

MEDICA®

Background Information, June 2009

What are coverage policies?

Coverage policies are developed to communicate the Benefit Interpretation Committee's decisions about coverage and benefits for various medical services. Each coverage policy contains a description of the medical service, as well as the coverage determination, product application, coding considerations and requirements for prior authorization. For medical services that require prior authorization, please refer to the utilization management (UM) policies section of your manual.

How are coverage policies developed?

Medica's Product Management department chairs the benefit interpretation and coverage determination process with executive sponsorship by the Senior Vice President and Chief Medical Officer. Potential topics for review are identified by the Medical Technology Assessment Committee and other departments within Medica. Topics are researched and documented using a comprehensive decision tool. Determinations are made after considering analysis of assessments from the Medical Technology Assessment Committee, market segment requirements, specific product issues, regulatory/compliance issues, financial impact, operational issues, community standards, and other pertinent factors.

A coverage policy is drafted based on the Benefit Interpretation Committee's coverage determination. The approved policy is posted on medica.com. Coverage policies are reviewed at least every three years.

Role of Medical Technology Assessment in Medica's Coverage Decisions:

Coverage decisions on new developments in medical technology are made through a systematic, evidence-based assessment process. New developments in technology are identified through provider, customer, or internal inquires, monitoring of the literature and regulatory agencies. Internal committees, which include medical directors, use an evidence-based approach in determining the investigative status of a technology. Technologies are evaluated for their safety, effectiveness, and effect on health outcomes.

The evidence used when making a determination includes the following:

- Well-designed and well-conducted investigations published in peer-reviewed medical journals. The quality of the studies and consistency of results are considered.
- National medical association and consensus or expert panel opinions
- Technology assessment reports
- FDA and other regulatory approval status
- Local physician input including network specialty physicians and other local consensus opinions, such as the Institute for Clinical Systems Improvement (ICSI).

Medica reviews medical technologies for which a coverage determination has been made at least every three years or sooner if changes in the medical literature or community practice dictate. Medica continuously monitors new information on existing coverage and UM policies to ensure that the policies reflect the most up-to-date reliable clinical data and community standards of care.

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What is the Benefit Interpretation Committee?

The Benefit Interpretation Committee is an internal cross-functional committee charged with making coverage determinations for Medica. The committee also makes benefit interpretation and assessment determinations. The Benefit Interpretation Committee evaluates coverage and makes determinations using a comprehensive decision-making process. The Benefit Interpretation Committee is governed by Medica officers.

How do I obtain future updates or additional coverage policies?

Information regarding new or updated coverage policies will be available through a number of sources:

- Medica's Web site in the "Providers," "Clinical & Quality Resources," "Medical Policies" section at www.medica.com.
- Published list of updates published in *Connections* and other standard, regularly published communications.
- To receive the latest update or current copies of coverage policies, call the Provider Literature Request Line at 1-800-458-5512, select option 1, and then select option 5, ext. 2-2355.