverage determinations for Medicare Part B drugs. This includes pharmaceuticals administered or dispensed in all settings.

For Medicare Part B drugs, the Plan does not maintain a formulary or require specific pharmaceutical classes, generic substitution, therapeutic interchange, or step therapy. The Plan does not place any restrictions or limitations on the use of certain pharmaceuticals. Specific drug selection is at the discretion of the ordering provider.

An annual review and update of policies and procedures related to pharmaceuticals covered under Medicare Part B is performed by the Utilization Management Committee, and involves clinical pharmacists as needed. These policies and procedures are available in the Plan's provider manual and on the Plan's website for both Providers and Members. This information is updated at least annually and when updates are made.

Information about pharmaceutical management procedures, including pharmaceuticals covered under Medicare Part B and Part D dispensed in all settings, is available on the Plan's website for Members and prescribers. This information is provided by mail upon request. This information is updated annually and after updates are made. Members and prescribers are notified annually and when significant changes are made, as required by CMS**.**

New Technology Evaluation

The Utilization Management Committee is the formal mechanism to evaluate and address new developments in technology and new applications of existing technology for inclusion in LH benefit plans. This includes the evaluation of medical procedures, behavioral healthcare procedures, pharmaceuticals, and devices. New technologies, including pharmaceuticals, when covered, are supported by scientific evidence, peer-reviewed literature, and/or evaluation by national medical associations.

As part of the formal review process, members of the Utilization Management Committee will incorporate input from relevant specialists and professionals who have expertise in the new technology as needed to support access to safe and effective care. Behavioral healthcare professionals are involved in the decision-making process for behavioral healthcare services. The Plan reviews information from appropriate government regulatory bodies such as CMS and the FDA and published scientific evidence in peer-reviewed medical literature.

The Plan uses the following objective criteria, as appropriate, to assess new technologies or new applications of existing technologies including medical and behavioral healthcare procedures, pharmaceuticals, and devices. The technology/service must meet all of the following:

- Must be medically necessary and appropriate.
- Must have final approval from the appropriate regulatory body, such as the FDA, and used for the approved indications and age.
- Must be supported by published scientific evidence in peer-reviewed medical literature demonstrating consistent and repeatable outcomes or recommendations from professional societies.
- Is generally accepted as safe and effective by the medical community and is furnished in a manner consistent with community standards of care.
- Must be as beneficial as any established alternative.
- Must provide measurable improvement in health outcomes or health risks.
- Must have documented obtainable improvement outside of the investigational settings.
- Must be furnished in a setting (place of service) consistent with the patient's medical needs and condition.
- Is furnished at a level, duration, dosage, or frequency appropriate for the patient or clinical condition.
- Is not considered obsolete by the medical community and replaced by more efficacious services.
- Is not furnished in a manner primarily for the convenience of the patient or provider.

- In addition, the following is taken into consideration:
    - Acceptance as a national standard, medical specialty society position statement, or clinical practice guidelines;
    - Determination and program memoranda from the Centers for Medicare and Medicaid Services (CMS).

New technologies that do not meet the above criteria are considered experimental and investigational and therefore, not covered by the Plan.

Change Log

Document Version	Major or Minor Revision?	Date	Name	Comments
1	NEW	3/26/2024	Stefanie Caswell	NEW
2	Minor	12/15/2024	Stefanie Caswell	Formatting updates, minor language updates
3	Major	6/1/2025	Stefanie Caswell	Addition of clarifying information and information surrounding new technology evaluation
4	N/A	12/12/2025	Stefanie Caswell	Annual Review, No changes