Community Care

POLICY AND PROCEDURE

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Title: Prior Authorization Criteria Guide

Policy Identifier: UM - Utilization Management

Scope: ( ) Organization Wide
( ) Program Operations ( ) Family Care (X) Partnership ( ) PACE
(X) Departmental:

Related Documents: Authorization of Medically Necessary Services and Decision-Making by the UM Department (Scope-Partnership)

Policy Statement:
The 2024 Medicare Advantage (MA) final rule CMS-4201-F for 2024 specifies that all MA plans, including the Family Care Partnership program, establish a Utilization Management Committee to review all utilization management prior authorization policies annually and ensure that they comply with National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and general coverage and benefit conditions included in traditional Medicare laws.

Under this final rule, when coverage criteria are not fully established in applicable Medicare statute, regulation, NCD or LCD, MA plans may create internal coverage criteria under specific circumstances described at § 422,101(b)(6)(i). In these circumstances, an MA plan is permitted to choose to use a product, such as InterQual or MCG Health Care Guidelines (MCG) or something similar, to assist in creating internal coverage criteria only so long as the requirements in § 422.101(b), (c) and § 422.566(d) are met.

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, NCD and/or LCDs may exist, and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs which may be self-administered.

In the absence of any specific Medicare criteria to determine medical necessity for Long-Care Acute Hospital (LTACH), Community Care utilizes applicable MCG Health Care Guidelines (MCG) to determine medical necessity.

Purpose: Serve as a guide to the prior authorization criteria utilized by Community Care for prior authorization of medically necessary services.

Definitions:
NCD: National Coverage Determinations

LCD: Local Coverage Determinations
MAC: Medicare Administrative Contractor

Procedures:

SERVICE NAME	MAC JURISDICTION	THIRD PARTY CRITERIA	CMS CRITERIA
A. Post-Acute Facility Stay			
1. Inpatient Rehab Facility/TBI unit		N/A	CMS Criteria
2. Long-Term Acute Care Hospital		MCG	
3. SNF-Sub Acute Medicare Stays		N/A	CMS Criteria
B. Bariatric Surgery		N/A	CMS Criteria
C. Transplant Surgery		NA	CMS Criteria
D. Physician-Administered Medications			
1. J0896-Luspatercept	J-06		CMS Criteria
2. J1561-Immune globulin	J-06		CMS Criteria
3. J1745-Infliximab	J-06		CMS Criteria
4. J2350-Ocrelizumab	J-06	MCG	1. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist, and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs, which may be self-administered. 2. There is no NCD or LCD that covers J2350-Ocrelizumab. Because there is no active LCD for J2350, Medicare generally follows standard reasonable and necessary guidelines for Part B. 3. Medicare covers drugs for FDA-approved indications. Ocrelizumab is an FDA-approved CD20-directed cytolytic antibody. Covered indications for adults include:

			• Relapsing forms of Multiple Sclerosis (MS) (including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive MS) and primary progressive MS (PPMS). 4. Additional Criteria-MCG. Coverage criteria are not fully established in applicable Medicare statute, regulation, NCD or LCD.
5. J9022-Atezolizumab	J-06		CMS Criteria
6. J9173-Durvalumab	J-06		CMS Criteria
7. J9228-Ipilimumab	J-06		CMS Criteria
8. J9271-Pembrolizumab	J-06		CMS Criteria
9. J9299-Nivolumab	J-06		CMS Criteria
10. J9305-Pemetrexed	J-06		CMS Criteria
11. J9306-Pertuzumab	J-06		CMS Criteria
12. J9312-Rituximab	J-06		CMS Criteria
13. J9355-Trastuzumab	J-06		CMS Criteria
14. J3247-Secukinumab (intravenous)	J-06	MCG	1. Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determinations (NCDs) and/or Local Coverage Determinations (LCDs) may exist, and compliance with these policies is required where applicable. Local Coverage Articles (LCAs) may also exist for claims payment purposes or to clarify benefit eligibility under Part B for drugs, which may be self-administered. • There is no NCD or LCD that covers J3247-IV Secukinumab. Because there is no active LCD for J3247, Medicare generally follows standard reasonable and necessary guidelines for Part B. 2. Medicare covers drugs for FDA approved indications. Cosentyx (secukinumab) is a human interleukin-17A antagonist. Cosentyx (secukinumab) for IV injection indicated for the treatment of: • Adult patients with active psoriatic arthritis. • Adult patients with active ankylosing spondylitis. • Adult patients with active non-radiographic axial Spondyloarthritis with objective signs of inflammation.

			3. Additional Medical Necessity Criteria-MCG. Coverage criteria are not fully established in applicable Medicare statute, regulation, NCD or LCD.
E. Botox and Related Medications 1. J0580 Onabotulinumtoxin toxin A (Botox) 2. J0586- Dysport 3. J0587- Myobloc 4. J0588 Xeomin 5. J0589 Daxxify	J-06		CMS Criteria
F. Radiology: PET/SPECT (imaging only)			CMS Criteria
G. Genetic Testing	J-06		CMS Criteria

Exceptions or Exemptions:

References:

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