

Clinical Policy: Clinical Trials

Reference Number: HNCA.CP.MP.94

Date of Last Revision: 07/24

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Medical necessity guidelines for routine costs of clinical trials in accordance with Centers for Medicare & Medicaid (CMS) and the Patient Protection and Affordable Care Act (PPACA) requirements.

Note: For experimental technologies, refer to *CP.MP.36 Experimental Technologies*

Health Net of California

Please refer to the following for California specific guidelines:
Senate Bill No 583 Chapter 482 Section 10145.4 of the Insurance Code (Effective January 2020) and S.4742 (Effective January 2022), relating to clinical trials:
http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB583
<https://www.congress.gov/bill/116th-congress/senate-bill/4742/text?r=1&s=1>

Policy/Criteria

It is the policy of Health Net of California[®] that routine costs of a qualifying clinical trial and services used to diagnose and treat complications arising from participating in a qualifying clinical trial are medically necessary based upon the following guidelines and limitations¹⁻²:

- I. *Routine costs in a clinical trial include all items and services generally considered medically necessary and a covered benefit to Plan members/enrollees that are provided in either the experimental or control arms and include:*
 - A. Items or services that are typically provided absent a clinical trial;
 - B. Items or services required solely for the provision of the investigational item or service (e.g., administration of a non-covered chemotherapy agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications;
 - C. Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service – in particular, for the diagnosis or treatment of complications.
- II. *Excluded costs/services*
 - A. The investigational item or service itself;
 - B. Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan);
 - C. Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

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III. Administrative limitations

- A. All applicable Plan limitations for coverage of out-of-network care applies to routine costs in a clinical trial;
- B. All existing utilization management guidelines apply to routine care for members/enrollees in clinical trials, including prior-authorization and notification requirements.

IV. Qualifying clinical trials must meet the following:

- A. The clinical trial must have a written protocol that describes a scientifically sound study and be approved by all relevant institutional review boards (IRBs);
- B. The subject or purpose of the trial must be the evaluation of an item or service that falls within a covered benefit category (i.e. physician's service, durable medical equipment, diagnostic test, etc.);
- C. The trial must have therapeutic intent and not solely designed to test toxicity or disease pathophysiology;
- D. Trials of therapeutic interventions must enroll patients with the diagnosed disease (trials of diagnostic interventions may enroll healthy patients in order to have a proper control group);
- E. Trials must be federally-funded or approved by one of the following groups:
 1. Agency for Healthcare Research and Quality (AHRQ); or
 2. Centers for Disease Control and Prevention (CDC); or
 3. Centers for Medicare and Medicaid Services (CMS); or
 4. National Institutes of Health (NIH); or
 5. A cooperative group or center of any of the above listed entities or the Department of Defense (DoD) or Department of Veterans Affairs (VA); or
 6. A qualified nongovernmental research entity identified in the guidelines issued by the NIH for center support grants; or
 7. The Departments of VA, DoD, or Department of Energy (DoE) if the trial has been reviewed and approved through a system of peer review comparable to the system used by the NIH and that ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; or
 8. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or
 9. The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Background

This policy was adapted from Medicare Coverage ~ Clinical Trials, Final National Coverage Decision policy.

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed	12/13	01/14
References reviewed	01/15	01/15

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Reviews, Revisions, and Approvals	Revision Date	Approval Date
Converted into new template Added parameters for what qualifies as a “qualified clinical trial” in IV.E	01/16	01/16
References reviewed	12/16	12/16
References reviewed	11/17	12/17
References reviewed.	09/18	10/18
References reviewed and updated.	10/19	10/19
For Health Net of California – added references to CA SB583 to the corporate policy. No other change	12/19	12/19
Added reference to CP.MP.36 Experimental Technologies. References reviewed and updated.	06/20	06/20
Incorporated the Centene Corporate Clinical Trials policy changes including: References reviewed, updated and reformatted. Replaced all instances of “member” with “member/enrollee.” Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.” Maintained reference to CA SB583 as the only difference between these policies	7/21	7/21
Added S.4742 to CA specific guideline section	11/21	11/21
Corporate Update: Annual review. Criteria I.,II.,III.,IV. updated to remove “and” after semi-colons. Criteria IV.B. “et al” changed to “etc.” Criteria IV.E. #7 abbreviation updated for Department of Energy (DoE). References reviewed and updated.	07/22	07/22
Corporate Update: 6/23 Annual review completed; policy reformatted. Minor rewording with no clinical significance. References reviewed and updated.	6/23	7/23
References reviewed and updated. No update to criteria	7/24	7/24

References

1. National coverage determination: routine costs in clinical trials (301.1). Centers for Medicare and Medicaid Services Web site. <http://www.cms.hhs.gov/mcd/search.asp>. Published October 09, 2007. Accessed May 9, 2023.
2. Office of the Legislative Counsel for the use of the U.S. House of Representatives. Compilation of Patient Protection and Affordable Care Act. <https://www.hhs.gov/sites/default/files/ppacacon.pdf?language=es>. Published June 09, 2010. Accessed May 9, 2023.
3. National Institutes of Health U.S. National Library of Medicine. ClinicalTrials.gov. <https://clinicaltrials.gov/>. Accessed May 9, 2023.
4. Senate Bill No 583 Chapter 482 Section 10145.4 of the Insurance Code, relating to clinical trials: Senate Bill No 583 Chapter 482 Section 10145.4 of the Insurance Code, relating to clinical trials: http://leginfo.legislature.ca.gov/faces/billTextClient.xhtml?bill_id=201920200SB583

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Member/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers,

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members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

Note: For Medicaid members/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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