Introduction

Corporate Medical Protocols

Our Corporate Medical Protocols provide a concise overview of the criteria used for clinical determinations for a member's coverage.

The protocols are based on research showing evidence of scientific merit (or lack of it) to determine if a service is medically necessary, not medically necessary, or investigational/ experimental. Generally, protocols do not address standard services as discussed in Plan Practice Guidelines, nor do they duplicate state- or federal-mandated benefits.

- When a service is denied because it does not meet the medical necessity criteria, the required preauthorization is not in place, or the service is investigational/experimental, the member is held harmless and cannot be billed.
- The existence of a protocol does not guarantee that a service will be approved or covered. Coverage is always subject to multiple considerations, including member benefits, eligibility at the time services are rendered, and state or federal laws.
- Protocols are not medical advice. Treating practitioners are solely responsible for medical advice and for treatment of patients/members. Due to the technically complex content, we recommend that members who use these protocols review them with their practitioner(s).

The plan reviews and reevaluates protocols annually or more frequently as new information emerges. A cover letter describing any changes is issued 30 days prior to their effective date. Notification of availability appears in the quarterly practitioner (provider) newsletter, *Vital Signs*.

Protocol format

- **Heading:** includes the title (and former title if recently changed), effective date, all of the review dates (past and next scheduled), and whether preauthorization is required.
- **Disclaimer:** contains important information, such as how policy statements apply to Medicare Advantage and the members' liability when stated criteria are not met.
- **PICO tables:** summarize the populations, interventions, comparators, and outcomes for the content of the protocol.
- **Description:** a brief introduction and definition of the technology, disease, or condition addressed by the protocol**.**
- **Summary of evidence:** a short discussion and examination of the evidence from which the policy statement is derived.
- **Policy statements**: contain the plan's determination for the service as medically necessary, not medically necessary, or experimental/investigational, including relevant criteria.

- **Policy guidelines:** included when appropriate to provide information regarding medical criteria, patient selection criteria, indications, or conditions applicable to the policy statement.
- **Medicare Advantage:** reflects Medicare Advantage coverage decisions when different from the policy statements.
- **Medicare Advantage policy guidelines:** provide additional information or conditions applicable to the Medicare Advantage policy statement.
- **Background:** provides an explanation of the purpose of the procedure, test, or device, and how it is performed or used.
- **Regulatory status:** is included when applicable, including FDA approval information.
- **End disclaimer:** acts as a reminder that all services must be considered medically necessary in order to be considered for payment, pending member eligibility and benefits. It also states that claims submitted could be subject to prepayment or post-payment review even when there is no preauthorization requirement.
- **References:** a listing of the literature and governing-body statements that were reviewed during the course of developing and reevaluating the protocol.