NAME: **SS#:**
Regarding:

Bakers Union and FELRA Health and Welfare Fund

EMPLOYER:	Giant	**LOCAL:**	68
DATE OF HIRE:	October 1, 1997	**STATUS:**	Full Time
PLAN:	1		

ISSUE: Hospital/Medical – Experimental #M17/120-0171

FUND RULE:
"**General Exclusions**
24. Services, supplies, drugs, devices, medical treatment, procedures or care of any kind which is experimental in nature, or which is not accepted practice by the medical community practicing as determined by the Fund (see "Experimental" under the Definitions section)."
(Bakers Union and FELRA SPD, Page 116, #24)

"Experimental Treatment
A drug, device, medical treatment or procedure is considered experimental or investigative unless:
1. Approved by the U.S. Food and Drug Administration prior to the time the drug or device is furnished."
(Bakers Union and FELRA SPD, Page 11, #1)

SUMMARY:	Date(s) of Service:	April 7, 2017; May 5, 2017; June 9, 2017
	Received:	April 14, 2017 through June 16, 2017
	Denied:	April 24, 2017 through June 23, 2017
	Appeal Received:	August 16, 2017 through October 16, 2017

The **participant** is appealing for payment of claims for her daughter (DOB: 1-30-1998) that were denied. Included with the appeal was a letter from the provider's office which states, "Upon examination, Dr. Timothy Polk determined that Avastin treatment was necessary in the right eye due to the patient's diagnosis of retinal neovascularization. This is a form of treatment widely used by Retina Specialists in this area and found to be very beneficial in helping to control the progression of the disease."

Fund records indicate The Retina Care Center submitted claims for Avastin (generic Bevacizumab) injections on April 7, 2017; May 5, 2017; and June 9, 2017 with the diagnosis "retinal neovascularization." The claims were denied because Avastin has not been FDA-approved for the treatment of retinal neovascularization.

After the appeal was received, it was sent to CareAllies for review. CareAllies advised on July 18, 2017 that they are unable to issue a recommendation of medical necessity for this treatment based on the coverage guidelines of the Plan.

ACTION: **Approved** ☐ **Denied** ☐ **Tabled** ☐
COMMENTS: