| **Patient Name:**, | | | | **CLQ System ID:** | **Sub ID #:** |
| --- | --- | --- | --- | --- | --- |
| **Title:** | | **Generic Medical Policy MD Form No Med Policy Fibergraft**  **Billed Descriptor for review:** **FIBERGRAFT BG PUTTY 6CC** | | | |
| **MD Determination:** | | | APPROVE  MODIFY  DENY  UPHOLD  **(Explanation for MD if approved):** | | |
| **NOT MEDICALLY NECESSARY** | | | | | |
|  | **NOT MEDICALLY NECESSARY**  *(EOB JLK MD Not Medically Necessary)*  **PRINCIPAL REASON:**  A Physician Advisor has reviewed the information provided and determined that the requested service(s) would not be covered as medically necessary.  **CLINICAL RATIONALE**:  The patient’s condition does not meet the criteria for the use of as established by scientific evidence.  The requested service (s), Insert service requested here, may be considered medically necessary for the treatment of Insert condition or diagnosis here when **one or more** of the following have been met:   * Insert criteria here * Insert criteria here * Insert criteria here   The medical records do not show that you have met **one or more** of the above conditions. Therefore, the requested service has been determined to be not medically necessary.  The criteria or resource used in making this decision is:  UpToDate <https://www.uptodate.com/home>    Hayes, Inc <https://www.hayesinc.com/>    Food and Drug Administration <https://www.fda.gov/Drugs/default.htm>    Other:  Additional comments: | | | | |
|  | **NOT MEDICALLY NECESSARY Lack of Information**  *(EOB JLK MD Not Medically Necessary)*  **PRINCIPAL REASON:**  A Physician Advisor has reviewed the information provided and determined that the requested service(s) would not be covered as medically necessary.  The medical need for       has not been established following review of the documentation submitted.  Please submit the supporting documentation:  Doctors’ progress notes  Doctors' Orders  Admitting History and Physical report  Discharge Summary  Operative Report and Implant Log  Other  Additional comments: | | | | |
| **INVESTIGATIONAL/EXPERIMENTAL** | | | | | |
|  | **INVESTIGATIONAL/EXPERIMENTAL**  (*EOB J5X investigational or experimental)*  **PRINCIPAL REASON:**  A Physician Advisor has reviewed the information provided and determined by national standards as investigational or experimental and therefore, is not covered.  **CLINICAL RATIONALE**:  The patient’s condition does not meet the criteria for the use of as established by scientific evidence.  The clinical benefit and/or safety of the service or items over standard evaluation and/or treatment have not been established in the published scientific peer-reviewed literature. There is insufficient evidence in the peer- reviewed literature regarding its effect on improving health outcomes. Therefore, the requested service has been determined to be investigational or experimental and thus, not covered. Your plan does provide for standard treatment and services.    Additional comments:  The criteria or resource used in making this decision is: | | | | |
| **NOT A COVERED BENEFIT**  FACETS (AJQ-claim, JII-line) | | | | | |
|  | **PRINCIPAL REASON:**  A Blue Shield of California Medical Director has reviewed the submitted medical documentation and has determined the service is not a covered benefit per your Evidence of Coverage (EOC).  EOC Provision Page Number:  EOC Provision Language:       **COMMENTS**: | | | | |