Network Notifications

New Hampshire

WellSense HEALTH PLAN

Date:	August 31, 2022	Number: 74
To:	All WellSense Providers	
From:	WellSense Health Plan	
Subject:	**August Medical Policy Network Notifications**	
Product:	☒ NH Medicaid ☒ NH Medicare Advantage	

August Network Notifications

The following WellSense Health Plan medical policies will be updated with revisions to clinical review criteria and/or applicable coding included in the medical policies (excluding industry-wide code updates and/or codes that do not require prior authorization). The revised medical policies will be effective on November 1, 2022:

1. **Chromosomal Microarray Analysis for Unexplained Intellectual Disabilities and/or Multiple Congenital Anomalies, OCA 3.573**
2. **Clinical Review Criteria, OCA 3.201**
3. **Complementary and Alternative Medicine, OCA 3.194**
4. **Facet Joint Nerve Injections, OCA 3.9641**
5. **Gender Affirmation Services, OCA 3.11**
6. **Genetic/Genomic Testing and Pharmacogenetics, OCA 3.727**
7. **Genetic Testing for Fragile X-Associated Disorders, OCA 3.571**
8. **Genetic Testing for Hereditary Thrombophilia, OCA 3.728**
9. **Minimally Invasive Procedures to Treat Back Pain, OCA 3.713**
10. **Non-Emergency Transportation Services, OCA 3.191**
11. **Occupational Therapy in the Outpatient Setting, OCA 3.543**
12. **Osteochondral Treatments for Defects of the Knee, Talus or Other Joints, OCA 3.965**

13. **Pelvic Floor Stimulation for the Treatment of Incontinence and/or Overactive Bladder, OCA 3.561**
14. **Physical Therapy in the Outpatient Setting, OCA 3.544**
15. **Posterior Tibial Nerve Stimulation, 3.562**
16. **Sacroiliac Joint Injections, OCA 3.9642**
17. **Speech Therapy, OCA 3.542**
18. **Temporomandibular Joint Disorders, OCA 3.968**

General Information

All WellSense Health Plan medical policies are located on the Provider's page at https://www.wellsense.org/providers/nh/policies under the Policies link. If you do not have Web access, you may contact your provider relations representative for a copy of the policies. The updated policies listed above will be posted on the website and available from your provider relations representative on September 1, 2022.

Questions?

If you have any questions about this Network Notification, please contact your dedicated provider relations consultant or call the Provider Line at 877-957-1300, option 3 (for NH Medicaid) or 866-808-3833 (for Medicare Advantage). WellSense Health Plan Network Notifications and Reimbursement Policies are available online at wellsense.org.

Medical Policy – Policy with InterQual Criteria Retired and AIM Criteria Adopted as of 11/01/22

Chromosomal Microarray Analysis for Unexplained Intellectual Disabilities and/or Multiple Congenital Anomalies

Policy Number: OCA 3.573
Version Number: 20
Policy Retired Date: 11/01/22

Impacted Products

- ☒ **All Products**
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☒ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

Genetic testing using chromosomal microarray analysis (CMA) is considered medically necessary for the diagnosis of an adult or pediatric member with unexplained intellectual disability, developmental delay, symptoms or findings consistent with an autism spectrum disorder, and/or multiple congenital anomalies when AIM clinical appropriateness guidelines are met. Prior authorization from AIM Specialty Health is required for genetic testing.

Clinical Criteria

No medical policy criteria.

Limitations and Exclusions

None.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for the Plan's Senior Care Options (SCO) members and New Hampshire Medicare Advantage HMO members, including but not limited to national coverage

determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, NCD 190.3 includes guidelines for the use of cytogenetic studies. Verify CMS guidelines in effect on the date of the prior authorization request. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. The list of applicable codes included in this policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization from AIM for genetic testing, even if an applicable code appropriately describing the service is not included in this policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT/HCPCS Codes	Code Description
81228	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number variants (e.g., Bacterial Artificial Chromosome [BAC] or oligo-based comparative genomic hybridization [CGH] microarray analysis)
81229	Cytogenomic constitutional (genome-wide) microarray analysis; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for chromosomal abnormalities
81349	Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number and loss-of-heterozygosity variants, low-pass sequencing analysis
S3870	Comparative genomic hybridization (CGD) microarray testing for developmental delay, autism spectrum disorder and/or intellectual disability Plan note: Code is NOT payable for the Senior Care Options and NH Medicare Advantage HMO products.

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Next Review Date

Not applicable

Retired Date

11/01/22

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:
Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity;

utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 11/20/13: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 12/19/13: Quality Improvement Committee (QIC)	03/01/14 Version 1	Director of Medical Policy as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	MPCTAC and QIC

* Effective date for QHP Commercial product: 01/01/12
* Effective date for New Hampshire Medicaid product: 01/01/13
* Effective date for Senior Care Options product: 01/01/16
* Effective date for New Hampshire Medicare Advantage HMO product: 01/01/22

Note: Effective 03/01/14 to 04/30/16, the policy title was *Cytogenomic Microarray Analysis for Unexplained Intellectual Disabilities and/or Multiple Congenital Anomalies*. Effective 05/01/16, policy renamed *Chromosomal Microarray Analysis for Unexplained Intellectual Disabilities and/or Multiple Congenital Anomalies*. Policy retired and service managed by AIM Specialty Health as of 11/01/22.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
01/30/14	Off cycle review for effective date 04/01/14. Added ICD10 diagnosis code equivalents of existing ICD9 diagnosis codes.	04/01/14 Version 2	01/27/14: MPCTAC 01/30/14: QIC
11/01/14	Review for effective date 03/01/15. Revised criteria in the Medical Policy Statement and Limitations sections. Updated the Summary, Description of Item or Service, Definitions, and Clinical Background Information sections. Revised review calendar.	03/01/15 Version 3	11/19/14: MPCTAC 12/10/14: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Revised language in the Applicable Coding section.	01/01/16 Version 4	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC

01/01/16	Review for effective date 05/01/16. Revised language in the Applicable Coding section and updated the list of waived pregnancy diagnosis codes and corresponding procedure codes. Updated Summary, Description of Item or Service, Definitions, Clinical Background Information, and References sections. Revised title. Revised criteria in the Medical Policy Statement and Limitations sections.	05/01/16 Version 5	01/20/16: MPCTAC 02/10/16: QIC
09/28/16	Review for effective date 11/01/16. Administrative changes to clarify language related to gender.	11/01/16 Version 6	09/30/16: MPCTAC (electronic vote) 10/12/16: QIC
01/01/17	Review for effective date 05/01/17. Revised ICD-10 pregnancy diagnosis codes in the Applicable Coding section. Updated Summary, Definitions, References, and Reference to Applicable Laws and Regulations sections. Updated criteria in the Medical Policy Statement section.	05/01/17 Version 7	01/18/17: MPCTAC 02/08/17: QIC
01/01/18	Review for effective date 02/01/18. Updated Summary, Description of Item or Service, Definitions, References, and Reference to Applicable Laws and Regulations sections. Administrative changes made to the Medical Policy Statement and Applicable Coding sections.	02/01/18 Version 8	01/17/18: MPCTAC
01/01/19	Review for effective date 04/01/19. Administrative changes made to the Policy Summary, Definitions, Applicable Coding, Clinical Background Information, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections. Revised criteria in the Medical Policy Statement and Limitations sections.	04/01/19 Version 9	01/16/19: MCPTAC
02/01/19	Review fore effective date 04/01/19. Administrative changes made to the Medical Policy Statement section to clarify guidelines. Updated Plan notes in the Applicable Coding section (without revising the applicable code list). Revised the Policy Summary and Other Applicable Policies sections.	04/01/19 Version 10	02/20/19: MPCTAC
06/01/19	Review for effective date 07/01/19. Revised language in the Policy Summary, Medical Policy Statement, and Applicable Coding section to clarify that the prior authorization waiver for the specified primary pregnancy diagnosis codes	07/01/19 Version 11	06/19/19: MPCTAC

	only applies to genetic tests ordered, administered, and processed by participating providers and participating laboratories.		
07/01/19	Review for effective date 10/01/19. Medical policy criteria retired and InterQual® criteria adopted. Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, and Other Applicable Policies sections. Updated Plan notes in the Applicable Coding section. Maintained guidelines for testing with CMA and Fragile X testing. Maintained diagnosis code list for prior authorization pregnancy waiver and updated corresponding procedure code list.	10/01/19 Version 12	07/17/19: MPCTAC
09/01/19	Review for effective date 12/01/19. Added high-risk diagnosis code in the Applicable Coding section.	12/01/19 Version 13	09/18/19: MPCTAC
12/01/19	Review for effective date 01/01/20. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, Applicable Coding, and Definitions sections.	01/01/20 Version 14	12/18/19: MPCTAC
01/01/20	Review for effective date 02/01/20. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections.	02/01/20 Version 15	01/15/20: MPCTAC
02/01/21	Review for effective date 03/01/21. Updated the Policy Statement and References sections. Administrative changes made to the Applicable Coding section.	03/01/21 Version 16	02/17/21: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, the Medical Policy Statement section renamed the Clinical Criteria section, and the Limitations section renamed the Limitations and Exclusions section. Added NH Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections.	12/01/21 Version 17	11/17/21: MPCTAC
12/01/21	Review for effective date 01/01/22. Industry-wide code revision made to the Applicable Coding section.	01/01/22 Version 18	Not applicable because industry-wide code revision; 12/15/21: MPCTAC review

01/01/22	Review for effective date 02/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, and References sections.	02/01/22 Version 19	01/19/22: MPCTAC
08/01/22	Review for policy retired date 11/01/22. Revised the Policy Summary, Clinical Criteria, Limitations and Exclusions, and Applicable Coding sections. InterQual medical necessity criteria and medical policy retired on 11/01/22. Plan prior authorization waivers removed after 10/31/22. AIM medical necessity criteria adopted for genetic testing on 11/01/22. Plan prior authorization waivers removed after 10/31/22. AIM prior authorization is required for genetic testing as of 11/01/22, even when applicable codes are not listed in this Plan policy.	11/01/22 Version 27	08/26/22: MPCTAC (electronic vote)

Administrative Policy

Clinical Review Criteria

Policy Number: OCA 3.201
Version Number: 29
Version Effective Date: 11/01/22

Impacted Products

- ☒ **All Products**
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☒ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

This policy defines the Plan's process for making utilization review decisions using written clinical review criteria based on sound and current clinical evidence. The Plan conducts all utilization review activities in accordance with applicable policies and procedures and the Plan's Utilization Management (UM) Program. Plan-adopted written clinical review criteria are used to determine the medical necessity of services that require utilization review, including medical services, surgical treatment, pharmacotherapy and pharmacy services, behavioral health services, radiological services, dental services, and durable medical equipment, prosthetics, orthotics and supplies (DMEPOS). In addition, clinical review criteria are used to determine the most clinically appropriate level of care and intensity of services to ensure the provision of medically necessary services. Plan-adopted written clinical review criteria include the Plan's internally developed medical and pharmacy policies, InterQual® criteria, and clinical guidelines established by delegated management partners (for related services provided to Plan members for applicable Plan products). All Plan-adopted written clinical review criteria are reviewed at least annually and are developed in accordance with contractual requirements, state and federal regulations, and guidelines from accrediting organizations, including National Committee for Quality Assurance (NCQA). Review the Plan's *Prior Authorization/Notification Requirements Matrix, Code Look-up Tools,* medical and pharmacy policies, and the Plan's pharmacy formulary (available via the drug search tool or the formulary guidebook) to determine if prior authorization is required.

The Plan's clinical coverage criteria and UM decision tools are applied equitably across the Plan's membership. However, the Plan's Office of Clinical Affairs (OCA) UM staff (or the delegated clinical vendor's professional staff when the management of services is delegated to the vendor) will take into account the member's individual needs, circumstances, and healthcare services requested and/or currently provided to the member to integrate healthcare for continuity, coordination, and collaboration of services, as well as assessing the local healthcare delivery system's ability to meet the member's healthcare needs, when determining the medical necessity of services. Plan guidelines (including but not limited to appeals and/or clinical reconsiderations) comply with all applicable Plan contract terms with providers, employers, governmental agencies, and other contracting entities.

The Plan complies with coverage guidelines for all applicable state and federally-mandated benefits. Plan authorizations, as well as authorizations by each of the Plan's delegated clinical vendors conducting utilization management, are based on a comprehensive and individualized needs assessment that addresses all member needs, including but not limited to social determinants of health and a subsequent person-centered planning process. Plan prior authorization requirements (and those of each of the Plan's delegated clinical vendors) comply with parity in mental health and substance use disorders. The Plan and the Plan's delegated clinical vendors conducting utilization management do NOT discriminate, arbitrarily deny, or impose stricter requirements by reducing the amount, duration, or scope of required and medically necessary services for ANY Plan member based on the member's diagnosis, type of illness, health status or condition, sex, gender identity or dysphoria, or sexual orientation.

See the member's product-specific handbook on the Plan's website for benefit coverage guidelines and a summary of member rights and responsibilities, as well as the Plan's process for receiving and promptly resolving inquires, grievances, or appeals from a member (or an authorized representative acting on behalf of the member). Member appeals may be related to issues that include but are not limited to benefit coverage, the evaluation of clinical technology (including new technology and a new indication for an established technology), and/or the application of the Plan's clinical review criteria for the member's requested indication for treatment.

The Plan's *Cosmetic, Reconstructive, and Restorative Services* medical policy, policy number OCA 3.69, includes the product-specific definitions of cosmetic services and reconstructive surgery and procedures. The product-specific definitions of experimental or investigational treatment are listed in the Plan's *Experimental and Investigational Treatment* medical policy, policy number OCA 3.12. Product-specific definitions for medically necessary services (i.e., medical necessity) are listed in the Plan's *Medically Necessary* medical policy, policy number OCA 3.14. The *Clinical Technology Evaluation* administrative policy, policy number OCA 3.13, outlines the Plan's process for evaluating new technology and new clinical application(s) of existing technology. Review the Plan's applicable reimbursement policy for payment guidelines related to clinical trials.

Policy Statement

When the Plan conducts utilization review (UR), appropriate professional utilization management (UM) Plan staff consistently apply current, Plan-adopted written clinical review criteria, including the Plan's

internally developed criteria specified in internal medical policies and Plan pharmacy policies, InterQual® criteria, and clinical guidelines established by delegated management partners (for related services provided Plan members for applicable Plan products). Plan staff (including but not limited to representatives from the Plan's Accreditation, Utilization Management, Pharmacy, and Vendor Management Departments) routinely collects and reviews documentation to verify that quality standards are met by clinical vendors who are delegated to conduct utilization management on behalf of Plan members, including but not limited to contractual obligations and the guidelines specified in the Delegated Management section of this policy. When national clinical guidelines (e.g., InterQual® criteria) are not available or not adopted by the Plan, Plan-specific criteria may be established and documented in internally developed medical and pharmacy policies.

The development and review of the Plan's internal clinical criteria include input from participating practitioners and consultant specialists in the related specialties that may include but are not limited to licensed pharmacists, community-based providers, behavioral health clinicians, and physician specialists in neonatology, pediatrics, family medicine, internal medicine, medical/pediatric/surgical subspecialties, and geriatrics. Practitioners with professional expertise and relevant credentials in the clinical area being reviewed have the opportunity to advise or comment on the development, adoption, and implementation of all UM criteria utilized by the Plan; this includes feedback from qualified practitioners on staff at the Plan or delegated clinical vendors, outside physician consultants, provider reviewers, participating providers in the Plan's network, and practitioners treating Plan members. The Plan-adopted written clinical review criteria (i.e., the Plan's internal medical policies and pharmacy policies, InterQual® criteria, and clinical guidelines implemented by the Plan's delegated management partners for related services provided Plan members by Plan product type) are objective, scientifically derived, and evidence-based for the requested service(s) and indication(s) for treatment and are compliant with applicable legal obligations , regulatory requirements, and national accreditation organization standards.

The Plan's clinical coverage criteria and UM decision tools are applied equitably across the Plan's membership. All Plan-adopted written clinical review criteria (including criteria specified in the Plan's internal medical policies and pharmacy policies, InterQual® criteria, and clinical guidelines developed and implemented by the Plan's delegated management partners for related services provided Plan members by Plan product type) are clinically reviewed at least annually to verify that these clinical guidelines are developed and implemented in accordance with generally accepted standards of medical/clinical practice which are based on objective and credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying on controlled clinical trials. On at least an annual basis, Plan staff confirm that all clinical review criteria utilized by the Plan (including all of the Plan's internal medical and pharmacy policies, InterQual® criteria, and clinical guidelines implemented by the Plan's delegated management partners for related services provided Plan members by Plan product type) have had an annual clinical review and the procedures for applying those clinical review criteria are documented.

Updates to clinical review criteria are implemented as new treatments, applications, and technologies are adopted and become components of generally accepted professional practice for behavioral health, medical/surgical services, dental services, and/or pharmacotherapy. The Plan's Office of

Clinical Affairs (OCA) UM staff applies the clinical review criteria consistently; however, OCA UM staff also takes into account the member's individual needs and circumstances. The Plan's Medical Directors and/or licensed Plan pharmacists consider member-specific factors when applying clinical criteria to a request for services. When clinical review criteria are not met for a requested treatment such that medical necessity cannot be established for the member's condition or indication for treatment, OCA UM staff engages in discussions with licensed Plan pharmacists, OCA UM clinicians, and/or Plan Medical Directors to determine if the clinical review criteria are appropriate for the member's circumstances or local delivery system (utilizing qualified Plan clinicians applicable for the member's condition and requested treatment). If the clinical review criteria are not appropriate, OCA UM staff may make the utilization determination based on the member's condition and other unique circumstances. The Delegated Management section of this policy includes delegated management guidelines applicable for the Plan's partner clinical vendors, including Plan oversight and the development, review, and application of the clinical vendors' clinical review criteria.

Change Health staff analyze over 3,000 medical literature sources daily to review and update current InterQual® clinical review criteria and to develop criteria for new technologies and new application(s) of existing technologies. InterQual® criteria are developed and implemented in accordance with generally accepted standards of medical/clinical practice which are based on objective and credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying on controlled clinical trials. In addition, InterQual® criteria are evaluated by an independent clinical review panel drawn from more than 900 experts for authoritative peer review, utilizing providers with expertise and appropriate credentials in the applicable clinical area under consideration. Inter-rater reliability testing is conducted annually by the Plan using the Plan-adopted InterQual® criteria sets. InterQual® criteria are revised, as necessary, throughout the year (at least annually but may occur quarterly).

Delegated Management

The Plan's delegated clinical vendors conduct utilization management for behavioral health services, radiology services, pharmacy services, dental services, and durable medical equipment, prosthetics, orthotics and supplies on behalf of Plan members (when applicable for the Plan product). Practitioners with clinical expertise in the area being reviewed have the opportunity to advise or comment on the development, adoption, and implementation of utilization management criteria established by the Plan's delegated management partners; this includes feedback from qualified practitioners on staff at the Plan or delegated clinical vendors, outside physician consultants, provider reviewers, participating providers in the Plan's network, and practitioners treating Plan members.

All Plan-adopted written clinical review criteria, including clinical guidelines established by delegated management partners, are reviewed at least annually (or more frequently when policy revisions require more immediate implementation). Clinical review criteria utilized by the Plan's delegated clinical vendors are develop with oversight by the clinical vendor's Medical Director who is an actively practicing physician and who is responsible for the oversight of the clinical vendor's utilization management program. Proposed new and revised clinical guidelines are evaluated by the clinical vendor's expert panel, all of whom are practicing clinicians and acknowledged experts in the relevant

fields and pertinent specialties. All clinical review criteria are developed in accordance with applicable state and federal requirements and guidelines from applicable national accreditation organizations.

The clinical review criteria and UM decision tools from each of the Plan's delegated clinical vendors are applied equitably across the Plan's membership. However, the delegated clinical vendor's professional staff (when the management of services is delegated to the clinical vendor) will take into account the member's individual needs, circumstances, and healthcare services requested and/or currently provided to the member to integrate healthcare for continuity, coordination, and collaboration of services, as well as assessing the local healthcare delivery system's ability to meet the member's healthcare needs, when determining the medical necessity of services. Inter-rater reliability testing is utilized by the Plan's delegated clinical vendors to assess the consistency and adherence to clinical review criteria. At least quarterly, the consistency with which the healthcare professionals involved in prior authorization apply criteria in decision making is evaluated by the delegated clinical vendors using a variety of mechanisms. The application of medical necessity criteria by Medical Directors and non-physician reviewers are assessed to ensure consistency and accuracy in the application of the clinical review criteria. Results are reported to the Plan.

Below are delegated management guidelines applicable for the Plan's partner clinical vendors, including Plan oversight and the development, review, and application of the clinical vendors' clinical review criteria, as specified below in items 1 through 3:

1. **Plan's Delegated Services and Partner Clinical Vendors**:

   When applicable for the Plan product, the following services are managed by a delegated clinical vendor for a Plan member, as stated in items a through f:

   a. Behavioral Health Services (Beacon Health Strategies, LLC):

      Effective March 1, 2010, the Plan delegated management of behavioral health services to an NCQA-accredited managed behavioral health organization (MBHO), Beacon Health Strategies, LLC. The MBHO has its own clinical criteria policy which has been approved as part of delegation oversight.

   b. Dental Services (DentaQuest for Senior Care Options Members):

      Effective June 18, 2015, the Plan delegated dental services to Dental Service of Massachusetts, Inc. (DSM) for DentaQuest to administer the Senior Care Options (SCO) dental benefit. This clinical vendor establishes policies for communicating criteria to providers and the vendor has its own clinical criteria policy and procedure which has been approved as part of delegation oversight.

   c. Dental Services (Delta Dental for Qualified Health Plan Pediatric Members):

Effective November 23, 2016, the Plan delegated dental services to Dental Service of Massachusetts, Inc. (DSM) for Delta Dental to administer the Qualified Health Plans (QHP) pediatric dental benefit. This clinical vendor establishes policies for communicating criteria to providers and DSM has its own clinical criteria policy and procedures which have been approved as part of delegation oversight.

d. Durable Medical Equipment, Prosthetics, Orthotics and Supplies (Northwood, Inc.):

Effective April 1, 2011, the Plan delegated management of durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) to a URAC-accredited DMEPOS clinical vendor, Northwood, Inc. The Plan has retained the management of medical necessity denial decisions and notifications. This clinical vendor has its own clinical criteria policy and procedure which has been approved as part of delegation oversight.

e. Pharmacy Benefits Manager (Express Scripts):

Effective January 1, 2021, Express Scripts is the Plan's pharmacy benefits manager for the Plan's products. Express Scripts adopts the guidelines included in this Plan's *Clinical Review Criteria* administrative policy and adheres to the Plan's administrative UM policies and clinical policy criteria, unless specifically delegated such as the Plan's Medicare product lines. Policies delegated to Express Scripts have been approved as part of delegation oversight. Effective December 1, 2019, the Plan's pharmacy mail order company for all of the Plan's Massachusetts and New Hampshire products is Cornerstone Health Solutions.

f. Radiology Services, Musculoskeletal Services, Genetic Testing, and Outpatient Rehabilitation Services (AIM Specialty Health):

Effective November 1, 2022, the Plan delegated the management of radiology services, musculoskeletal services (i.e., spine surgeries, joint surgeries, and interventional pain management treatments), genetic testing, and outpatient rehabilitation services (i.e., physical therapy, occupational therapy, and speech therapy after the initial evaluation) to an NCQA-accredited managed care clinical vendor, AIM Specialty Health. AIM develops and utilizes criteria to make utilization management decisions for requested services, establishes policies for communicating those criteria to providers and members, and evaluates consistency in the application of those criteria through inter-rater reliability testing when determining medical necessity for these delegated services.

2. **Clinical Vendor Clinical Review:**

a. Review and Application of Clinical Vendor's Established Clinical Review Criteria:

The Plan's Clinical Vendor Oversight Committee conducts an annual review of each clinical vendor that conducts delegated management for Plan members to ensure that all of the following guidelines are met: each clinical vendor conducts an annual review of its clinical

criteria, approving and implementing criteria that are objective, scientifically-derived, and evidence-based for the requested service(s) and indication(s) for treatment and compliant with applicable legal obligations; each clinical vendor completes an annual review and approval of policies and procedures developed to ensure that the clinical vendor's clinical criteria are consistently applied to Plan members for a requested service. The service may include a treatment, procedure, supply, device, biologic, or drug that will be used to prevent, diagnose, stabilize, or treat a disease, condition, or disorder that results in health impairment or disability, or the service allows the member to attain, maintain, or regain functional capacity. The clinical vendor will also consider member-specific factors impacting the member's individual healthcare needs when applying clinical review criteria to determine if the service is medically necessary for the requested indication. Individual consideration includes an assessment of any member-specific factor impacting care, including one or more of the following:

(1) Member's condition;

(2) Member's comorbidities;

(3) Member's age, including the assessment of the member's age-appropriate growth, development, and competencies, as well as evaluation of age-related and condition-specific healthcare needs and associated issues;

(4) Relevant past medical/surgical/behavioral health/dental/pharmacotherapy history;

(5) Complications;

(6) Progression of the member's condition, illness, or injury;

(7) Diagnostic test results;

(8) Treatment outcomes;

(9) Treatment options;

(10) Psychosocial circumstances;

(11) Home and environmental factors impacting member's clinical condition (e.g., homelessness, employment status, poverty, neighborhood);

(12) Other healthcare services requested and/or provided to the member to integrate healthcare for continuity, coordination, and collaboration of services;

(13) Local healthcare delivery system's ability to meet the healthcare needs of the member's specific condition;

(14) Member's reasonable accessibility to a qualified provider with appropriate credentials, licensure, clinical expertise and/or resources in the applicable clinical area necessary to adequately manage the member's condition (including but not limited to pharmacotherapy, behavioral health services, dental services, radiology services, and/or durable medical equipment, prosthetics, orthotics and supplies);

(15) Other factors related to the member's plan of care or health outcomes; AND/OR

(16) If applicable, verification that the requested device, therapeutic, biologic, or drug is being prescribed/requested and will be utilized according to its FDA-approved or compendia indication and guideline information, including intended use for the member's age and medical condition.

b. Clinical Vendor Review of Requested Service Without Written Clinical Review Criteria:

If written clinical review criteria have not been established for the requested service (for the specified indication) by the Plan's delegated management clinical vendors, these clinical vendors will use published and applicable generally accepted, scientifically-based standards of care and objective and credible scientific evidence published in peer-reviewed medical/clinical literature, and/or reviewing observational studies for a request for services for a Plan member to make medical necessity determination. If scientifically-based standards of care are not available, observational studies from more than one (1) institution that suggest a causal relationship between the service or treatment and health outcomes may be used by the delegated utilization management clinical vendor to make medical necessity determinations if these observational studies are clinically appropriate with respect to the member's clinical presentation. The Plan's delegated management clinical vendors will also consider member-specific factors impacting the member's individual healthcare needs to determine if the service is medically necessary for the requested indication. The service may include a treatment, procedure, supply, device, biologic, or drug and will be used to prevent, diagnose, stabilize, and/or treat a disease, condition, and/or disorder that results in health impairment and/or disability, and/or the service allows the member to attain, maintain, or regain functional capacity. Individual consideration includes an assessment of any member-specific factors impacting care, including one or more of the following:

(1) Member's condition;

(2) Member's comorbidities;

(3) Member's age, including the assessment of the member's age-appropriate growth, development, and competencies, as well as evaluation of age-related and condition-specific healthcare needs and associated issues;

(4) Relevant past medical/surgical/behavioral health/dental/pharmacotherapy history;

(5) Complications;

(6) Progression of the member's condition, illness, or injury;

(7) Diagnostic test results;

(8) Treatment outcomes;

(9) Treatment options;

(10) Psychosocial circumstances;

(11) Home and environmental factors impacting member's clinical condition (e.g., homelessness, employment status, poverty, neighborhood);

(12) Other healthcare services requested and/or provided to the member to integrate healthcare for continuity, coordination, and collaboration of services;

(13) Local healthcare delivery system's ability to meet the healthcare needs of the member's specific condition;

(14) Member's reasonable accessibility to a qualified provider with appropriate credentials, licensure, clinical expertise or resources in the applicable clinical area necessary to adequately manage the member's condition, including but not limited to pharmacotherapy, behavioral health services, dental services, radiology services, or durable medical equipment (prosthetics, orthotics and supplies);

(15) Other factors related to the member's plan of care or health outcomes; AND/OR

(16) If applicable, verification that the requested device, system, biologic, or drug is being prescribed/requested and will be utilized according to its FDA-approved or compendia indication and guideline information, including intended use for the member's age and medical condition.

c. Clinical Vendor Evaluation of New Technology:

The Plan's partner clinical vendors evaluate new technology and new application(s) of an established technology to develop new clinical review criteria or revise established clinical review criteria when clinically appropriate. The Plan's partner clinical vendor will use published and applicable generally accepted, scientifically-based standards of care and objective and credible scientific evidence published in peer-reviewed medical/clinical literature, and/or reviewing observational studies for the new technology or new

application(s) of an existing technology to establish written clinical review criteria that will be used to make medical necessity determinations (in addition to individual consideration of the member's status and healthcare needs). When a requested service that does not have established, applicable clinical review criteria, the medical necessity of the service is determined on a case-by-case basis for individual consideration, as specified above in the Clinical Vendor Review of Requested Service Without Written Clinical Review Criteria section.

d. Out-of-Network Providers:

The clinical vendor will authorize a member's care from an out-of-network provider when, as determined by the clinical vendor, the care and necessary resources are needed by the member are not available or are not reasonably accessible to the member.

e. Input from Practicing Practitioners:

Actively practicing practitioners with appropriate credentials and clinical expertise in the applicable clinical area have the opportunity to submit comments on clinical review criteria utilized by clinical vendors who are delegated to conduct utilization management on behalf of Plan members (with feedback related to the development, ongoing management, and/or application of those criteria). Practitioners may submit feedback through the Plan's Provider Information Mailbox available at Provider.Info@BMCHP-wellsense.org.

If the practitioner would like to provide input on a clinical vendor's clinical review criteria and have those comments considered during the criteria's next annual review, supporting documentation must be provided that includes position statements developed or endorsed by nationally recognized professional associations, consensus reports or guidelines from specialty societies, and/or standards adopted by governmental agencies (e.g., National Institutes of Health, Agency for HealthCare Research and Quality, Center for Medicare & Medicaid Services, Massachusetts Executive Office of Health and Human Services, or New Hampshire Department of Health and Human Services). Published scientific evidence from additional reputable sources may also be submitted for consideration.

Issues related to clinical review criteria that must be addressed before each clinical vendor's annual review will be evaluated immediately during a prior authorization request for services; clinical vendors conducting delegated utilization will engage in individual case discussions with qualified clinicians applicable for the member's condition and requested treatment to determine if the clinical review criteria are appropriate for the member's circumstances or care provided by a local delivery system according to the guidelines specified below in the Application of the Plan's Clinical Review Criteria section of this policy.

f. Access to Clinical Review Criteria:

The Plan makes all of its clinical review criteria available to practitioners and members upon oral or written request. Providers and member may call or fax the Plan with a request for a copy of the specific criteria, as stated in writing in the provider manual on the Plan's website. This access to clinical review criteria includes applicable copyrighted commercial criteria used by the Plan's partner delegated clinical vendors. Participating providers are notified at least 60 calendar days before the implement of substantive revisions to applicable coding (excluding industry-wide code updates) and/or clinical review criteria (i.e., implementation of new medical necessity guidelines and/or revised clinical review criteria) used by the Plan's partner delegated clinical vendors. The current version of clinical review criteria is available to all providers, members, and the general public on the Plan's extranet site.

3. **Plan Oversight:**

Plan staff (including but not limited to representatives from the Plan's Accreditation, Utilization Management, Pharmacy, and Vendor Management Departments) routinely collects and reviews documentation to verify that quality standards are met by clinical vendors who are delegated to conduct utilization management on behalf of Plan members. In addition, an annual review of each clinical vendor is completed by the Plan's Clinical Vendor Oversight Committee to ensure that each clinical vendor complies with delegated utilization management requirements, including but not limited to contractual obligations and the guidelines specified in this section of this policy related to the development, review, and application of objective, scientifically-derived, and evidence-based clinical review criteria, with individual consideration of the member's status (when appropriate). If established quality standards are not met, the delegated utilization management clinical vendor develops and implements a targeted and measurable corrective action plan that is monitored by the Plan. For services managed by clinical vendors with whom the Plan has delegated utilization management, the Plan evaluates member access to treating facilities and availability of qualified providers (including care from an out-of-network provider when clinically appropriate), member satisfaction, provider satisfaction, member and provider timely access to applicable clinical review criteria, and the vendor's process for evaluating recommended revisions to clinical review criteria submitted by actively practicing practitioners with appropriate credentials and clinical expertise.

Procedure

The Plan-adopted clinical review criteria are developed and implemented in accordance with generally accepted standards of medical/clinical practice which are based on objective and credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying on controlled clinical trials. Practitioners with clinical expertise in the area being reviewed have the opportunity to advise or comment on the development, adoption, and implementation of all UM criteria utilized by the Plan; this includes feedback from qualified practitioners on staff at the Plan or delegated clinical vendors, outside physician consultants, provider reviewers, participating providers in the Plan's network, and practitioners treating Plan members.

See the Policy Summary and the Delegated Management sections of this policy for guidelines related to applicable clinical review criteria and services managed by partner clinical vendors with whom the Plan has delegated utilization management (by Plan product), including behavioral health services, radiology services, pharmacy benefits administration, and durable medical equipment, prosthetics, orthotics and supplies. Review the *Clinical Technology Evaluation* administrative policy, policy number OCA 3.13, for a description of the Plan's process for evaluating new technology and the new application of existing technology.

1. **Development and Review of the Plan's Internal Clinical Review Criteria**:

   The Plan's internal clinical review criteria are specified in the Plan's medical policies or pharmacy policies. Internal clinical review criteria are developed, reviewed at least annually, and updated as necessary, utilizing the following resources (as applicable) to evaluate the clinical services, treatments, and technologies for the specified indications and the application of medical necessity criteria, as stated below in items a through l:

   a. In consultation with the Plan's Medical Director(s) and other Plan staff, as appropriate; AND

   b. With input from actively practicing specialists and/or professionals or serving as consultants who have expertise and appropriate credentials in the applicable clinical area under consideration, as appropriate; e.g., criteria review by board-certified physician experts in the Plan's service area, feedback from participants of the local network-based Provider Advisory Committee, and/or independent medical criteria review from board-certified physician consultants from Advanced Medical Reviews (AMR). Consultants may include but are not limited to pharmacists, community-based providers, behavioral health clinicians, dentists, and/or board-certified physicians actively practicing in specialties that include neonatology, pediatrics, family medicine, internal medicine, medical/surgical subspecialties, and/or geriatrics; AND

   c. In accordance with the Plan's definition of medical necessity (as specified in the *Medically Necessary* medical policy, policy number OCA 3.14), the Plan's definition of experimental and investigational services (as stated in the *Experimental and Investigational Treatment* medical policy, policy number OCA 3.12), and the Plan's definition of cosmetic and reconstructive or restorative services (as documented in the *Cosmetic, Reconstructive, and Restorative Services* medical policy, policy number OCA 3.69); AND

   d. Review of unbiased, evidence-based assessments of health technologies, clinical programs, and/or healthcare services to determine the impact of intervention(s) on patient safety and clinical outcomes; AND

   e. Review of position papers and guidelines established or endorsed by nationally recognized medical associations, specialty societies, dental organizations, or governmental agencies, including but not limited to practice guidelines adopted by the Plan; AND

f. Clinical studies published in peer-reviewed scientific literature evaluating the use of the clinical service as an alternative treatment strategy to established interventions considered the standard of care for the specified indication (considering the patient's medical condition, age, comorbidities, and other factors applicable to the health outcomes of the clinical technology) to determine if the service improves the net health outcome, is cost-effective compared to the standard of care, and if the clinical outcomes outweigh any harmful effects; AND

g. The documented, favorable health outcomes are reasonably expected to be attainable outside of the investigational settings (i.e., in a standard clinical setting) to a degree comparable in the published, scientifically derived and evidence-based investigations; AND

h. When applicable, the clinical technology, including drugs, biologics, devices, or other products requiring final approval to market, has final approval for the specified indication from the appropriate governmental body(ies) with the authority to regulate the clinical technology (e.g., the U.S. Food and Drug Administration); AND

i. Policies, position statements, consensus reports, and standards adopted by governmental agencies which may include but are not limited to the National Institutes of Health (NIH), Agency for HealthCare Research and Quality (AHRQ), U.S. Center for Disease Control and Prevention (CDC), Center for Medicare & Medicaid Services (CMS), Massachusetts Executive Office of Health and Human Services, or New Hampshire Department of Health and Human Services (e.g., U.S. Preventive Services Task Force, AAP Bright Futures); AND

j. Published scientific evidence from additional reputable sources concerning the safety and effectiveness of the clinical treatment on health outcomes (i.e., proven benefit, unproven benefit, insufficient evidence to determine effect, or documented harm) such as industry-standard, evidence-based guidelines and recommendations (such as those established by InterQual®, National Institute for Health and Care Excellences, National Comprehensive Cancer Network); AND

k. Other sources deemed necessary to evaluate the clinical technology for the specified clinical indication and to develop the Plan's clinical coverage criteria; AND

l. With input from actively practicing practitioners with appropriate credentials and clinical expertise in the applicable clinical area who have the opportunity to submit comments on clinical review criteria utilized for Plan members (with feedback related to the development, ongoing management, and/or application of those criteria). Practitioners may submit feedback at any time through the Plan's Provider Information Mailbox available at Provider.Info@BMCHP-wellsense.org. The Plan will thoroughly research recommendations and comments submitted from providers.

   On at least an annual basis, Plan staff review all clinical review criteria utilized by the Plan and the procedures for applying those clinical review criteria; the Plan will evaluate provider feedback submitted by practicing practitioners when evaluating applicable clinical review

criteria. If the practitioner would like to provide input on clinical review criteria that will be considered during the internal policy's next annual review, it is recommended that comments and supporting references be submitted to the Plan a few months before the applicable policy's scheduled annual review date (as specified in the Next Review Date section at the end of each internal policy). Supporting documentation must include position statements developed or endorsed by nationally recognized professional associations, consensus reports or guidelines from specialty societies, or standards adopted by governmental agencies (e.g., National Institutes of Health, Agency for HealthCare Research and Quality, Center for Medicare & Medicaid Services, Massachusetts Executive Office of Health and Human Services, or New Hampshire Department of Health and Human Services). Published scientific evidence from additional reputable sources may also be submitted for consideration.

Issues related to clinical review criteria that must be addressed before the policy's annual review date will be evaluated immediately during a prior authorization request for services; OCA UM staff will engage in individual case discussions with licensed Plan pharmacists, OCA UM clinicians, and/or Plan Medical Directors (utilizing qualified Plan clinicians applicable for the member's condition and requested treatment) to determine if the clinical review criteria are appropriate for the member's circumstances or care provided by a local delivery system according to the guidelines specified below in the Application of the Plan's Clinical Review Criteria section of this policy.

Providers may email feedback on the Plan's internal medical policies to the Medical Policy Mailbox at medical.policy@bmchp-wellsense.org. It is important to include the medical policy title and policy number with the comments so Plan staff can thoroughly research the issue. An integral component of the Plan's annual medical policy review process is to evaluate provider comments and recommendations.

2. **Application of Plan's Internal Clinical Review Criteria and Plan-Adopted InterQual® Criteria**:

Review the Policy Summary and the Delegated Management sections (rather than this section of the policy) for guidelines related to clinical review criteria and services managed by partner clinical vendors with whom the Plan has delegated utilization management by Plan product. Application of the Plan's clinical review criteria (including internal clinical review criteria and InterQual® criteria) follows the procedure specified below in items a through g:

a. The Plan's Office of Clinical Affairs (OCA) includes OCA UM staff, Plan licensed pharmacists, and Plan Medical Directors who apply applicable Plan clinical review criteria consistently when determining the medical necessity of healthcare services. The Plan's OCA UM staff includes both the Pharmacy UM staff and UM staff. Reporting to the Director of Pharmacy, the Pharmacy UM staff reviews requests for pharmacotherapy or directs requests to a partner clinical vendor for delegated utilization management. Reporting to the Directors of Utilization Management, UM staff reviews medical/surgical/behavioral health requests for service or

directs requests to a partner clinical vendor for delegated utilization management according to guidelines in both item (1) and item (2):

(1) The Plan's OCA UM staff applies clinical review criteria consistently for all Plan members according to the standards specified in this policy (e.g., requests for transplant services), as well as complying with the Plan's out-of-network guidelines and product-specific requirements outlined in the *Out-of-Network Services* medical policy, policy number OCA 3.18. When standard clinical criteria are not met, qualified OCA UM staff also considers member-specific factors impacting the member's individual healthcare needs to determine if the service is medically necessary for the requested indication. The service may include a treatment, procedure, supply, device, biologic, or drug and will be used to prevent, diagnose, stabilize, and/or treat a disease, condition, and/or disorder that results in health impairment and/or disability, and/or the service allows the member to attain, maintain, or regain functional capacity. Individual consideration includes an assessment of any member-specific factors impacting care, including one or more of the following:

    (a) Member's condition;

    (b) Member's comorbidities;

    (c) Member's age, including the assessment of the member's age-appropriate growth, development, and competencies, as well as evaluation of age-related and condition-specific healthcare needs and associated issues;

    (d) Relevant past medical/surgical/behavioral health/dental/pharmacotherapy history;

    (e) Complications;

    (f) Progression of the member's condition, illness, or injury;

    (g) Diagnostic test results;

    (h) Treatment outcomes;

    (i) Treatment options;

    (j) Psychosocial circumstances;

    (k) Home and environmental factors impacting member's clinical condition (e.g., homelessness, employment status, poverty, neighborhood);

    (l) Other healthcare services requested and/or provided to the member to integrate healthcare for continuity, coordination, and collaboration of services;

(m) Local healthcare delivery system's ability to meet the healthcare needs of the member's specific condition;

(n) Member's reasonable accessibility to a qualified provider with appropriate credentials, licensure, clinical expertise or resources in the applicable clinical area necessary to adequately manage the member's condition, including but not limited to pharmacotherapy, behavioral health services, dental services, radiology services, or durable medical equipment (prosthetics, orthotics and supplies);

(o) Other factors related to the member's plan of care or health outcomes; AND/OR

(p) If applicable, verification that the requested device, system, biologic, or drug is being prescribed/requested and will be utilized according to its FDA-approved or compendia indication and guideline information, including intended use for the member's age and medical condition; AND

(2) When clinical review criteria are NOT met for a specified service such that medical necessity cannot be established, OCA UM staff will engage in individual case discussions with licensed Plan pharmacists, OCA UM clinicians, and/or Plan Medical Directors (utilizing qualified Plan clinicians applicable for the member's condition and requested treatment) to determine if the clinical review criteria are appropriate for the member's circumstances or care provided by a local delivery system. If the clinical review criteria are not appropriate, OCA UM staff may make the utilization determination based on the member's condition and other unique circumstances; AND

b. OCA UM staff considers the following characteristics of the healthcare delivery system listed in items (1) through (4) to assess the local healthcare delivery system's ability to meet the member's healthcare needs when applying clinical review criteria to each request:

(1) Availability and member access to acute and subacute care facilities, including but not limited to acute care inpatient hospitals (with access to inpatient and outpatient specialty hospital services such as major burn care, transplantation, specialty pediatric care, specialty outpatient centers for HIV/AIDS, sickle cell disease, hemophilia, craniofacial and congenital anomalies), surgi-centers, rehabilitation facilities, transitional care facilities, skilled nursing facilities (SNF), home health agencies, and hospice programs, as applicable for the member's clinical needs; AND

(2) Member's reasonable accessibility to a qualified provider with appropriate credentials and clinical expertise in the applicable clinical area necessary to adequately treat the member's condition; AND

Note: The Plan will authorize a member's care from an out-of-network provider when, as determined by the Plan, the care needed by the member is not available or is not reasonably accessible to the member.

(3) Covered benefits for acute and subacute care facilities, including but not limited to acute care inpatient hospitals, surgi-centers, rehabilitation facilities, transitional care facilities, SNF, or home health agencies, as applicable for the member's clinical needs; AND

(4) The ability of acute and subacute care facilities, including but not limited to acute care inpatient hospitals, surgi-centers, rehabilitation facilities, transitional care facilities, SNF, or home health agencies, to provide the following services, as specified below in BOTH items (a) and (b):

(a) Provide the recommended medically necessary services to the member within the estimated amount, frequency, and duration of treatment (including the estimated length of stay, when applicable); medically necessary services required by the member and provided by the facility/treating provider may include routine medical/surgical services, highly specialized healthcare services (such as transplant services or cancer care), rehabilitative care, habilitative services, and/or support services after hospital discharge; AND

(b) Provide the medically necessary clinical support to the Plan member after the member's hospital discharge and/or transition to a less intense clinical setting or to home, as applicable for the member's treatment plan; AND

c. When an OCA UM staff member is unable to authorize care by establishing medical necessity, the OCA UM staff will forward the request and documentation to the appropriate Medical Director or licensed Plan pharmacist for a determination (utilizing qualified Plan clinicians applicable for the member's condition and requested treatment); AND

d. When medical necessity cannot be established through existing clinical review criteria, the Plan's Medical Directors and/or licensed Plan pharmacists consider alternate methods of determining medical necessity, as defined in the *Medically Necessary* medical policy, policy number OCA 3.14. If Plan-adopted written clinical review criteria have not been established for the requested service for the specified indication, the Plan's Medical Directors and/or licensed Plan pharmacists will use published and applicable generally accepted, scientifically-based standards of care to determine medical necessity. If scientifically-based standards of care are not available, observational studies from more than one (1) institution that suggest a causal relationship between the service or treatment and health outcomes may be used by the Plan's Medical Directors and/or licensed Plan pharmacists to make medical necessity determinations if these observational studies are clinically appropriate with respect to the member's clinical presentation. The Plan's Medical Directors and/or licensed Plan pharmacists also consider member-specific factors when applying clinical criteria, evaluating standards of care and credible scientific evidence published in peer-reviewed medical/clinical literature, and/or reviewing observational studies for a request for services for a Plan member to make medical necessity determinations; AND

e. The Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC), Pharmacy and Therapeutics (P&T) Committee, Utilization Management Committee (UMC), and other applicable committees meet annually or more frequently as needed to review and/or and authorize all clinical review criteria used by the Plan along with the policies and procedures for application; AND

f. OCA UM staff training and annual inter-rater reliability testing are conducted to review the application of internal clinical review criteria (including criteria in the Plan's internal medical policies and internal pharmacy policies) and Plan-adopted InterQual® criteria to ensure the consistency of medical necessity determinations among the OCA UM staff, Plan pharmacists, and Plan Medical Directors (according to the definitions of inter-rater reliability, OCA Staff, and OCA UM Staff in the Definitions section of this policy); AND

g. The Plan makes all of its clinical review criteria available to practitioners, members, regulatory agencies, and accreditation organizations, upon oral or written request. Providers and member may call or fax the Plan with a request for a copy of the specific criteria, as stated in writing in the Plan's provider manual and Plan's website. This access to clinical review criteria includes applicable copyrighted commercial criteria such as those used by the Plan's partner delegated clinical vendors and Plan-adopted InterQual® criteria.

   The current version of clinical review criteria included in the Plan's internal medical policies and internal pharmacy policies are available to all providers, members, and the general public on the Plan's extranet site. Participating providers receive network notifications via email at least 60 calendar days before the effective date of material changes to internal clinical review criteria and/or coding (excluding industry-wide code updates and administrative changes) or when new versions of InterQual® criteria are adopted by the Plan. Copies of internal medical policies with material changes to clinical review criteria and/or coding are included these provider network notifications (sent at least 60 calendar days before the effective date); updated internal medical policies will be available at the Plan's website on the effective date of the revisions. Providers may email feedback on the Plan's medical policies to the Medical Policy Mailbox at medical.policy@bmchp-wellsense.org. It is important to include the medical policy title and policy number with the comments so Plan staff can thoroughly research the issue. An integral component of the Plan's annual medical policy review process is to evaluate provider comments and recommendations.

   The Plan will submit material revisions to its medical necessity guidelines, including clinical review criteria and related utilization management protocols, to the Massachusetts Office of Patient Protection, Massachusetts Executive Office of Health and Human Services (EOHHS), New Hampshire Department of Health and Human Services (DHHS), and the Centers for Medicare & Medicaid Services (CMS) at least 60 calendar days before the effective date of these material revisions (or another timeframe specified by the organization) when these changes may impact services provided to the organization's enrollees; a designated contact person must be provided in writing to the Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) by the organization or its designee.

Internal pharmacy policy revisions are communicated to providers 60 calendar days before the effective date of the revisions. Pharmacy policies for the Plan's NH Medicaid product are submitted to DHHS for review and approval prior to implementation. Once approved, pharmacy policies are available on the Plan's website 30 calendar days before the effective date. For Medicaid and commercial lines of business, providers may email feedback on the Plan's pharmacy policies at pharmacym@bmchp-wellsense.org, or provide feedback as part of the UM process during Peer to Peer discussions with the Plan's clinical staff. During the annual pharmacy policy review process, the Plan evaluates provider feedback and recommendations. Pharmacy policies for Medicaid and commercial products are approved by the Plan's Pharmacy & Therapeutics (P&T) Committee. For MA Senior Care Options (SCO) and NH Medicare Advantage products, the pharmacy policies are approved by the Centers for Medicare & Medicaid Services. Pharmacy utilization management functions and the P&T Committee responsibilities are delegated to the Pharmacy Benefit Manager for MA SCO and NH Medicare Advantage products.

Responsibility and Accountability

See the Policy Summary and Delegated Management sections of this policy for guidelines related to clinical review criteria and services managed by clinical vendors with whom the Plan has delegated utilization management (by Plan product), including behavioral health services, radiology services, dental services, pharmacy benefits administration, and durable medical equipment, prosthetics, orthotics and supplies. Responsibility and accountability related to the development, implementation, and monitoring of the Plan's internal clinical review criteria (included in the Plan's medical policies and internal pharmacy policies) are specified below in items 1 through 4:

1. The Utilization Management Committee (UMC), chaired by the Director of UM Program Oversight and Member Appeals and Grievances**,** oversees and is accountable for the adoption, development, review, update, and implementation of the Plan's clinical review criteria. Generally, the Plan adopts nationally developed and accepted criteria (e.g., InterQual®). When national criteria are not available or not utilized by the Plan, Plan-specific criteria may be developed that are objective, scientifically derived, and evidence-based, with input from participating practitioners and consistent with applicable legal, regulatory, and national accreditation organization standards.

2. The Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) is responsible for developing and approving medical policies, and the Pharmacy and Therapeutics (P&T) Committee is responsible for developing and approving pharmaceutical coverage policies.

3. The Directors of OCA (including but not limited to the Directors of Utilization Management and the Director of Pharmacy), Chief Medical Officer, Plan Medical Directors, Plan pharmacists, and other OCA UM staff use the Plan's clinical review criteria in accordance with applicable Plan policies and procedures.

4. The Directors of OCA, including but not limited to the Directors of Utilization Management and the Director of Pharmacy, or their designee(s) are responsible for ensuring OCA UM staff training, evaluating, and monitoring. The Chief Medical Officer or designee is responsible for ensuring Medical Director training, evaluation, and monitoring to ensure consistent application of clinical review criteria and medical necessity determinations.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for the Plan's Senior Care Options (SCO) members and New Hampshire Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. Verify CMS guidelines in effect on the date of the prior authorization request. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Definitions

Clinical Review Criteria (Definition for MassHealth and Senior Care Options Products): Criteria used to determine the most clinically appropriate and necessary level of care and intensity of services to ensure the provision of medically necessary services. Medical necessity guidelines established by the Plan will be no more restrictive than the applicable contractual MassHealth ACO and MCO definition of Medically Necessary or Medical Necessity and the same services furnished to members under MassHealth fee-for-service, as specified in the Plan's *Medically Necessary* medical policy, policy number OCA 3.14. Any new or amended pre-authorization requirement or restriction shall NOT be implemented unless the Plan's and/or partner clinical vendor's respective website has been updated to clearly reflect the new or amended requirement or restriction.

Clinical Review Criteria (Definition for Qualified Health Plans/ConnectorCare/Employer Choice Direct Definition Products): In accordance with 958 CMR 3.020, clinical review criteria are the written screening procedures, decisions, abstracts, clinical protocols and/or practice guidelines used by the Plan to determine the medical necessity and appropriateness of health care services. Utilization review criteria shall be up to date and applied consistently by the Plan or the Plan's partner clinical vendor and made easily accessible to members, providers, and the general public on the Plan's website; or, in the alternative, on the Plan's partner clinical vendor's website so long as the Plan provides a link on its website to the vendor's website; provided, however, that the Plan shall not be required to disclose licensed, proprietary criteria purchased by the Plan or partner clinical vendor on its website, but must disclose such criteria to a provider or subscriber upon request. Review the Plan's *Medically Necessary* medical policy, policy number OCA 3.14, for the product-specific definition of medically necessary treatment. Any new or amended pre-authorization requirement or restriction shall NOT be implemented unless the Plan's and/or partner clinical vendor's respective website has been updated to clearly reflect the new or amended requirement or restriction.

Clinical Review Criteria (Definition for New Hampshire Medicaid Product): A set of medical decision standards employed in the utilization review process in order to ensure members receive

appropriate care, at an appropriate time, in an appropriate setting by an appropriate provider and at an appropriate level of care. Criteria are consistent with an efficient and effective utilization of resources available to recipients. Medical necessity guidelines established by the Plan will be no more restrictive than the contractual definition of Medically Necessary for the New Hampshire Department of Health and Human Services (DHHS) and the same services furnished in the New Hampshire DHHS fee-for-service Medicaid program, as specified in the Plan's *Medically Necessary* medical policy, policy number OCA 3.14. Any new or amended pre-authorization requirement or restriction shall NOT be implemented unless the Plan's and/or partner clinical vendor's respective website has been updated to clearly reflect the new or amended requirement or restriction.

Inter-Rater Reliability (IRR): A performance measurement tool used to compare and evaluate the level of consistency in healthcare determinations between two (2) or more medical and behavioral health utilization management (UM) clinicians. The tool is used to minimize variation in the application of clinical review criteria and identify potentially avoidable utilization target areas that need improvement and evaluate the ability to identify quality of care issues.

Office of Clinical Affairs (OCA) Staff: Plan staff members within the OCA that include but are not limited to OCA Utilization Management (UM) staff, Plan licensed pharmacists, Plan Medical Directors, and the Chief Medical Officer. The Directors of OCA, including the Directors of Utilization Management and the Director of Pharmacy, or their designees are responsible for ensuring OCA UM staff training, evaluating, and monitoring. The Plan's OCA UM staff, Plan licensed pharmacists, and Plan Medical Directors consistently use applicable Plan clinical review criteria when determining the medical necessity of healthcare services. The Chief Medical Officer or designee is responsible for ensuring Medical Director training, evaluation, and monitoring to ensure consistent application of clinical review criteria and medical necessity determinations.

Office of Clinical Affairs (OCA) Utilization Management (UM) Staff: The Plan's OCA UM staff includes both the Pharmacy UM staff and UM staff. Reporting to the Director of Pharmacy, the Pharmacy UM staff reviews requests for pharmacotherapy or directs requests to a partner clinical vendor for delegated utilization management. Reporting to the Directors of Utilization Management, appropriately qualified UM staff reviews medical, surgical, behavioral health, and/or dental requests for service or directs requests to a partner clinical vendor for delegated utilization management.

Plan-Adopted Clinical Review Criteria: Written clinical review criteria used to determine medical necessity, including internally developed criteria specified in Plan medical policies and Plan pharmacy policies, InterQual® criteria utilized by the Plan, and clinical guidelines established by delegated management partners (for related services provided Plan members for applicable Plan products).

Practitioner (Definition for the Qualified Health Plans, ConnectorCare, and Employer Choice Direct): A professional who provides healthcare services. Practitioners are usually required to be licensed as defined by law.

Utilization Review (UR): A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, healthcare services, procedures, or

settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, and/or retrospective review.

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Next Review Date

06/01/23

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Other Applicable Policies

Administrative Policy - *Clinical Technology Evaluation,* policy number OCA 3.13
Administrative Policy - *Inter Rater Reliability*, policy number OCA 3.216
Medical Policy - *Clinical Trials*, policy number OCA 3.192
Medical Policy - *Cosmetic, Reconstructive, and Restorative Services*, policy number OCA 3.69
Medical Policy - *Experimental and Investigational Treatment*, policy number OCA 3.12
Medical Policy - *Medically Necessary*, policy number OCA 3.14
Medical Policy - *Out-of-Network Services*, policy number OCA 3.18
Reimbursement Policy - *Clinical Trials*, policy number 4.134
Reimbursement Policy - *Clinical Trials*, policy number SCO 4.134
Reimbursement Policy - *Clinical Trials*, policy number WS 4.12
Reimbursement Policy - *Early Intervention*, policy number 4.3
Reimbursement Policy - *Early and Periodic Screening, Diagnosis and Treatment (EPSDT)*, policy number WS 4.15
Reimbursement Policy - *General Billing and Coding Guidelines*, policy number 4.31
Reimbursement Policy - *General Billing and Coding Guidelines*, policy number SCO 4.31
Reimbursement Policy - *General Billing and Coding Guidelines*, policy number WS 4.17
Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number 4.108
Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number SCO 4.108
Reimbursement Policy - *General Clinical Editing and Payment Accuracy Review Guidelines*, policy number WS 4.18
Reimbursement Policy - *Hospital*, policy number WS 4.21
Reimbursement Policy - *Inpatient Hospital*, policy number 4.110
Reimbursement Policy - *Inpatient Hospital*, policy number SCO 4.110
Reimbursement Policy - *Non-Participating Provider,* policy number WS 4.5
Reimbursement Policy - *Non-Reimbursed Codes*, policy number 4.38
Reimbursement Policy - *Non-Reimbursed Codes*, policy number WS 4.38
Reimbursement Policy - *Outpatient Hospital*, policy number 4.17
Reimbursement Policy - *Outpatient Hospital*, policy number SCO 4.17
Reimbursement Policy - *Physician and Non-Physician Practitioner Services*, policy number 4.608
Reimbursement Policy - *Physician and Non-Physician Practitioner Services*, policy number SCO 4.608
Reimbursement Policy - *Physician and Non-Physician Practitioner Services*, policy number WS 4.28
Reimbursement Policy - *Provider Preventable Conditions and Serious Reportable Events*, policy number 4.610
Reimbursement Policy - *Provider Preventable Conditions and Serious Reportable Events*, policy number SCO 4.610
Reimbursement Policy - *Provider Preventable Conditions and Serious Reportable Events*, policy number WS 4.29

Reference to Applicable Laws and Regulations

42 CFR 405.1060. Code of Federal Regulations. Applicability of National Coverage Determinations.

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42 CFR 438.100. Code of Federal Regulations. Public Health, Centers for Medicare & Medicaid Services. Managed Care. Enrollee Rights and Protections. Enroll Rights.

42 CFR §438.210. Code of Federal Regulations. Public Health. Centers for Medicare & Medicaid Services. Medical Assistance Programs. Managed Care. Coverage and Authorization of Services.

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211 CMR 52.02. Code of Massachusetts Regulations. Division of Insurance. Managed Care Consumer Protections and Accreditation of Carriers. Definitions. Clinical Review Criteria.

211 CMR 52.02. Code of Massachusetts Regulations. Division of Insurance. Managed Care Consumer Protections and Accreditation of Carriers. Definitions. Medical Necessity or Medically Necessary.

211 CMR 52.02. Code of Massachusetts Regulations. Division of Insurance. Managed Care Consumer Protections and Accreditation of Carriers. Definitions. Utilization Review.

958 CMR 3.020. Code of Massachusetts Regulations. Health Insurance Consumer Protection. Definitions. Clinical Review Criteria.

958 CMR 3.020. Code of Massachusetts Regulations. Health Insurance Consumer Protection. Definitions. Utilization Review.

958 CMR 3.020. Code of Massachusetts Regulations. Health Insurance Consumer Protection. Definitions. Medical Necessity or Medically Necessary.

958 CMR 3.020. Code of Massachusetts Regulations. Health Insurance Consumer Protection. Definitions. Utilization Review.

958 CMR 3.101. Code of Massachusetts Regulations. Health Insurance Consumer Protection. Definitions. Carrier's Medical Necessity Guidelines.

958 CMR 3.400. Code of Massachusetts Regulations. Health Insurance Consumer Protection. External Review.

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He-W 530.05(b)(4). New Hampshire Code of Administrative Rules. Medical Assistance. Non-Covered Services. Experimental or Investigational Procedures.

He-W 531. New Hampshire Code of Administrative Rules. Medical Assistance. Physician Services.

He-W 531.01(a). New Hampshire Code of Administrative Rules. Medical Assistance. Physician Services. Cosmetic Purpose.

He-W 543. New Hampshire Code of Administrative Rules. Medical Assistance. Hospital Services.

He-W 546. New Hampshire Code of Administrative Rules. Medical Assistance. Early and Periodic Screening, Diagnosis and Treatment Service.

MGL c 233. Massachusetts General Laws. An Act Relative to HIV-Associated Lipodystrophy Syndrome Treatment.

MGL c 1760. Massachusetts General Laws. Health Insurance Consumer Protections.

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The Center for Consumer Information & Insurance Oversight. Centers for Medicare and Medicaid Services (CMS).

Newborns' and Mothers Health Protection Act of 1996 (NMHPA). The Center for Consumer Information & Insurance Oversight. Centers for Medicare and Medicaid Services (CMS).

New Hampshire Department of Health and Human Services (DHHS). Certified Administrative Rules. RSA 417-D:2-b. New Hampshire Revised Statutes Annotated. Women's Health Care. Reconstructive Surgery.

RSA Chapter 420-E. New Hampshire Revised Statutes. Insurance. Licensure of Medical Utilization Review Entitles.

Social Security Act. Title XIX. 1902(a)(43), 1905(a)(4)(B), 1905(r). Grants to States for Medical Assistance Programs. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).

Social Security Act. Title XXI. State Children's Health Insurance Program.

U.S. Women's Health and Cancer Right Act of 1998.

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: 08/01/08 MH Review: 02/19/10 Internal Approval: 07/24/07 and 08/13/07	08/13/07 Version 1	Director of Medical Policy as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	Utilization Management Committee (UMC)

*Effective date for MA QHP commercial product: 01/01/12
*Effective date for New Hampshire Medicaid product: 01/01/13
*Effective date for MA Senior Care Options product: 01/01/16
*Effective date for New Hampshire Medicare Advantage HMO product: 01/01/22

Note: Policy title was *Clinical Criteria* until 07/31/17. Policy title changed to *Clinical Review Criteria* as of 08/01/17.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
04/22/08	Typos and formatting corrected. Removed bullet stating Chief Medical Officer conducts review on all criteria annually.	Version 2	04/22/08: UMC
05/07/08	Added authority for plan pharmacists to render pharmacy denials.	Version 3	05/20/08: UMC 06/19/08: Quality Improvement Committee (QIC)
08/20/09	Changed titles within Health Services, minor typos and formatting, updated references, changed definition for clinical criteria.	Version 4	09/22/09: UMC 09/23/09: QIC
07/21/10	Updated names, departments and references, extra definition for medically necessary was removed.	Version 5	07/21/10: MPCTAC 08/25/10: QIC
07/01/11	Added medically necessary definition and language for Commercial product.	Version 6	07/22/11: MPCTAC 08/24/11: QIC
07/01/12	References updated, moved Purpose section of policy to the beginning of the document and added reference for the Plan's Prior Authorization/ Notification Requirements matrix. Referenced the Plan's Medically Necessary policy for a definition of medically necessary for each member type and deleted	Version 7	07/18/12: MPCTAC 08/15/12: MPCTAC

	medically necessary definitions from this policy. Added language regarding delegated management in Policy Statement section. Added reference to Physician Reviewers in policy. Changed definition title from "Clinical Criteria" to "Clinical Review Criteria."		
08/15/12	Off cycle review for New Hampshire Medicaid product. Revised the Purpose, Definitions, Policy Statement, reformatted Procedure, updated references for all Plan products.	Version 8	08/17/12: MPCTAC 09/13/12: QIC
9/01/12	Added language to clarify the Plan's UR process that includes the evaluation of member's circumstances and local delivery system, when clinically appropriate.	Version 9	09/19/12: MPCTAC 09/26/12: QIC
06/01/13	Review for effective date 07/18/13. Revised title of chair for the Utilization Management Committee.	07/18/13 Version 10	06/19/13: MPCTAC 07/18/13: QIC
06/01/14	Review for effective date 10/01/14. Updated Purpose, Policy Statement, Delegated Management, Procedure, Responsibility and Accountability, Definitions, and References sections.	10/01/14 Version 11	06/09/14: MPCTAC 07/09/14: QIC
06/01/15	Review for effective date 07/08/15. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available. Administrative changes made to Purpose, Policy Statement, Delegated Management, and Procedure sections.	07/08/15 Version 12	06/17/15: MPCTAC 07/08/15: QIC
09/01/15	Review for effective date 10/14/15. Added reference to eviCore healthcare in the Delegated Management section. Updated list of applicable products, including the removal of Common-wealth Care, Commonwealth Choice, and Employer Choice because the products are no longer available.	10/14/15 Version 13	09/16/15: MPCTAC 10/14/15: QIC
06/01/16	Review for effective date 07/13/16. Updated with administrative changes to the Delegated Management, References, and References to Applicable Laws and Regulations sections.	07/13/16 Version 14	06/15/16: MPCTAC 07/13/16: QIC
05/01/17	Review for effective date 06/01/17. Administrative changes made to the policy title and the Purpose, Policy Statement, Responsibility and Accountability, Definitions, References, and Reference to Applicable Laws and Regulations sections to clarify the Plan's clinical criteria review process and the	06/01/17 Version 15	05/17/17: MPCTAC

	use of these clinical criteria in utilization review activities.		
08/31/17	Updated the definition of Clinical Review Criteria (for Massachusetts products) to include requirements for the medical necessity guidelines applicable for the Accountable Care Organization (ACO). Updated Product Applicability and Reference sections to incorporate ACO.	08/31/17 Version 16	08/31/17: MPCTAC (electronic vote)
06/01/18	Review for effective date 07/01/18. Administrative changes made to the Policy Statement, Procedure, Responsibility and Accountability, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.	07/01/18 Version 17	06/20/18: MPCTAC
09/01/18	Review for effective date 12/01/18. Administrative changes made to the Purpose and Policy Summary sections. Updated criteria in the Procedure section (clarifying the existing process).	12/01/18 Version 18	09/19/18: MPCTAC
11/01/18	Review for effective date 12/01/18. Administrative changes made to the Policy Statement, Delegated Management, and Procedure sections to clarify the existing process available for practitioners to submit comments related to clinical review criteria.	12/01/18 Version 19	11/21/18: MPCTAC
06/01/19	Review for effective date 07/01/19. Administrative changes made to the Policy Summary (formerly Purpose section), Policy Statement, Delegated Management, Procedure, Definitions, Responsibility and Accountability, References, and Reference to Applicable Laws and Regulations sections to clarify the existing process.	07/01/19 Version 20	06/19/19: MPCTAC
12/01/19	Review for effective date 01/01/20. Administrative changes made to the Delegated Management and Procedure sections.	01/01/20 Version 21	12/18/19: MPCTAC
06/01/20	Review for effective date 07/01/20. Administrative changes made to the Policy Summary, Procedure, References, and Reference to Applicable Laws and Regulations sections.	07/01/20 Version 22	06/17/20: MPCTAC
12/01/20	Review for effective date 01/01/21. Administrative changes made to the Delegated Management, Responsibility and Accountability, and Definitions sections.	01/01/21 Version 23	12/16/20: MPCTAC

12/22/20	Review for effective date 01/01/21 (replacing version 23). Updated documentation related to the Plan's Pharmacy Manager, Express Scripts, in the Delegated Management section.	01/01/21 Version 24	12/23/20: MPCTAC (electronic vote)
06/01/21	Review for effective date 07/01/21. Clarified current guidelines with administrative changes made to the Policy Summary, Policy Statement, Delegated Management, and Procedure sections to clarify existing guidelines. Updated References section.	07/01/21 Version 25	06/16/21: MPCTAC
08/01/21	Review for effective date 09/01/21. Administrative changes made to the Policy Summary, Policy Statement, Definitions, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections to clarify current guidelines.	09/01/21 Version 26	08/13/21: MPCTAC (electronic vote)
11/01/21	Review for effective date 12/01/21. Added NH Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary and Policy Statement sections. Added the Variations section.	12/01/21 Version 27	11/17/21: MPCTAC
07/01/22	Review for effective date 08/01/22. Administrative changes made to the Policy Summary, Policy Statement, Delegated Management, Procedure, Responsibility and Accountability, Definitions, and Other Applicable Policies sections.	08/0/122 Version 28	07/25/22: MPCTAC (electronic vote)
08/01/22	Review for effective date 11/01/22. Revised the list of the Plan's delegated services and partner clinical vendors in the Delegated Management section. eviCore healthcare served as the Plan's delegated vendor for radiology services from 03/15/20 to 10/31/22. Effective 11/01/22, the Plan will delegate the management of radiology services, musculoskeletal services (i.e., spine surgeries, joint surgeries, and interventional pain management treatments), genetic testing, and outpatient rehabilitation services (i.e., physical therapy, occupational therapy, and speech therapy after the initial evaluation) to AIM Specialty Health.	11/01/22 Version 29	08/26/22: MPCTAC (electronic vote)

Medical Policy

Complementary and Alternative Medicine

Policy Number: OCA 3.194
Version Number: 21
Version Effective Date: 11/01/22

Impacted Products

- ☐ **All Products**
- ☐ NH Medicaid
- ☒ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☐ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers complementary and alternative medicine (CAM) NOT medically necessary unless the service (including indication for treatment) is covered for the member. Prior authorization from AIM Specialty Health is required for outpatient therapeutic services.

Clinical Criteria

The member's product-specific benefit documents will determine coverage for CAM services, as specified below in items 1 and 2:

1. The Plan considers CAM services NOT medically necessary for Plan members, except as covered in the member's applicable benefit documents.

2. There may be separate medical policies that address the treatment of specific conditions or procedures that supersede this policy. See the Plan's *Prior Authorization/Notification Requirements* matrix available at the Plan's website for prior authorization guidelines by service type.

Limitations and Exclusions

The Plan considers CAM to NOT be medically necessary due to insufficient scientific evidence demonstrating the clinical validity and clinical utility of treatment unless the service (including indication for treatment) is covered for the member. CAM include but are not limited to any of the following services:

1. Whole medicine systems (e.g., homeopathic and naturopathic medicine, traditional Chinese medicine such as Ayurveda).

2. Mind body medicine to improve the mind's ability to affect bodily function and symptoms (e.g., biofeedback except for treatment of urinary incontinence, hypnotherapy/hypnosis, meditation, prayer, mental healing, therapies that use creative outlets such as art, music, or dance).

3. Substances found in nature (e.g., herbal products, vitamins, dietary supplements).

4. Manipulative and body based practices (e.g., massage, myotherapy, craniosacral therapy, osteopathic manipulation, hippotherapy, yoga, reflexology).

5. Energy medicine (e.g., Reiki, therapeutic touch, pulsed fields, magnetic fields, electromagnetic, or alternating-current or direct-current field).

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and NH Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, there was no applicable clinical policies by CMS. Verify CMS guidelines in effect on the date of the prior authorization request for the service and indication for treatment. When there is no guidance from CMS for the requested service, plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. Since these codes may be updated at different intervals than the medical policy review cycle, the list of applicable codes included in a policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of a medical policy, even if an applicable code appropriately describing the service is not included in the policy's Applicable Coding

section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT/HCPCS Codes	Description: Service is considered NOT medically necessary, except as specified in the member's applicable benefit document
90880	Hypnotherapy Plan note: Code is NOT payable for the Senior Care Options product.
M0075	Cellular therapy Plan note: Code is NOT payable for the Senior Care Options and NH Medicare Advantage HMO products.

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Next Review Date

02/01/23

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

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Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 07/28/09: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 08/26/09: Quality Improvement Committee (QIC)	11/01/09 Version 1	Director of Medical Policy as Chair of MPCTAC	MPCTAC and QIC

*Effective Date for QHP Commercial Product: 01/01/12
*Effective Date for Senior Care Options Product: 01/01/16
*Effective Date for NH Medicare Advantage HMO Product: 01/01/22

Policy title was *Complementary and Alternative Medicine, Including Acupuncture Treatment* until 06/30/19. As of 07/01/19, policy title changed to *Complementary and Alternative Medicine, Including Acupuncture*. As of 01/01/22, policy title changed to *Complementary and Alternative Medicine*.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
07/01/10	Removed osteopathic manipulation from the list of CAM services. Changed the "non-covered" language to "not medically necessary," added massage by a massage therapist and updated references.	Version 2	07/21/10: MPCTAC 08/25/10: QIC
07/01/11	Updated references and added commercial language.	Version 3	07/22/11: MPCTAC 08/24/11: QIC
07/01/12	Updated references, added language to Applicable Code section and added applicable code list. Updated Summary section and Applicable Code section to specify that acupuncture is considered a medically necessary service for Commonwealth Care and MassHealth members when used for substance abuse detoxification, as managed and authorized by Beacon Health Strategies. Included statement that acupuncture is not a covered service for Commercial members and	Version 4	07/18/12: MPCTAC 08/22/12: QIC

	added a reference to the Medically Necessary policy in the Summary section.		
05/01/13	Review for effective date 09/01/13. Updated Summary section and applicable code list. Referenced Reimbursement Guidelines: Chiropractic Services (Spinal Manipulation), policy number 4.114. Medical Policy Statement section revised without changing criteria. Hippotherapy added to applicable code list, and the reference to the Hippotherapy policy deleted from Medical Policy Statement section (since Hippotherapy policy will be retired effective 09/01/13). Renumbered policy from OCA: 3.193 to OCA: 3.194.	09/01/13 Version 5	05/15/13: MPCTAC 06/20/13: QIC
05/01/14	Review for effective date 07/01/14. Updated Summary section. Added acupuncture services in the Description of Item or Service and Clinical Background Information sections. Revised language in Medical Policy Statement section and Limitations section without changing criteria. Updated references. Revised policy title.	07/01/14 Version 6	05/21/14: MPCTAC 06/11/14: QIC
01/01/15	Review for effective date 03/01/15. Updated Medical Policy Statement section to clarify guidelines without changing criteria. Updated references.	03/01/15 Version 7	01/21/15: MPCTAC 02/11/15: QIC
04/01/15	Review for effective date 06/01/15. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available. Administrative changes made to the Applicable Coding section, but no changes made to the code list. Updated Summary and References sections.	06/01/15 Version 8	04/15/15: MPCTAC 05/13/15: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Administrative changes made to the Summary, Medical Policy Statement, and Limitations section without revising criteria. Revised language in the Applicable Coding section.	01/01/16 Version 9	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
04/01/16	Review for effective date 06/01/16. Updated the Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections.	06/01/16 Version 10	04/20/16: MPCTAC 05/23/16: QIC

04/01/17	Review for effective date 05/08/17. Administrative changes made to the Medical Policy Statement and Applicable Coding sections (without changing the code list or criteria). Updated Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections.	05/08/17 Version 11	04/19/17: MPCTAC
02/01/18	Review for effective date 03/01/18. Updated Description of Item or Service and Other Applicable Policies sections.	03/01/18 Version 12	02/21/18: MPCTAC
05/01/18	Review for effective date 06/01/18. Administrative changes made to the Limitations sections. Updated Plan notes in the Applicable Coding section without changing the code list. Removed QHP/ConnectorCare/Employer Choice Direct from the list of applicable products for this policy. Updated Policy Summary, Definitions, References, and Other Applicable Policies sections.	06/01/18 Version 13	05/16/18: MPCTAC
03/01/19	Review for effective date 04/01/19. Administrative changes made to the Description of Item or Service, Limitations, Applicable Coding (with Plan notes added), References, and Other Applicable Policies sections.	04/01/19 Version 14	03/20/19: MPCTAC
04/01/19	Review for effective date 05/01/19. Administrative changes made to the Policy Summary, Description of Item or Service, Medical Policy Statement, and Limitations sections. Revised the policy title. Removed non-payable code listed as not medical necessary (administrative change) and updated Plan notes in the Applicable Coding section.	05/01/19 Version 15	04/18/19: MPCTAC (electronic vote)
12/01/19	Review for effective date 01/01/20. Administrative changes made to Plan notes in the Applicable Coding section, References section, and Reference to Applicable Laws and Regulations section.	01/01/20 Version 16	12/18/19: MPCTAC
04/01/20	Review for effective date 07/01/20. Administrative changes made to the Policy Summary, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Revised the Plan notes in the Applicable Coding section. Add a prior authorization requirement for acupuncture	07/01/20 Version 17	04/15/20: MPCTAC

	for Senior Care Options members in the Medical Policy Statement and Limitations sections.		
12/01/20	Review for effective date 01/01/21. Administrative changes made to the Description of Item or Service, Medical Policy Statement, Applicable Coding, and References sections.	01/01/21 Version 18	12/16/20: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, the Medical Policy Statement section renamed the Clinical Criteria section, and the Limitations section renamed the Limitations and Exclusions section. Added NH Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections.	01/01/22 Version 19	11/17/21: MPCTAC
12/01/21	Review for effective date 01/01/22. Removed acupuncture references. Review the Plan's *Acupuncture* medical policy, policy number OCA 3.17, rather than this policy for acupuncture services as of 01/01/22.	01/01/22 Version 20	12/15/21: MPCTAC
08/01/22	Review for effective date 11/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, and Limitations and Exclusions sections. Revised coding in the Applicable Coding section.	11/01/22 Version 21	08/26/22: MPCTAC (electronic vote)

Medical Policy – Policy Retired and AIM Criteria Adopted as of 11/01/22

Facet Joint Nerve Injections

Policy Number: OCA 3.9641
Version Number: 23
Policy Retired Date: 11/01/22

Impacted Products

- ☒ **All Products**
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☒ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers diagnostic or therapeutic facet joint nerve injections (including intra-facet injections/facet blocks and facet medial branch blocks) to be medically necessary when AIM clinical appropriateness guidelines are met. Prior authorization from AIM Specialty Health is required.

Clinical Criteria

No medical policy criteria.

Limitations and Exclusions

None.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and NH Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, (LCD) L35936 includes guidelines for facet joint injections, medial branch blocks, and facet joint radiofrequency ablation. Verify CMS guidelines in effect on the date of the prior authorization request. When there is no

guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. The list of applicable codes included in this policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization from AIM for this service, even if an applicable code appropriately describing the service is not included in the policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Codes	Code Descriptions
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s)
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s)
0213T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; single level
0214T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; second level
0215T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, cervical or thoracic; third and any additional level(s)
0216T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; single level
0217T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; second level

0218T	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with ultrasound guidance, lumbar or sacral; third and any additional level(s)

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Next Review Date

Not applicable

Retired Date

11/01/22

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or

investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.
Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 06/10/08: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC 06/24/08: Utilization Management Committee (UMC) 08/13/08: Quality Improvement Committee (QIC)	11/01/08 Version 1	Director of Medical Policy as Chair of MPCTAC	MPCTAC, UMC, and QIC

*Effective Date for the QHP Commercial Product: 01/01/12
*Effective Date for the New Hampshire Medicaid Product: 01/01/13
*Effective Date for the Senior Care Options Product: 01/01/16
*Effective Date for the New Hampshire Medicare Advantage HMO Product: 01/01/22

Effective 06/01/13, this medical policy replaced the *Facet Joint Nerve Injections and Sacroiliac Joint Injections for Chronic Neck Pain and Chronic Back Pain* medical policy, policy number OCA 3.964, which was effective from 11/01/08 to 05/31/13. Policy retired and service managed by AIM Specialty Health as of 11/01/22.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
06/23/09	Changed name of the policy, added additional criteria for SIJ injections and replaced the criteria for radiological findings negative for disc herniation and nerve root compression with: negative physical signs of radiculopathy or radicular pain, including negative straight leg raising or root tension signs, normal neurological examination, absence of signs of radiculopathy on any electrodiagnostic examinations. Updated the diagnostic clinical criteria to allow no more than 2 joint levels bilaterally or 3 joint levels unilaterally in a 7 to 14-day period to determine the origin of the patient's pain. For SIJ injections, no more than 2 procedures may be allowed in a 7 to 14-day period to determine the origin of the patient's pain. Updated references and coding sections. Effective date of changes is 10/01/09.	10/01/09 Version 2	06/23/09: MPCTAC 06/23/09: UMC 07/22/09: QIC

Policy Revisions History			
06/01/10	No changes to criteria. Updated references and coding.	Version 3	06/30/10: MPCTAC 07/28/10: QIC
06/01/11	Updated clinical criteria to clarify that the absence of prior spinal fusion must be at the clinically suspect levels, updated references.	Version 4	06/29/11: MPCTAC 07/27/11: QIC
07/01/12	Updated references and revised the introductory paragraph in Applicable Coding section. Code descriptions updated but no change to list of applicable codes. Revised policy title and text to specify the policy relates to chronic neck pain and chronic back pain. Added the following additional contraindication for procedures: 'Patient with a malignancy at the injection site.' Medical criteria updated for facet joint nerve injections and sacroiliac joint injections. Definitions added for radiculopathy and straight leg raise test. For facet joint injections, added symptoms of axial pain and signs of facet disease. For sacroiliac joint injections, added types of tests used for a sacroiliac exam. Added definition of a comprehensive pain management program and referenced the Plan's *Medically Necessary* policy.	Version 5	06/20/12: MPCTAC 07/18/12: MPCTAC 08/22/12: QIC
08/01/12	Off cycle review for the New Hampshire Medicaid product. No changes.	Version 6	08/13/12: MPCTAC 09/06/12: QIC
12/01/12	Revised sacroiliac joint injection frequency guidelines in Medical Policy Statement section.	Version 7	12/19/12: MPCTAC 12/20/12: QIC
02/01/13	Review for effective date 06/01/13. Separated facet joint nerve injections and sacroiliac joint injections into two separate policies; policy formerly titled *Facet Joint Nerve Injections and Sacroiliac Joint Injections for Chronic Neck Pain and Chronic Back Pain* (formerly 3.964). Revised title and re-numbered policy. Updated language in Summary, Description of Item or Service, Definitions, and Clinical Background Information sections. Changed name of policy category from "Clinical Coverage Guidelines" to "Medical Policy." Revised applicable code list and updated references. Revised and added clinical criteria in the Medical Policy Statement section (formerly named the Clinical Guideline Statement section), and revised limitations.	06/01/13 Version 8	02/20/13: MPCTAC 03/21/13: QIC
08/14/13 and 08/15/13	Off cycle review for the New Hampshire Medicaid product and merged policy format. Incorporate policy revisions dated 12/01/12 and 02/01/13 (as specified above) for the New Hampshire Medicaid product; these policy revisions were approved by	Version 9	08/14/13: MPCTAC (electronic vote) 08/15/13: QIC

Policy Revisions History			
	MPCTAC (on 12/19/12 and 02/20/13) and QIC (on 12/20/12 and 03/21/13) for applicable Plan products.		
03/01/14	Review for effective date 07/01/14. Updated Summary, Description of Item or Service, Definitions, Clinical Background Information, and References section. Revised policy title from *Fact Joint Nerve Injections for Chronic Back Pain and Chronic Neck Pain* to *Facet Joint Nerve Injections*. Revised and reformatted criteria in the Medical Policy Statement section and Limitations section.	07/01/14 Version 10	03/19/14: MPCTAC 04/16/14: QIC
02/01/15	Review for effective date 06/01/15. Updated Definitions and References sections. Revised criteria in the Medical Policy Statement section. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available.	06/01/15 Version 11	02/27/15: MPCTAC (electronic vote) 03/11/15: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Revised language in the Applicable Coding section.	01/01/16 Version 12	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
02/01/16	Review for effective date 06/01/16. Updated criteria in the Medical Policy Statement and Limitations sections. Updated the Summary, Description of Item or Service, Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections.	06/01/16 Version 13	02/17/16: MPCTAC 03/09/16: QIC
01/01/17	Review for effective date 05/01/17. Updated Summary, Definitions, Clinical Background Information, and References sections. Administrative changes made to the Limitations section. Revised criteria in the Medical Policy Statement section.	05/01/17 Version 14	01/18/17: MPCTAC 02/08/17: QIC
02/01/18	Review for effective date 05/01/18. Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, References, and Other Applicable Policies sections. Revised criteria in the Medical Policy Statement and Limitations sections.	05/01/18 Version 15	02/21/18: MPCTAC
02/01/19	Review for effective date 05/01/19. Administrative changes made to the Policy Summary, Clinical Background Information, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections. Updated criteria in the Medical Policy Statement and Limitations sections.	05/01/19 Version 16	02/20/19: MPCTAC
02/01/20	Review for effective date 03/01/20. Administrative changes made to the Description of Item or Service,	03/01/20 Version 17	02/19/20: MPCTAC

Policy Revisions History			
	Medical Policy Statement, Limitations, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections.		
11/01/20	Review for effective date 12/01/20. Administrative changes made to the Medical Policy and Limitations sections to clarify clinical review criteria.	12/01/20 Version 18	11/18/20: MPCTAC
02/01/21	Review for effective date 03/01/21. Administrative changes made to the References section.	03/01/21 Version 19	02/17/21: MPCTAC
03/01/21	Review for effective date 06/01/21. Administrative changes made to the Policy Summary, Limitations, and Other Applicable Policies sections. Criteria revised in the Medical Policy Statement section.	06/01/21 Version 20	03/17/21: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, the Medical Policy Statement section renamed the Clinical Criteria section, and the Limitations section renamed the Limitations and Exclusions section. Added NH Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections.	12/01/21 Version 21	11/17/21: MPCTAC
02/01/22	Review for effective date 03/01/22. Updated the References section. Administrative changes made to the Applicable Coding section.	03/01/22 Version 22	02/16/22: MPCTAC
08/01/22	Review for policy retired date 11/01/22. Administrative changes made to the Policy Summary and Applicable Coding sections. Criteria revised in the Clinical Criteria and Limitations and Exclusions sections. AIM medical necessity criteria adopted for this service and AIM prior authorization is required as of 11/01/22, even when applicable codes are not listed in this Plan policy.	11/01/22 Version 23	08/26/22: MPCTAC (electronic vote)

Medical Policy

Gender Affirmation Services

Policy Number: OCA 3.11
Version Number: 21
Version Effective Date: 11/01/22

Impacted Products

- ☒ **All Products**
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☒ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

Gender affirmation surgeries and permanent hair removal require prior authorization and are considered medically necessary for a member seeking treatment for gender dysphoria when Plan medical criteria are met. Gender affirmation surgeries may include one (1) or more surgical procedures and are part of a complex treatment plan involving medical, surgical, and behavioral health interventions to achieve the desired outcomes for the individual.

Voice therapy is considered medically necessary as a treatment option for gender dysphoria when AIM clinical appropriateness guidelines are met; prior authorization from AIM Specialty Health is required. The Plan and the Plan's delegated clinical vendors conducting utilization management do NOT discriminate, arbitrarily deny, and/or impose stricter requirements by reducing the amount, duration, and/or scope of required and medically necessary services for ANY Plan member based on the member's diagnosis, type of illness, health status or condition, sex, gender identity/gender dysphoria, and/or sexual orientation. The full range of medical and/or surgical treatment options available to individuals diagnosed with gender dysphoria may include, but are not limited to, those listed in professional medical publications such as the current version of WPATH Standards of Care for Health and Transsexual, Transgender and Gender-Nonconforming People.

Breast reconstruction used for the treatment of members with persistent, well-documented gender dysphoria may include the medically necessary surgical removal of breast implants and/or the

replacement of breast implants after implant explantation (including when the implant was initially inserted as a component of a gender affirmation surgery); review the criteria in the *Breast Reconstruction* medical policy, policy number OCA 3.43, rather than the criteria included in this policy. Feminizing/masculinizing hormonal therapy and/or gender affirmation surgeries may limit the member's fertility. Infertility services are covered for some Plan products. Review the Plan's *Infertility Services* medical policy, policy number OCA 3.725.

Clinical Criteria

Applicable criteria must be met for gender affirmation services in item I for gender affirmation surgery and permanent hair removal and/or item II for gender affirmation services that require Plan Medical Director review.

I. The Plan considers gender affirmation services medically necessary for the treatment of gender dysphoria, and Plan prior authorization is required for the services specified in this section. ALL applicable Plan clinical review criteria must be met in items A through C:

   A. Referral/Initial Assessment by Qualified Licensed Mental Health Professional:

      There is a referral/initial assessment from a licensed qualified mental health professional that contains ALL of the following documentation listed in items 1 through 8:

      1. Gender identity resulting in a definitive diagnosis of persistent, well-documented gender dysphoria (meeting DSM-5 criteria) for at least 6 months, history and development of gender dysphoric feelings, and impact of stigma attached to gender nonconformity; AND

      2. If living in an identity-congruent gender role, documentation of member's experience, start date, and if living full-time in identity-congruent gender role; AND

      3. The member's general identifying characteristics; AND

      4. Results of psychosocial assessment, including any diagnoses and confirmation that other behavioral health conditions are appropriately managed, reasonably controlled, and not contributing to gender dysphoria); AND

      5. Duration of mental health professional's relationship with member, including type of evaluation and therapy/counseling to date; AND

      6. Written clinical rationale supporting member's request for specific treatment(s); AND

      7. Statement that mental health professional is available for coordination of care and plan of care is in place; AND

      8. Member's psychological readiness for the requested treatment(s) with no contraindications to treatment documented, including member's capacity to make a fully informed decision

and has the capacity to consent for treatment(s), and includes parental or guardian consent (as applicable) if the member is younger than age 18 on the date of service unless the adolescent member is emancipated at the time the service is rendered; AND

B. Member age 18 or older on the date of service; AND

C. Service-Specific Criteria:

Criteria must be met in item 1 for all gender affirmation surgical procedures and procedure specific criteria must be met in item 2:

1. Gender Affirmation Surgical Procedures:

All criteria must be met in items a through e for any gender affirmation surgery:

a. Requests for prior authorization for each gender affirmation surgery must be submitted by the surgeon (or the surgeon's designee) performing the procedure and accompanied by written clinical documentation; AND

b. Surgeon has reviewed the documentation by the qualified licensed mental health professional (referenced above in item A), including the DSM-5 diagnosis of gender dysphoria, and documentation from the member's health care provider; AND

c. Surgeon has discussed risks and complications of proposed surgery and various surgical techniques, surgeon's own complication rates, impact on fertility, procedures for preservation of fertility, and has obtained member's informed consent; AND

d. If hormone therapy is a required criterion for a gender affirmation surgery (as specified below in the procedure-specific criteria), medical records must document member compliance with the prescribed regimen and clinical response over the course of hormone therapy; AND

e. Member's treating surgeon has documented that there are no contraindications to the planned surgery, verified significant medical conditions are stable, and agrees with the plan of care; AND

2. Procedure-Specific Criteria:

Procedure-specific criteria must be met for ANY procedure listed in items a through h:

a. Chest Procedures:

(1) Bilateral augmentation mammoplasty (with implantation of breast prostheses or lipofilling) when the member has had 12 continuous months of clinician-supervised

hormone therapy (unless hormone therapy is medically contraindicated for the member), and the hormone therapy has not resulted in sufficient breast development as self-reported by the member to the treating provider; OR

(2) Bilateral breast reduction, mastectomy, and/or chest reconstruction is requested; OR

b. Feminizing Genital Surgery:

ALL guidelines must be met in items (1) through (4):

(1) ANY of the procedures in items (a) through (g) will be performed:

(a) Clitoroplasty/neoclitoroplasty;
(b) Labiaplasty/neolabiaplasty;

(c) Orchiectomy;

(d) Penectomy;

(e) Urethroplasty and urethra-meatoplasty;

(f) Vaginoplasty (also known as neovaginoplasty); e.g., penile inversion vaginoplasty, colovaginoplasty, peritoneal pulldown vaginoplasty;

(g) Vulvoplasty/neovulvoplasty; AND

(2) Member has been assessed by 2 independently licensed health professionals, one of whom must be a licensed qualified behavioral health professional (referenced above in item A) and the other a clinician familiar with the member's health, with each assessment resulting in a diagnosis of gender dysphoria meeting DSM-5 criteria. The initial diagnosis (from one professional) must have been present for at least 6 months; AND

(3) Member has had 12 continuous months of living as the gender that is congruent with the member's identity. Exceptions may be provided on a case-by-case basis should the request for prior authorization document that compliance with this requirement would jeopardize the health, safety, and/or well-being of the member; AND

(4) The member has had 12 continuous months of clinician-supervised hormone therapy appropriate to the member's gender goals, unless hormone therapy is medically contraindicated; OR

c. Masculinizing Genital Surgery:

ALL guidelines must be met in items (1) through (4):

(1) ANY of the procedures listed in items (a) through (i) will be performed:

(a) Hysterectomy;

(b) Metoidioplasty;

(c) Oophorectomy;

(d) Phalloplasty with implantation of penile prosthesis;

(e) Salpingectomy;

(f) Scrotoplasty with insertion of testicular implants;

(g) Urethroplasty;

(h) Vaginectomy;

(i) Vulvectomy; AND

(2) Member has been assessed by 2 independently licensed health professionals, one of whom must be a licensed qualified behavioral health professional (referenced above in item A) and the other a clinician familiar with the member's health, with each assessment resulting in a diagnosis of gender dysphoria meeting DSM-5 criteria. The initial diagnosis (from 1 professional) must have been present for at least 6 months; AND

(3) Member has had 12 continuous months of living as the gender that is congruent with the member's identity. Exceptions may be provided on a case-by-case basis should the request for PA document that compliance with this requirement would jeopardize the health, safety, or well-being of the member; AND

(4) Member has had 12 continuous months of clinician-supervised hormone therapy appropriate to the member's gender goals, unless hormone therapy is medically contraindicated; OR

d. Facial Feminization or Facial Masculinization Surgical Procedures:

ONE (1) or more of the procedures listed in items (1) through (12) will be performed:

(1) Blepharoplasty (eyelid surgery) ONLY in conjunction with other medically necessary facial feminization or facial masculinization procedures;

(2) Brow reconstruction/brow lift;

(3) Cheek augmentation;

(4) Forehead contouring (including forehead reshaping or forehead reduction);

(5) Genioplasty (chin augmentation, chin reconstruction, or chin reduction/narrowing);

(6) Scalp/hairline advancement;

(7) Lateral canthopexy;

(8) Surgical lip lift;

(9) Lysis intranasal synechiae;

(10) Mandibuloplasty;

(11) Osteoplasty;

(12) Rhinoplasty and septoplasty;

(13) Rhytidectomy (facelift surgery) of the forehead, cheek, and/or neck (platysmaplasty);

(14) Suction-assisted lipectomy in conjunction with medically necessary facial procedures; AND/OR

(15) Tracheoplasty/tracheal shave; OR

e. Hair Removal with Laser or Electrolysis:

Electrolysis and/or laser treatments for face and neck hair removal is performed by a licensed and qualified treating clinician and ALL criteria are met in items (1) through (5):

(1) A licensed qualified health professional recommends hair removal of the face and/or neck as part of the member's medically necessary treatment for gender dysphoria; AND

(2) A letter from the clinician performing the hair removal is submitted to the Plan and includes attestation of the medical necessity of hair removal and a summary of the member's care as it relates to gender dysphoria treatment; AND

(3) Documentation submitted to the Plan includes the area size and location(s) for permanent hair removal, the type of hair removal treatment (laser or electrolysis), and the expected timeframe and number of treatments requested. The Plan will authorize medically necessary requests for electrolysis and/or laser ablation treatments for medically necessary permanent hair removal of the face and/or neck for up to 12 calendar months from the date of the authorization request. Additional treatments require a separate Plan authorization; AND

(4) Clinician performing the hair removal has discussed risks and complications of the proposed procedure, including the clinician's own complication rates, and has obtained informed consent from the member; AND

(5) Member has had 12 continuous months of clinician-supervised hormone therapy appropriate to the member's gender goals unless hormone therapy is medically; OR

f. Hair removal for standard pre-operative preparation for genital gender affirmation surgery:

Electrolysis and/or laser treatments for hair removal is performed by a licensed and qualified treating provider and ALL criteria are met in items (1) through (4):

(1) Permanent hair removal is required as part of the standard pre-operative preparation for genital affirming surgery(ies) and is recommended by the treating surgeon, with documentation verifying that hair removal is medically necessary; AND

(2) A letter from the clinician performing the hair removal is submitted to the Plan and includes attestation of the medical necessity of hair removal and a summary of the member's care as it relates to gender dysphoria treatment; AND

(3) Documentation submitted to the Plan includes the area size and location(s) for permanent hair removal, the type of hair removal treatment (laser or electrolysis), expected timeframe and number of treatments requested, and the estimated date of the genital gender affirmation surgical procedure(s). The Plan will authorize medically necessary requests for electrolysis and/or laser ablation treatments for medically necessary pre-operative permanent hair removal as standard preparation for genital gender affirmation surgery for up to 18 calendar months from the date of the authorization request. Additional treatments require a separate Plan authorization; AND

(4) Clinician performing the hair removal has discussed risks and complications of the proposed procedure, including the clinician's own complication rates, and has obtained informed consent from the member; OR

g. Gender Affirmation Procedures NOT Requiring Medically Necessary Permanent Hair Removal of Graft Site:

The Plan will authorize medically necessary requests for gender affirmation surgery(ies) up to 12 calendar months from the date of the authorization request; OR

h. Genital Gender Affirmation Procedures Requiring Medically Necessary Permanent Hair Removal of Graft Site:

The Plan will authorize medically necessary requests for genital gender affirmation procedure(s) that require pre-operative permanent hair removal as standard preparation for surgery up to 18 calendar months from the date of the authorization request.

II. The following requests require Plan Medical Director review:

A. Permanent hair removal in preparation for planned genital gender affirmation procedure if the procedure has not yet been authorized by the Plan.

B. Hair removal when documentation from the member's surgeon and/or qualified licensed health provider(s) is within 13-18 calendar months of the prior authorization request and permanent hair removal is NOT a medically necessary component of pre-operative preparation for genital gender affirmation procedure(s). Additional documentation must be submitted to the Plan to report the extenuating circumstances that necessitate an extension of the standard 12 calendar month time limit.

C. Gender affirmation surgery for a member who does NOT meet DSM-5 definitive diagnosis of persistent gender dysphoria (e.g., non-binary members who do not meet traditional diagnostic criteria for gender dysphoria).

D. Gender affirmation services for a member unable to live in the chosen gender role full-time. This includes members who identify as genders other than male or female. Treating provider must submit documentation indicating why it would be clinically inappropriate to require the member to meet this criterion and why this requirement should be waived.

E. Gender affirmation surgery and/or permanent hair removal for a member age 17 or younger on the date of service. The Plan Medical Director will review the current version of WPATH Standards of Care and member's clinical situation, including but not limited to the amount of time the adolescent member has been living in the gender congruent role, treatment timeframe with hormone therapy, age of the member, and the requested intervention. Adolescent

members may be eligible for interventions when adolescents and their parents (or guardian) make informed decisions about treatment, and the service is a covered benefit for the Plan member. Informed consent by a parent or guardian for treatment of an adolescent member may not apply if the adolescent member is emancipated at the time the service is rendered (as determined by state requirements).

F. Surgical revision of a previously performed gender affirmation surgery.

G. Laparoscopic prostatectomy as a component of gender affirmation surgical procedure(s).

H. Post-operative lodging is NOT routinely covered by the Plan; Plan Medical Director review is required.

Limitations and Exclusions

A. External review will be available to the members enrolled in Qualified Health Plans, ConnectorCare, or Employer Choice Direct products when the Plan determines that coverage for treatment of gender dysphoria is NOT medically necessary or the Plan considers the treatment experimental or investigational. The external review for Qualified Health Plans, ConnectorCare, or Employer Choice Direct products will be based upon the Massachusetts definition of medical necessity. (Source: The Commonwealth of Massachusetts, Health Policy Commission, Memo: External Review for Denials of Coverage for Medical and/or Surgical Treatment of Gender Dysphoria, July 2, 2015.)

B. Hair removal is ONLY covered when criteria are met in the Clinical Criteria section for the method of hair removal (i.e., electrolysis and/or laser hair removal). Any other method of hair removal or indication for treatment is NOT covered.

C. The Plan considers any services or surgical procedures used to reverse gender affirmation surgery to NOT be medically necessary.

D. The following procedures/services in items 1 through 17 are NOT covered for the treatment of gender dysphoria:

1. Blepharoplasty (eyelid surgery) NOT in conjunction with other facial feminization or facial masculinization procedures used for the treatment of gender dysphoria; OR

2. Body contouring procedures, including abdominoplasty, liposuction, lipofilling, and/or suction-assisted lipectomy UNLESS the treatment is listed as medically necessary in the Clinical Criteria section (e.g., facial procedures for the treatment of gender dysphoria) and ALL applicable clinical review criteria are met for the gender affirmation surgical procedure; OR

3. Calf augmentation (calf implants); OR

4. Collagen injections; OR

5. Facial feminization surgery, facial masculinization surgery, facial bone reduction, or facial implants or injections UNLESS the treatment is specified as medically necessary in the Clinical Criteria section and applicable clinical review criteria are met for the facial feminizing or facial masculinizing gender affirmation surgical procedure; OR

6. Gluteal augmentation (gluteal implants and/or lipofilling); OR

7. Hair transplantation or hair reconstruction (see the Clinical Criteria section for guidelines for hairline advancement surgery); OR

8. Laryngoplasty (technique to alter the voice tract and adjust vocal range); OR

9. Lip reduction or lip enhancement (see the Clinical Criteria section for guidelines related to lip lift); OR

10. Osteoplasty UNLESS clinical review criteria are met for the facial feminization or facial masculinization gender affirmation surgical procedure in the Clinical Criteria section); OR

11. Otoplasty (surgical reshaping of the outer ear); OR

12. Pectoral augmentation (pectoral implants); OR

13. Removal of redundant skin including but NOT limited to panniculectomy and/or abdominoplasty when used for the treatment of gender dysphoria UNLESS the procedure is listed as medically necessary in the Clinical Criteria section and applicable criteria are met; OR

    Note: Review the Plan's medical necessity guidelines included in the *Panniculectomy and Related Redundant Skin Surgery* medical policy, policy number OCA 3.722.

14. Silicone injections of the breast; OR

15. Skin resurfacing treatments including but NOT limited to chemical peels and/or dermabrasion; OR

16. Tattooing; OR

17. Vocal cord surgery (laryngoplasty, cricothyroid approximation or shortening of the vocal cords).

E. Reimbursement for travel expenses is NOT covered by the Plan unless the Plan's product-specific criteria are met, as specified in the Non-Emergency Transportation Services medical policy applicable for the member's product, policy number OCA 3.191.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for the Plan's Senior Care Options (SCO) members and New Hampshire Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, NCD 140.9 states CMS has determined that no NCD is appropriate at this time for gender affirmation surgery for Medicare beneficiaries with gender dysphoria. LCA A53793 includes billing, coding, and treatment guidelines for gender affirmation services for gender dysphoria. Verify CMS guidelines in effect on the date of the prior authorization request. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. Since these codes may be updated at different intervals than the medical policy review cycle, the list of applicable codes included in a policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of a medical policy, even if an applicable code appropriately describing the service is not included in the policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

ICD-10 Codes	**Description: The following primary diagnosis codes apply to gender dysphoria and require prior authorization when billed with a medically necessary procedure code covered by the Plan for gender affirmation surgeries and/or hair removal.** Each gender affirmation surgery requires Plan prior authorization for ALL diagnosis and procedure codes, even if coding is not included in this Applicable Coding section. See the member's applicable benefit document to determine coverage of services. Plan Medical Director review is required for each gender affirmation surgery when the member has a diagnosis of gender incongruence (without a diagnosis of gender dysphoria) for individual consideration.
F64.0-F64.9	Gender identity disorders
Z87.890	History of sex reassignment surgery

CPT Codes	Description: Services considered medically necessary for the treatment of gender dysphoria if Plan clinical review criteria are met (when billed with a primary ICD-10 diagnosis code listed above). Prior authorization is required.
11960	Insertion of tissue expander(s) for other than breast, including subsequent expansion
11970	Replacement of tissue expander with permanent prosthesis
11971	Removal of tissue expander(s) without insertion of prosthesis
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14041	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10.1 sq cm to 30.0 sq cm
15769	Grafting of autologous soft tissue, other, harvested by direct excision (e.g., fat, dermis, fascia)
15771	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms and/or legs; 50 cc or less injectate
15772	Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms and/or legs; each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
15824	Rhytidectomy; forehead Plan note: Code is NOT payable for the MassHealth and QHP products.
15825	Rhytidectomy; neck with platysmal tightening (platysmal flap, P-flap) Plan note: Code is NOT payable for the MassHealth and QHP products.
15826	Rhytidectomy; glabellar frown lines Plan note: Code is NOT payable for MassHealth and QHP products.
15828	Rhytidectomy; cheek, chin, and neck Plan note: Code is NOT payable for MassHealth and QHP products.
15876	Suction assisted lipectomy; head and neck
19301	Mastectomy partial (e.g., lumpectomy, tylectomy, quadrantectomy, segmentectomy)
19303	Mastectomy, simple, complete
19318	Breast reduction
19325	Breast augmentation with implant Plan note: Breast reconstruction for male-to-female members with persistent, well-documented gender dysphoria may include the medically necessary surgical removal of breast implants and/or the replacement of breast implants after implant explantation (including when the implant was initially inserted as a component of a gender affirmation surgery); review the criteria in the *Breast Reconstruction* medical policy, policy number OCA 3.43, rather than the criteria included in this policy for Plan prior authorization guidelines for these surgical procedures.
19350	Nipple/areola reconstruction
21120	Genioplasty; augmentation (autograft, allograft, prosthetic material)

21121	Genioplasty; sliding osteotomy, single piece
21122	Genioplasty; sliding osteotomies, 2 or more osteotomies (e.g., wedge excision or bone wedge reversal for asymmetrical chin)
21123	Genioplasty; sliding, augmentation with interpositional bone grafts (includes obtaining autografts)
21125	Augmentation, mandibular body or angle; prosthetic material
21127	Augmentation, mandibular body or angle; with bone graft, onlay or interpositional (includes obtaining autograft)
21137	Reduction forehead; contouring only
21138	Reduction forehead; contouring and application of prosthetic material or bone graft (includes obtaining autograft)
21139	Reduction forehead; contouring and setback of anterior frontal sinus wall
21141	Reconstruction midface, LeFort I; single piece, segment movement in any direction (e.g., for Long Face Syndrome), without bone graft
21142	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft
21143	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, without bone graft
21145	Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
21146	Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted unilateral alveolar cleft)
21147	Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (e.g., ungrafted bilateral alveolar cleft or multiple osteotomies)
21150	Reconstruction midface, LeFort II; anterior intrusion (e.g., Treacher-Collins Syndrome)
21151	Reconstruction midface, LeFort II; any direction, requiring bone grafts (includes obtaining autografts)
21154	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); without LeFort I
21155	Reconstruction midface, LeFort III (extracranial), any type, requiring bone grafts (includes obtaining autografts); with LeFort I
21159	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); without LeFort I
21160	Reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc), requiring bone grafts (includes obtaining autografts); with LeFort I
21172	Reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, with or without grafts (includes obtaining autografts)
21175	Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (e.g., plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)
21179	Reconstruction, entire or majority of forehead and/or supraorbital rims; with grafts (allograft or prosthetic material)
21180	Reconstruction, entire or majority of forehead and/or supraorbital rims; with autograft (includes obtaining grafts)
21188	Reconstruction midface, osteotomies (other than LeFort type) and bone grafts (includes obtaining autografts)

21196	Reconstruction of mandibular rami and/or body, sagittal split; with internal rigid fixation
21208	Osteoplasty, facial bones; augmentation (autograft, allograft, or prosthetic implant)
21209	Osteoplasty, facial bones; reduction
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
21230	Graft; rib cartilage, autogenous, to face, chin, nose or ear (includes obtaining graft
21244	Reconstruction of mandible, extraoral, with transosteal bone plate (e.g., mandibular staple bone plate)
21245	Reconstruction of mandible or maxilla, subperiosteal implant; partial
21246	Reconstruction of mandible or maxilla, subperiosteal implant; complete
21248	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); partial
21249	Reconstruction of mandible or maxilla, endosteal implant (e.g., blade, cylinder); complete
21270	Malar augmentation, prosthetic material
21282	Lateral canthopexy
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum and osteotomies
30465	Repair of nasal vestibular stenosis (e.g., spreader grafting, lateral nasal wall reconstruction)
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
30560	Lysis intranasal synechia
31599	Unlisted procedure, trachea, bronchi
31750	Tracheoplasty; cervical Plan note: Code used for trachea shaving for male-to-female transition.
40799	Unlisted procedure, lips Plan note: Code used for lip lift.
49329	Peritoneal Flap, Unlisted
53410	Urethroplasty, 1-stage reconstruction of male anterior urethra
53415	Urethroplasty, transpubic or perineal, 1-stage, for reconstruction or repair of prostatic or membranous urethra
53420	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; first stage
53425	Urethroplasty, 2-stage reconstruction or repair of prostatic or membranous urethra; second stage
53430	Urethroplasty, reconstruction of female urethra
53450	Urethromeatoplasty, with mucosal advancement
54120	Amputation of penis; partial

54125	Amputation of penis; complete
54400	Insertion of penile prosthesis; non-inflatable (semi-rigid)
54401	Insertion of penile prosthesis; inflatable (self-contained)
54405	Insertion of multi-component inflatable penile prosthesis, including placement of pump, cylinders, and reservoir
54520	Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach
54660	Insertion of testicular prosthesis (separate procedure)
54690	Laparoscopy, surgical; orchiectomy
55175	Scrotoplasty; simple
55180	Scrotoplasty; complicated
55970	Intersex surgery; male to female Plan note: Series of staged procedures to remove penis and create vagina.
55980	Intersex surgery; female to male Plan note: Series of staged procedures to remove or close vagina and for penis and testicles.
56620	Vulvectomy simple; partial
56625	Vulvectomy simple; complete
56800	Plastic repair of introitus
56805	Clitoroplasty for intersex state
56810	Perineoplasty, repair of perineum, non-obstetrical (separate procedure)
57106	Vaginectomy, partial removal of vaginal wall
57107	Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57110	Vaginectomy, complete removal of vaginal wall
57111	Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
57291	Construction of artificial vagina; without graft
57292	Construction of artificial vagina; with graft
57335	Vaginoplasty for intersex state
58150	Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)
58180	Supracervical abdominal hysterectomy (subtotal hysterectomy) with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250g or less
58262	Vaginal hysterectomy, for uterus 250g or less; with removal of tube(s), and/or ovary(s)
58275	Vaginal hysterectomy, with total or partial vaginectomy
58290	Vaginal hysterectomy, for uterus greater than 250g
58291	Vaginal hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)
58541	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250g or less
58542	Laparoscopy, surgical, supracervical hysterectomy, for uterus 250g or less; with removal of tube(s) and/or ovary(s)
58543	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g

58544	Laparoscopy, surgical, supracervical hysterectomy, for uterus greater than 250g; with removal of tube(s) and/or ovary(s)
58550	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250g or less
58552	Laparoscopy, surgical, with vaginal hysterectomy, for uterus 250 grams or less; with removal of tube(s) and/or ovary(s)
58553	Laparoscopy, surgical with vaginal hysterectomy, for uterus greater than 250g
58554	Laparoscopy, surgical, with vaginal hysterectomy, for uterus greater than 250 grams; with removal of tube(s) and/or ovary(s)
58570	Laparoscopy, surgical, with total hysterectomy, for uterus 250g or less
58571	Laparoscopy, surgical, with total hysterectomy, for uterus 250 g or less; with removal of tube(s) and/or ovary(s)
58572	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250g
58573	Laparoscopy, surgical, with total hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58661	Laparoscopy, surgical; with lysis of adhesions (salpingolysis, ovariolysis) (separate procedure); with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)
58720	Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)
58940	Oophorectomy, partial or total, unilateral or bilateral
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

HCPCS Code	**Description: Service is considered medically necessary for the treatment of gender dysphoria if Plan criteria are met and is billed with a primary ICD-10 diagnosis code listed above. Prior authorization is required.**
L8600	Implantable breast prosthesis, silicone or equal

CPT Codes	**Description: The following services require Plan Medical Director review and approval when used for the treatment of gender dysphoria (and billed with a primary ICD-10 diagnosis code listed above). Prior authorization is required.**
19316	Mastopexy
19380	Revision of reconstructed breast (e.g., significant removal of tissue, re-advancement and/or re-inset of flaps in autologous reconstruction or significant capsular revision combined with soft tissue excision in implant-based reconstruction)
31587	Laryngoplasty, cricoid split, without graft placement
55866	Laparoscopy, surgical prostatectomy, retropubic radical, including nerve sparing, includes robotic assistance, when performed
57295	Revision (including removal) of prosthetic vaginal graft; vaginal approach
57296	Revision (including removal) of prosthetic vaginal graft; open abdominal approach
57426	Revision (including removal) of prosthetic vaginal graft, laparoscopic approach

CPT Codes	**Description: Coverage guidelines based on the indication for treatment and type of service provided (when billed with a primary ICD-10 diagnosis code listed above for gender dysphoria). Prior authorization is required.**
17380	Electrolysis epilation, each 30 minutes
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue

	Plan note: Code used when billing for laser ablation for hair removal on a skin graft donor site for a genital gender affirmation surgery.

CPT Codes	**Description: Services NOT considered medically necessary for the treatment of gender dysphoria (and billed with a primary ICD-10 diagnosis code listed above). Prior authorization is required.**
11950	Subcutaneous injection of filling material (e.g., collagen); 1 cc or less
11951	Subcutaneous injection of filling material (e.g., collagen); 1.1 to 5.0 cc
11952	Subcutaneous injection of filling material (e.g., collagen); 5.1 to 10 cc or less
11954	Subcutaneous injection of filling material (e.g., collagen); over 10 cc
15775	Punch graft for hair transplant; 1-15 punch grafts
15776	Punch graft for hair transplant; more than 15 punch grafts
15780	Dermabrasion; total face (e.g., for acne scarring, fine wrinkling, rhytids, general keratosis)
15781	Dermabrasion; segmental, face
15782	Dermabrasion; regional, other than face
15783	Dermabrasion; superficial, any site (e.g., tattoo removal)
15786	Abrasion; single lesion (e.g., keratosis, scar)
15787	Abrasion; each additional 4 lesions or less (List separately in addition to code for primary procedure)
15788	Chemical peel, facial; epidermal
15789	Chemical peel, facial; dermal
15792	Chemical peel, nonfacial; epidermal
15793	Chemical peel, nonfacial; dermal
15830	Excision, excessive skin and subcutaneous tissue (including lipectomy); abdomen, infraumbilical panniculectomy
15832	Excision, excessive skin and subcutaneous tissue (including lipectomy); thigh
15833	Excision, excessive skin and subcutaneous tissue (including lipectomy); leg
15834	Excision, excessive skin and subcutaneous tissue (including lipectomy); hip
15835	Excision, excessive skin and subcutaneous tissue (including lipectomy); buttock
15836	Excision, excessive skin and subcutaneous tissue (including lipectomy); arm
15837	Excision, excessive skin and subcutaneous tissue (including lipectomy); forearm or hand
15838	Excision, excessive skin and subcutaneous tissue (including lipectomy); submental fat pad
15839	Excision, excessive skin and subcutaneous tissue (including lipectomy); other area
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (e.g., abdominoplasty) (includes umbilical transposition and fascial plication)
15877	Suction assisted lipectomy; trunk
15878	Suction assisted lipectomy; upper extremity
15879	Suction assisted lipectomy; lower extremity

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Next Review Date

04/01/23

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 03/18/15: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 04/08/15: Quality Improvement Committee (QIC)	07/01/15 Version 1	Medical Policy Manager as Chair of MPCTAC	MPCTAC and QIC

*Effective Date for QHP Commercial Product: 01/01/12
*Effective Date for NH Medicaid Product: 07/01/17
*Effective Date for Senior Care Options Product: 01/01/16
*Effective Date for NH Medicare Advantage HMO Product: 01/01/22

Policy title *Gender Reassignment Surgery* from 01/01/16 to 05/31/18. Policy title changed to *Gender Affirmation Surgeries* from 06/01/18 to 12/31/21. Policy title changed to *Gender Affirmation Services* as 01/01/22.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
09/01/15	Review for effective date 01/01/16. Updated criteria in the Medical Policy Statement and Limitations sections. Removed requirement for 18 months of treatment for gender dysphoria. Added guidelines on external review for services denied by the Plan when members are enrolled in Qualified Health Plans, ConnectorCare, and/or Employer Choice Direct products. Update the Summary, Clinical Background Information, Definitions, and References sections and the list of applicable products.	01/01/16 Version 2	09/16/15: MPCTAC 10/14/15: QIC
11/25/15	Review for effective date 01/01/16. Updated language in the Applicable Coding section.	01/01/16 Version 3	11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
04/01/16	Review for effective date 08/01/16. Revised the Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Removed ICD9 codes, added CPT code 17380 as applicable code, and added a Plan not in the Applicable Coding section.	08/01/16 Version 4	04/20/16: MPCTAC 05/23/16: QIC

Policy Revisions History			
	Revised criteria in the Medical Policy Statement and Limitations sections.		
07/05/16	Review for effective date 10/01/16. Revised criteria in the Medical Policy Statement and Limitations section. Revised the applicable code list and added Plan notes to codes. Updated Summary and References sections.	10/01/16 Version 5	07/05/16: MPCTAC (electronic vote) 07/13/16: QIC
09/01/16	Review for effective date 10/01/16. Added reference to the CMS Decision Memo for Gender Dysphoria and Gender Reassignment Surgery (CAG-00446N) effective 08/30/16 in the Clinical Background Information and References sections. CMS industry-wide update with no change to criteria and/or the applicable code list for Plan members (including members enrolled in a SCO product).	10/01/16 Version 6	Not applicable because industry-wide update of CMS guidelines with no change to criteria and/or the applicable code list
09/28/16	Review for effective date 11/01/16. Administrative changes made to clarify language related to gender. Revised Definitions section.	11/01/16 Version 7	09/30/16: MPCTAC (electronic vote) 10/12/16: QIC
06/01/17	Review for effective date 07/01/17. Added the NH Medicaid product as applicable new product for this policy as of 07/01/17 with the necessary administrative changes made to the Medical Policy Statement, Summary, Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. NH Medicaid criteria added in product-specific Medical Policy Statement section and product-specific Limitations section.	07/01/17 Version 8	06/21/17: MPCTAC
05/01/17	Review for effective date 08/01/17. Criteria for MA products were revised in the Medical Policy Statement section in 05/17 (with adequate provider notification); new criteria are effective 08/01/17 for MA products. Administrative changes made to the Summary, Definitions, and References sections.	08/01/17 Version 9	05/17/17: MPCTAC
06/01/17	Review for effective date 08/01/17. Administrative change made to combine criteria in the Medical Policy Statement sections and in the Limitations sections for all MA products and NH Medicaid product (since all criteria are consistent among Plan products as of 08/01/17). Administrative change made to the Limitations section to be consistent with the Applicable Coding section.	08/01/17 Version 10	06/21/17: MPCTAC
03/01/18	Review for effective date 06/01/18. Revised policy title. Administrative changes made to the Policy	06/01/18 Version 11	03/21/18: MPCTAC

Policy Revisions History			
	Summary, Description of Item or Service, Definitions, Clinical Background Information, References, and Other Applicable Policies sections. Criteria revised in the Medical Policy Statement and Limitations sections. Coding updated and Plan notes revised in the Applicable Coding section.		
05/01/19	Review for effective date 08/01/19. Administrative changes made to the Policy Summary, Description of Item or Service, Clinical Background Information, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections. Criteria updated in the Medical Policy Statement and Limitations sections. Coding updated in the Applicable Coding section.	08/01/19 Version 12	05/15/19: MPCTAC
12/01/19	Review for effective date 01/01/20. Industry-wide update to coding (as a code deletion) included in the Applicable Coding section.	01/01/20 Version 13	Not applicable because industry-wide code changes
04/01/20	Review for effective date 08/01/20. Administrative changes made to the Definitions, References, and Reference to Applicable Laws and Regulations sections. Criteria revised in the Medical Policy Statement and Limitations sections. Coding updated in the Applicable Coding section.	08/01/20 Version 14	04/15/20: MPCTAC
12/01/20	Review for effective date 01/01/21. Industry-wide updates to coding in the Applicable Coding section. Administrative changes made to the Limitations and Other Applicable Policies sections.	01/01/21 Version 15	Not applicable because industry-wide code changes; 12/16/20: MPCTAC review
01/01/21	Review for effective date 02/01/21. Revised criteria in the Medical Policy Statement section.	02/01/21 Version 16	01/22/21: MPCTAC (electronic vote)
04/01/21	Review for effective date 07/01/21. Revised criteria in the Medical Policy Statement and Limitations sections. Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, Clinical Background Information, and References sections. Updated the applicable code list.	07/01/21 Version 17	04/21/21: MPCTAC
10/01/21	Review for effective date 01/01/22. Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and Limitations section renamed Limitations and Exclusions section. Administrative changes made	01/01/22 Version 18 Version 18 replaced with version 19 as of	10/20/21: MPCTAC

Policy Revisions History			
	to the Policy Summary and References sections. Criteria revised in the Clinical Criteria and Limitations and Exclusions sections. Coding revised in the Applicable Coding section.	01/01/22 and version 18 not implemented	
11/01/21	Review for effective date 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations, and Applicable Coding sections. Criteria and coding for voice therapy used for the treatment of gender dysphoria moved from the Plan's speech therapy medical policies to this policy with Plan notification (rather than prior authorization) required when applicable coding guidelines followed. Revised policy title.	01/01/22 Version 19 Version 19 replaced version 18 as of 01/01/22 and all revisions in version 18 adopted	11/30/21: MPCTAC (electronic vote)
05/01/22	Review for effective date 08/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations, References and Applicable Coding sections. Added CPT codes 49329 and 53450. Non-material changes made to Clinical Criteria and Limitations and Exclusions sections.	08/01/22 Version 20	05/11/22: MPCTAC (electronic vote)
08/01/22	Review for effective date 11/01/22. Administrative changes made to Policy Summary, Clinical Criteria, and Applicable Coding sections. Removed coding and criteria for voice therapy when used for the treatment of gender dysphoria; prior authorization requests for voice therapy must be submitted to AIM Specialty Health as of 11/01/22.	11/01/22 Version 21	MPCTAC: 08/26/22 (electronic vote)

Medical Policy – Policy with InterQual Criteria Retired and AIM Criteria Adopted as of 11/01/22

Genetic/Genomic Testing and Pharmacogenetics

Policy Number: OCA 3.727
Version Number: 44
Policy Retired Date: 11/01/22

Impacted Products

- ☒ **All Products**
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☒ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers genetic and genomic testing to be medically necessary for the diagnosis of genetic disease in children and adults, for the determination of future risk of a suspected disease, for the prediction of drug responses, and/or for the detection of risks of specific diseases to future children when AIM clinical appropriateness guidelines are met. Prior authorization from AIM Specialty Health is required for genetic testing.

Clinical Criteria

No medical policy criteria.

Limitations and Exclusions

None.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for the Plan's Senior Care Options (SCO) members and New Hampshire Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review,

there are CMS guidelines for some types of genetic testing (e.g., NCD 90.1 for pharmacogenomics testing for warfarin response, NCD 23.18, NCD 90.2 for next generation sequencing, NCD 190.3 for cytogenetic studies, NCD 210.3 for stool DNA test, and LCD L35000 for molecular pathology procedures). Verify if applicable CMS criteria are in effect (through an NCD, LCD, or other CMS guidelines) for the specified genetic test, product name, site-specific gene analysis, and the indication for testing on the date of the prior authorization request. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. The list of applicable codes included in this policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization from AIM for genetic testing, even if an applicable code appropriately describing the service is not included in the policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Codes	Code Descriptions
0001U	Red blood cell antigen typing, DNA, human erythrocyte antigen gene analysis of 35 antigens from 11 blood groups, utilizing whole blood, common RBC alleles reported
0004M	Scoliosis, DNA analysis of 53 single nucleotide polymorphisms (SNPs), using saliva, prognostic algorithm reported as a risk score
0005U	Oncology (prostate) gene expression profile by real-time RT-PCR of 3 genes (ERG, PCA3, and SPDEF), urine, algorithm reported as risk score
0006M	Oncology (hepatic), mRNA expression levels of 161 genes, utilizing fresh hepatocellular carcinoma tumor tissue, with alpha-fetoprotein level, algorithm reported as a risk classifier
0007M	Oncology (gastrointestinal neuroendocrine tumors), real-time PCR expression analysis of 51 genes, utilizing whole peripheral blood, algorithm reported as a nomogram of tumor disease index
0011M	Oncology, prostate cancer, mRNA expression assay of 12 genes (10 content and 2 housekeeping), RT-PCR test utilizing blood plasma and/or urine, algorithms to predict high-grade prostate cancer risk
0012M	Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and XCR2), utilizing urine, algorithm reported as a risk score for having urothelial carcinoma
0012U	Germline disorders, gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood, report of specific gene rearrangement(s)
0013M	Oncology (urothelial), mRNA, gene expression profiling by real-time quantitative PCR of five genes (MDK, HOXA13, CDC2 [CDK1], IGFBP5, and CXCR2), utilizing urine, algorithm reported as a risk score for having recurrent urothelial carcinoma

0013U	Oncology (solid organ neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, fresh or frozen tissue or cells, report of specific gene rearrangement(s)
0014U	Hematology (hematolymphoid neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood or bone marrow, report of specific gene rearrangement(s)
0016M	Oncology (bladder) mRNA, microarray gene expression profiling of 209 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as molecular subtype (luminal, luminal infiltrated, basal, basal claudin-low, neiroendocrine-like)
0016U	Oncology (hematolymphoid neoplasia), RNA, BCR/ABL1 major and minor breakpoint fusion transcripts, quantitative PCR amplification, blood or bone marrow, report of fusion not detected or detected with quantitation
0017M	Oncology (diffuse large B-cell lymphoma [DLBCL]), mRNA, gene expression profiling by fluorescent probe hybridization of 20 genes, formalin-fixed paraffin-embedded tissue, algorithm reported as cell of origin (Do not report 0017M in conjunction with 0120U)
0017U	Oncology (hematolymphoid neoplasia), JAK2 mutation, DNA, PCR amplification of exons 12-14 and sequence analysis, blood or bone marrow, report of JAK2 mutation not detected or detected
0018U	Oncology (thyroid), microRNA profiling by RT-PCR of 10 microRNA sequences, utilizing fine-needle aspirate, algorithm reported as a positive or negative result for moderate to high risk of malignancy
0019U	Oncology, RNA, gene expression by whole transcriptome sequencing, formalin-fixed paraffin embedded tissue or fresh frozen tissue, predictive algorithm reported as potential targets for therapeutic agents
0022U	Targeted genomic sequence analysis panel, non-small cell lung neoplasia, DNA and RNA analysis, 23 genes, interrogation for sequence variants and rearrangements, reported as presence/absence of variants and associated therapy(ies) to consider
0023U	Oncology (acute myelogenous leukemia), DNA, genotyping of internal tandem duplication, p.D835, p.I836, using mononuclear cells, reported as detection or non-detection of FLT3 mutation and indication for or against the use of midostaurin
0026U	Oncology (thyroid), DNA and mRNA of 112 genes, next-generation sequencing, fine needle aspirate of thyroid nodule, algorithmic analysis reported as a categorical result
0027U	JAK2 (Janus kinase 2) (e.g. , myeloproliferative disorder) gene analysis, targeted sequence analysis exons 12-15
0029U	Drug metabolism (adverse drug reactions and drug response), targeted sequence analysis (i.e., CYP1A2, CYP2C19, CYP2C9, CYP2D6, CYP3A4, CYP3A5, CYP4F2, SLCO1B1, VKORC1 and rs12777823)
0030U	Drug metabolism (warfarin drug response), targeted sequence analysis (i.e., CYP2C9, CYP4F2, VKORC1, rs12777823)
0031U	CYP1A2 (cytochrome P450 family 1, subfamily A, member 2)(e.g., drug metabolism) gene analysis, common variants (i.e., *1F, *1K, *6, *7)
0032U	COMT (catechol-O-methyltransferase)(drug metabolism) gene analysis, c.472G>A (rs4680) variant
0033U	HTR2A (5-hydroxytryptamine receptor 2A), HTR2C (5-hydroxytryptamine receptor 2C) (e.g., citalopram metabolism) gene analysis, common variants (i.e., HTR2A rs7997012 [c.614-2211T>C], HTR2C rs3813929 [c.- 759C>T] and rs1414334 [c.551-3008C>G])

0034U	TPMT (thiopurine S-methyltransferase), NUDT15 (nudix hydroxylase 15)(e.g., thiopurine metabolism), gene analysis, common variants (i.e., TPMT *2, *3A, *3B, *3C, *4, *5, *6, *8, *12; NUDT15 *3, *4, *5)
0036U	Exome (i.e., somatic mutations), paired formalin-fixed paraffin-embedded tumor tissue and normal specimen, sequence analyses
0037U	Targeted genomic sequence analysis, solid organ neoplasm, DNA analysis of 324 genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden
0040U	BCR/ABL1 (t(9;22)) (e.g., chronic myelogenous leukemia) translocation analysis, major breakpoint, quantitative
0045U	Oncology (breast ductal carcinoma in situ), mRNA, gene expression profiling by realtime RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence score
0046U	FLT3 (fms-related tyrosine kinase 3) (e.g., acute myeloid leukemia) internal tandem duplication (ITD) variants, quantitative
0047U	Oncology (prostate), mRNA, gene expression profiling by real-time RT-PCR of 17 genes (12 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a risk score
0048U	Oncology (solid organ neoplasia), DNA, targeted sequencing of protein-coding exons of 468 cancer-associated genes, including interrogation for somatic mutations and microsatellite instability, matched with normal specimens, utilizing formalin-fixed paraffin-embedded tumor tissue, report of clinically significant mutation(s)
0049U	NPM1 (nucleophosmin) (e.g., acute myeloid leukemia) gene analysis, quantitative
0050U	Targeted genomic sequence analysis panel, acute myelogenous leukemia, DNA analysis, 194 genes, interrogation for sequence variants, copy number variants or rearrangements
0055U	Cardiology (heart transplant), cell-free DNA, PCR assay of 96 DNA target sequences (94 single nucleotide polymorphism targets and two control targets), plasma
0056U	Hematology (acute myelogenous leukemia), DNA, whole genome nextgeneration sequencing to detect gene rearrangement(s), blood or bone marrow, report of specific gene rearrangement(s)
0060U	Twin zygosity, genomic targeted sequence analysis of chromosome 2, using circulating cell-free fetal DNA in maternal blood
0069U	Oncology (colorectal), microRNA, RT-PCR expression profiling of miR-31-3p, formalin-fixed paraffin-embedded tissue, algorithm reported as an expression score
0070U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, common and select rare variants (i.e., *2, *3, *4, *4N, *5, *6, *7, *8, *9, *10, *11, *12, *13, *14A, *14B, *15, *17, *29, *35, *36, *41, *57, *61, *63, *68, *83, *xN)
0071U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, full gene sequence (List separately in addition to code for primary procedure) (Use 0071U in conjunction with 0070U)
0072U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (i.e., CYP2D6-2D7 hybrid gene) (List separately in addition to code for primary procedure) (Use 0072U in conjunction with 0070U)
0073U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (i.e., CYP2D7-2D6 hybrid gene) (List separately in addition to code for primary procedure) (Use 0073U in conjunction with 0070U)

0074U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (i.e., non-duplicated gene when duplication/multiplication is trans) (List separately in addition to code for primary procedure) (Use 0074U in conjunction with 0070U)
0075U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (i.e., 5′ gene duplication/multiplication) (List separately in addition to code for primary procedure) (Use 0075U in conjunction with 0070U)
0076U	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism) gene analysis, targeted sequence analysis (i.e., 3′ gene duplication/ multiplication) (List separately in addition to code for primary procedure) (Use 0076U in conjunction with 0070U)
0078U	Pain management (opioid-use disorder) genotyping panel, 16 common variants (i.e., ABCB1, COMT, DAT1, DBH, DOR, DRD1, DRD2, DRD4, GABA, GAL, HTR2A, HTTLPR, MTHFR, MUOR, OPRK1, OPRM1), buccal swab or other germline tissue sample, algorithm reported as positive or negative risk of opioid-use disorder
0079U	Comparative DNA analysis using multiple selected single-nucleotide polymorphisms (SNPs), urine and buccal DNA, for specimen identity verification
0087U	Cardiology (heart transplant), mRNA gene expression profiling by microarray of 1283 genes, transplant biopsy tissue, allograft rejection and injury algorithm reported as a probability score
0088U	Transplantation medicine (kidney allograft rejection), microarray gene expression profiling of 1494 genes, utilizing transplant biopsy tissue, algorithm reported as a probability score for rejection
0089U	Oncology (melanoma), gene expression profiling by RTqPCR, PRAME and LINC00518, superficial collection using adhesive patch(es)
0090U	Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 23 genes (14 content and 9 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a categorical result (i.e., benign, indeterminate, malignant)
0094U	Genome (e.g., unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis
0101U	Hereditary colon cancer disorders (e.g., Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with MRNA analytics to resolve variants of unknown significance when indicated (15 genes [sequencing and deletion/duplication], EPCAM and GREM1 [deletion/duplication only])
0102U	Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with MRNA analytics to resolve variants of unknown significance when indicated (17 genes [sequencing and deletion/duplication])
0103U	Hereditary ovarian cancer (e.g., hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with MRNA analytics to resolve variants of unknown significance when indicated (24 genes [sequencing and deletion/duplication], EPCAM [deletion/duplication only])
0111U	Oncology (colon cancer), targeted KRAS (codons 12, 13, and 61) and NRAS (codons 12, 13, and 61) gene analysis utilizing formalin-fixed paraffin-embedded tissue
0113U	Oncology (prostate), measurement of PCA3 and TMPRSS2-ERG in urine and PSA in serum following prostatic massage, by RNA amplification and fluorescence-based detection, algorithm reported as risk score

0114U	Gastroenterology (Barrett's esophagus), VIM and CCNA1 methylation analysis, esophageal cells, algorithm reported as likelihood for Barrett's esophagus
0118U	Transplantation medicine, quantification of donor-derived cell-free DNA using whole genome next-generation sequencing, plasma, reported as percentage of donor-derived cell-free DNA in the total cell-free DNA
0120U	Oncology (B-cell lymphoma classification), mRNA, gene expression profiling by fluorescent probe hybridization of 58 genes (45 content and 13 housekeeping genes), formalin-fixed paraffin-embedded tissue, algorithm reported as likelihood for primary mediastinal B-cell lymphoma (PMBCL) and diffuse large B-cell lymphoma (DLBCL) with cell of origin subtyping in the latter
0129U	Hereditary breast cancer–related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis and deletion/duplication analysis panel (ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, and TP53)
0130U	Hereditary colon cancer disorders (e.g., Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), targeted mRNA sequence analysis panel (APC, CDH1, CHEK2, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, and TP53) (List separately in addition to code for primary procedure) u(Use 0130U in conjunction with 81435, 0101U)t
0131U	Hereditary breast cancer–related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (13 genes) (List separately in addition to code for primary procedure) u(Use 0131U in conjunction with 81162, 81432, 0102U)t
0132U	Hereditary ovarian cancer–related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (17 genes) (List separately in addition to code for primary procedure)u(Use 0132U in conjunction with 81162, 81432, 0103U)t
0133U	Hereditary prostate cancer–related disorders, targeted mRNA sequence analysis panel (11 genes) (List separately in addition to code for primary procedure) (Use 0133U in conjunction with 81162)
0134U	Hereditary pan cancer (e.g., hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (18 genes) (List separately in addition to code for primary procedure) (Use 0134U in conjunction with 81162, 81432, 81435)
0135U	Hereditary gynecological cancer (e.g., hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (12 genes) (List separately in addition to code for primary procedure) (Use 0135U in conjunction with 81162)
0136U	ATM (ataxia telangiectasia mutated) (e.g., ataxia telangiectasia) mRNA sequence analysis (List separately in addition to code for primary procedure) (Use 0136U in conjunction with 81408)
0137U	PALB2 (partner and localizer of BRCA2) (e.g., breast and pancreatic cancer) mRNA sequence analysis (List separately in addition to code for primary procedure) u(Use 0137U in conjunction with 81406)t
0138U	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) mRNA sequence analysis (List separately in addition to code for primary procedure) u(Use 0138U in conjunction with 81162)t

0153U	Oncology (breast), mRNA, gene expression profiling by next-generation sequencing of 101 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a triple negative breast cancer clinical subtype(s) with information on immune cell involvement
0154U	FGFR3 (fibroblast growth factor receptor 3) gene analysis (i.e., p.R248C [c.742C>T], p.S249C [c.746C>G], p.G370C [c.1108G>T], p.Y373C [c.1118A>G], FGFR3-TACC3v1, and FGFR3-TACC3v3)
0155U	PIK3CA (phosphatidylinositol-4,5-bisphosphate 3-kinase, catalytic subunit alpha) (e.g., breast cancer) gene analysis (i.e., p.C420R, p.E542K, p.E545A, p.E545D [g.1635G>T only], p.E545G, p.E545K, p.Q546E, p.Q546R, p.H1047L, p.H1047R, p.H1047Y)
0156U	Copy number (e.g., intellectual disability, dysmorphology), sequence analysis
0157U	APC (APC regulator of WNT signaling pathway) (e.g., familial adenomatosis polyposis [FAP]) mRNA sequence analysis (List separately in addition to code for primary procedure)(Use 0157U in conjunction with 81201)
0158U	MLH1 (mutL homolog 1) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)(Use 0158U in conjunction with 81292)
0159U	MSH2 (mutS homolog 2) (e.g., hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)(Use 0159U in conjunction with 81295)
0160U	MSH6 (mutS homolog 6) (e.g., hereditary colon cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure) (Use 0160U in conjunction with 81298)
0161U	PMS2 (PMS1 homolog 2, mismatch repair system component) (e.g., hereditary nonpolyposis colorectal cancer, Lynch syndrome) mRNA sequence analysis (List separately in addition to code for primary procedure)(Use 0161U in conjunction with 81317)
0162U	Hereditary colon cancer (Lynch syndrome), targeted mRNA sequence analysis panel (MLH1, MSH2, MSH6, PMS2) (List separately in addition to code for primary procedure)
0168U	Fetal aneuploidy (trisomy 21, 18, and 13) DNA sequence analysis of selected regions using maternal plasma without fetal fraction cutoff, algorithm reported as a risk score for each trisomy
0169U	NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (e.g., drug metabolism) gene analysis, common variants
0170U	Neurology (autism spectrum disorder [ASD]), RNA, next-generation sequencing, saliva, algorithmic analysis, and results reported as predictive probability of ASD diagnosis
0171U	Targeted genomic sequence analysis panel, acute myeloid leukemia, myelodysplastic syndrome, and myeloproliferative neoplasms, DNA analysis, 23 genes, interrogation for sequence variants, rearrangements and minimal residual disease, reported as presence/absence
0172U	Oncology (solid tumor as indicated by the label), somatic mutation analysis of BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) and analysis of homologous recombination deficiency pathways, DNA, formalin-fixed paraffin-embedded tissue, algorithm quantifying tumor genomic instability score
0173U	Psychiatry (i.e., depression, anxiety), genomic analysis panel, includes variant analysis of 14 genes
0175U	Psychiatry (e.g., depression, anxiety), genomic analysis panel, variant analysis of 15 genes

0177U	Oncology (breast cancer), DNA, PIK3CA (phosphatidylinositol-4,5-bisphosphate 3-kinase catalytic subunit alpha) gene analysis of 11 gene variants utilizing plasma, reported as PIK3CA gene mutation status
0179U	Oncology (non-small cell lung cancer), cell-free DNA, targeted sequence analysis of 23 genes (single nucleotide variations, insertions and deletions, fusions without prior knowledge of partner/breakpoint, copy number variations), with report of significant mutation(s)
0203U	Autoimmune (inflammatory bowel disease), mRNA, gene expression profiling by quantitative RT-PCR, 17 genes (15 target and 2 reference genes), whole blood, reported as a continuous risk score and classification of inflammatory bowel disease aggressiveness
0204U	Oncology (thyroid), mRNA, gene expression analysis of 593 genes (including BRAF, RAS, RET, PAX8, and NTRK) for sequence variants and rearrangements, utilizing fine needle aspirate, reported as detected or not detected
0205U	Ophthalmology (age-related macular degeneration), analysis of 3 gene variants (2 CFH gene, 1 ARMS2 gene), using PCR and MALDI-TOF, buccal swab, reported as positive or negative for neovascular age-related macular-degeneration risk associated with zinc supplements
0208U	Oncology (medullary thyroid carcinoma), mRNA, gene expression analysis of 108 genes, utilizing fine needle aspirate, algorithm reported as positive or negative for medullary thyroid carcinoma
0209U	Cytogenomic constitutional (genome-wide) analysis, interrogation of genomic regions for copy number, structural changes and areas of homozygosity for chromosomal abnormalities
0211U	Oncology (pan-tumor), DNA and RNA by next-generation sequencing, utilizing formalin-fixed paraffin-embedded tissue, interpretative report for single nucleotide variants, copy number alterations, tumor mutational burden, and microsatellite instability, with therapy association
0212U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband
0213U	Rare diseases (constitutional/heritable disorders), whole genome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, each comparator genome (e.g., parent, sibling)
0214U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, proband
0215U	Rare diseases (constitutional/heritable disorders), whole exome and mitochondrial DNA sequence analysis, including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants, each comparator exome (e.g., parent, sibling)
0216U	Neurology (inherited ataxias), genomic DNA sequence analysis of 12 common genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants
0217U	Neurology (inherited ataxias), genomic DNA sequence analysis of 51 genes including small sequence changes, deletions, duplications, short tandem repeat gene expansions, and variants

	in non-uniquely mappable regions, blood or saliva, identification and categorization of genetic variants
0218U	Neurology (muscular dystrophy), DMD gene sequence analysis, including small sequence changes, deletions, duplications, and variants in non-uniquely mappable regions, blood or saliva, identification and characterization of genetic variants
0228U	Oncology (prostate), multianalyte molecular profile by photometric detection of macromolecules adsorbed on nanosponge array slides with machine learning, utilizing first morning voided urine, algorithm reported as likelihood of prostate cancer
0229U	BCAT1 (Branched chain amino acid transaminase 1) or IKZF1 (IKAROS family zinc finger 1) (e.g., colorectal cancer) promoter methylation analysis
0230U	AR (androgen receptor) (e.g., spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation), full sequence analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions
0231U	CACNA1A (calcium voltage-gated channel subunit alpha 1A) (e.g., spinocerebellar ataxia), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) gene expansions, mobile element insertions, and variants in non-uniquely mappable regions
0232U	CSTB (cystatin B) (e.g., progressive myoclonic epilepsy type 1A, Unverricht-Lundborg disease), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions
0233U	FXN (frataxin) (e.g., Friedreich ataxia), gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, short tandem repeat (STR) expansions, mobile element insertions, and variants in non-uniquely mappable regions
0234U	MECP2 (methyl CpG binding protein 2) (e.g., Rett syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions
0235U	PTEN (phosphatase and tensin homolog) (e.g., Cowden syndrome, PTEN hamartoma tumor syndrome), full gene analysis, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions
0236U	SMN1 (survival of motor neuron 1, telomeric) and SMN2 (survival of motor neuron 2, centromeric) (e.g., spinal muscular atrophy) full gene analysis, including small sequence changes in exonic and intronic regions, duplications and deletions, and mobile element insertions
0237U	Cardiac ion channelopathies (e.g., Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia), genomic sequence analysis panel including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions
0238U	Oncology (Lynch syndrome), genomic DNA sequence analysis of MLH1, MSH2, MSH6, PMS2, and EPCAM, including small sequence changes in exonic and intronic regions, deletions, duplications, mobile element insertions, and variants in non-uniquely mappable regions
0239U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free DNA, analysis of 311 or more genes, interrogation for sequence variants, including substitutions, insertions, deletions, select rearrangements, and copy number variations

0242U	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 55-74 genes, interrogation for sequence variants, gene copy number amplifications, and gene rearrangements
0244U	Oncology (solid organ), DNA, comprehensive genomic profiling, 257 genes, interrogation for single-nucleotide variants, insertions/deletions, copy number alterations, gene rearrangements, tumor-mutational burden and microsatellite instability, utilizing formalin-fixed paraffin-embedded tumor tissue
0245U	Oncology (thyroid), mutation analysis of 10 genes and 37 RNA fusions and expression of 4 mRNA markers using next-generation sequencing, fine needle aspirate, report includes associated risk of malignancy expressed as a percentage
0250U	Oncology (solid organ neoplasm), targeted genomic sequence DNA analysis of 505 genes, interrogation for somatic alterations (SNVs [single nucleotide variant], small insertions and deletions, one amplification, and four translocations), microsatellite instability and tumor-mutation burden
0252U	Fetal aneuploidy short tandem–repeat comparative analysis, fetal DNA from products of conception, reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplications, mosaicism, and segmental aneuploidy
0253U	Reproductive medicine (endometrial receptivity analysis), RNA gene expression profile, 238 genes by next-generation sequencing, endometrial tissue, predictive algorithm reported as endometrial window of implantation (e.g., pre-receptive, receptive, post-receptive)
0254U	Reproductive medicine (preimplantation genetic assessment), analysis of 24 chromosomes using embryonic DNA genomic sequence analysis for aneuploidy, and a mitochondrial DNA score in euploid embryos, results reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplications, mosaicism, and segmental aneuploidy, per embryo tested
0258U	Autoimmune (psoriasis), mRNA, next[1]generation sequencing, gene expression profiling of 50-100 genes, skin-surface collection using adhesive patch, algorithm reported as likelihood of response to psoriasis biologics
0260U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping (For additional PLA code with identical clinical descriptor, see 0264U. See Appendix O or the most current listing on the AMA CPT website to determine appropriate code assignment.)
0262U	Oncology (solid tumor), gene expression profiling by real-time RT-PCR of 7 gene pathways (ER, AR, PI3K, MAPK, HH, TGFB, Notch), formalin-fixed paraffin[1]embedded (FFPE), algorithm reported as gene pathway activity score
0264U	Rare diseases (constitutional/heritable disorders), identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping (For additional PLA code with identical clinical descriptor, see 0260U. See Appendix O or the most current listing on the AMA CPT website to determine appropriate code assignment.)
0265U	Rare constitutional and other heritable disorders, whole genome and mitochondrial DNA sequence analysis, blood, frozen and formalin-fixed paraffin[1]embedded (FFPE) tissue, saliva, buccal swabs or cell lines, identification of single nucleotide and copy number variants
0266U	Unexplained constitutional or other heritable disorders or syndromes, tissue[1]specific gene expression by whole[1]transcriptome and next-generation sequencing, blood, formalin-fixed paraffin[1]embedded (FFPE) tissue or fresh frozen tissue, reported as presence or absence of splicing or expression changes

0267U	Rare constitutional and other heritable disorders, identification of copy number variations, inversions, insertions, translocations, and other structural variants by optical genome mapping and whole genome sequencing
0268U	Hematology (atypical hemolytic uremic syndrome [aHUS]), genomic sequence analysis of 15 genes, blood, buccal swab, or amniotic fluid
0269U	Hematology (autosomal dominant congenital thrombocytopenia), genomic sequence analysis of 14 genes, blood, buccal swab, or amniotic fluid
0270U	Hematology (congenital coagulation disorders), genomic sequence analysis of 20 genes, blood, buccal swab, or amniotic fluid
0271U	Hematology (congenital neutropenia), genomic sequence analysis of 23 genes, blood, buccal swab, or amniotic fluid
0272U	Hematology (genetic bleeding disorders), genomic sequence analysis of 51 genes, blood, buccal swab, or amniotic fluid, comprehensive
0273U	Hematology (genetic hyperfibrinolysis, delayed bleeding), genomic sequence analysis of 8 genes (F13A1, F13B, FGA, FGB, FGG, SERPINA1, SERPINE1, SERPINF2, PLAU), blood, buccal swab, or amniotic fluid
0274U	Hematology (genetic platelet disorders), genomic sequence analysis of 43 genes, blood, buccal swab, or amniotic fluid
0276U	Hematology (inherited thrombocytopenia), genomic sequence analysis of 23 genes, blood, buccal swab, or amniotic fluid
0277U	Hematology (genetic platelet function disorder), genomic sequence analysis of 31 genes, blood, buccal swab, or amniotic fluid
0278U	Hematology (genetic thrombosis), genomic sequence analysis of 12 genes, blood, buccal swab, or amniotic fluid
0285U	Oncology, response to radiation, cell-free DNA, quantitative branched chain DNA amplification, plasma, reported as a radiation toxicity score
0286U	CEP72 (centrosomal protein, 72-KDa), NUDT15 (nudix hydrolase 15) and TPMT (thiopurine S-methyltransferase) (e.g., drug metabolism) gene analysis, common variants
0287U	Oncology (thyroid), DNA and mRNA, nextgeneration sequencing analysis of 112 genes, fine needle aspirate or formalinfixed paraffin-embedded (FFPE) tissue, algorithmic prediction of cancer recurrence, reported as a categorical risk result (low, intermediate, high)
0288U	Oncology (lung), mRNA, quantitative PCR analysis of 11 genes (BAG1, BRCA1, CDC6, CDK2AP1, ERBB3, FUT3, IL11, LCK, RND3, SH3BGR, WNT3A) and 3 reference genes (ESD, TBP, YAP1), formalin-fixed paraffin-embedded (FFPE) tumor tissue, algorithmic interpretation reported as a recurrence risk score
0289U	Neurology (Alzheimer disease), mRNA, gene expression profiling by RNA sequencing of 24 genes, whole blood, algorithm reported as predictive risk score
0290U	Pain management, mRNA, gene expression profiling by RNA sequencing of 36 genes, whole blood, algorithm reported as predictive risk score
0291U	Psychiatry (mood disorders), mRNA, gene expression profiling by RNA sequencing of 144 genes, whole blood, algorithm reported as predictive risk score
0292U	Psychiatry (stress disorders), mRNA, gene expression profiling by RNA sequencing of 72 genes, whole blood, algorithm reported as predictive risk score
0293U	Psychiatry (suicidal ideation), mRNA, gene expression profiling by RNA sequencing of 54 genes, whole blood, algorithm reported as predictive risk score
0294U	Longevity and mortality risk, mRNA, gene expression profiling by RNA sequencing of 18 genes, whole blood, algorithm reported as predictive risk score - MindX Blood Test™ - Longevity

0296U	Oncology (oral and/or oropharyngeal cancer), gene expression profiling by RNA sequencing at least 20 molecular features (e.g., human and/or microbial mRNA), saliva, algorithm reported as positive or negative for signature associated with malignancy
0297U	Oncology (pan tumor), whole genome sequencing of paired malignant and normal DNA specimens, fresh or formalinfixed paraffin-embedded (FFPE) tissue, blood or bone marrow, comparative sequence analyses and variant identification
0298U	Oncology (pan tumor), whole transcriptome sequencing of paired malignant and normal RNA specimens, fresh or formalin-fixed paraffin-embedded (FFPE) tissue, blood or bone marrow, comparative sequence analyses and expression level and chimeric transcript identification
0299U	Oncology (pan tumor), whole genome optical genome mapping of paired malignant and normal DNA specimens, fresh frozen tissue, blood, or bone marrow, comparative structural variant identification
0300U	Oncology (pan tumor), whole genome sequencing and optical genome mapping of paired malignant and normal DNA specimens, fresh tissue, blood, or bone marrow, comparative sequence analyses and variant identification
81120	IDH1 (isocitrate dehydrogenase 1 [NADP+], soluble) (e.g., glioma), common variants (e.g., R132H, R132C)
81121	IDH2 (isocitrate dehydrogenase 2 [NADP+], mitochondrial) (e.g., glioma), common variants (e.g., R140W, R172M)
81161	DMD (dystrophin) (e.g., Duchenne/Becker muscular dystrophy) deletion analysis, and duplication analysis, if performed
81162	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis and full duplication/deletion analysis (i.e., detection of large gene rearrangements)
81163	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81164	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (i.e., detection of large gene rearrangements)
81165	BRCA1 (BRCA1, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81166	BRCA1 (BRCA1, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (i.e., detection of large gene rearrangements)
81167	BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full duplication/deletion analysis (i.e., detection of large gene rearrangements)
81168	CCND1/IGH (t(11;14)) (e.g., mantle cell lymphoma) translocation analysis, major breakpoint, qualitative and quantitative, if performed
81170	ABLI (ABL proto-oncogene 1, non-receptor tyrosine kinase) (e.g., acquired imatinib tyrosine kinase inhibitor resistance), gene analysis, variants in the kinase domain
81171	AFF2 (AF4/FMR2 family, member 2 [FMR2]) (e.g., fragile X mental retardation 2 [FRAXE]) gene analysis; evaluation to detect abnormal (e.g., expanded) alleles
81172	AFF2 (AF4/FMR2 family, member 2 [FMR2]) (e.g., fragile X mental retardation 2 [FRAXE]) gene analysis; characterization of alleles (e.g., expanded size and methylation status)
81173	AR (androgen receptor) (e.g., spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; full gene sequence
81174	AR (androgen receptor) (e.g., spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; full gene sequence

81175	ASXL1 (additional sex combs like 1, transcriptional regulator) (e.g., myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; full gene sequence
81176	ASXL1 (additional sex combs like 1, transcriptional regulator) (e.g., myelodysplastic syndrome, myeloproliferative neoplasms, chronic myelomonocytic leukemia), gene analysis; targeted sequence analysis (e.g., exon 12)
81177	ATN1 (atrophin 1) (e.g., dentatorubral-pallidoluysian atrophy) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81178	ATXN1 (ataxin 1) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81179	ATXN2 (ataxin 2) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81180	ATXN3 (ataxin 3) (e.g., spinocerebellar ataxia, Machado-Joseph disease) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81181	ATXN7 (ataxin 7) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81182	ATXN8OS (ATXN8 opposite strand [non-protein coding]) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81183	ATXN10 (ataxin 10) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81184	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (e.g., spinocerebellar ataxia) gene analysis; evaluation to detect abnormal (e.g., expanded) alleles
81185	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (e.g., spinocerebellar ataxia) gene analysis; full gene sequence
81186	CACNA1A (calcium voltage-gated channel subunit alpha1 A) (e.g., spinocerebellar ataxia) gene analysis; known familial variant
81187	CNBP (CCHC-type zinc finger nucleic acid binding protein) (e.g., myotonic dystrophy type 2) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81188	CSTB (cystatin B) (e.g., Unverricht-Lundborg disease) gene analysis; evaluation to detect abnormal (e.g., expanded) alleles
81189	CSTB (cystatin B) (e.g., Unverricht-Lundborg disease) gene analysis; full gene sequence
81190	CSTB (cystatin B) (e.g., Unverricht-Lundborg disease) gene analysis; known familial variant(s)
81191	NTRK1 (neurotrophic receptor tyrosine kinase 1) (e.g., solid tumors) translocation analysis
81192	NTRK2 (neurotrophic receptor tyrosine kinase 2) (e.g., solid tumors) translocation analysis
81193	NTRK3 (neurotrophic receptor tyrosine kinase 3) (e.g., solid tumors) translocation analysis
81194	NTRK (neurotrophic-tropomyosin receptor tyrosine kinase 1, 2, and 3) (e.g., solid tumors) translocation analysis
81200	ASPA (aspartoacylase) (e.g., Canavan disease) gene analysis, common variants (e.g., E285A, Y231X)
81201	APC (adenomatous polyposis coli) (e.g., familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; full gene sequence
81202	APC (adenomatous polyposis coli) (e.g., familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; known familial variants
81203	APC (adenomatous polyposis coli) (e.g., familial adenomatosis polyposis [FAP], attenuated FAP) gene analysis; duplication/deletion variants

81204	AR (androgen receptor) (e.g., spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; characterization of alleles (e.g., expanded size or methylation status)
81205	BCKDHB (branched-chain keto acid dehydrogenase E1, beta polypeptide) (e.g., Maple syrup urine disease) gene analysis, common variants (e.g., R183P, G278S, E422X)
81206	BCR/ABL1 (t[9;22]) (e.g., chronic myelogenous leukemia) translocation analysis; major breakpoint, qualitative or quantitative
81207	BCR/ABL1 (t[9;22]) (e.g., chronic myelogenous leukemia) translocation analysis; minor breakpoint, qualitative or quantitative
81208	BCR/ABL1 (t[9;22]) (e.g., chronic myelogenous leukemia) translocation analysis; other breakpoint, qualitative or quantitative
81209	BLM (Bloom syndrome, RecQ helicase-like) (e.g., Bloom syndrome) gene analysis, 2281del6Ins7 variant
81210	BRAF (B-Raf proto-oncogene, serine/threonine kinase) (e.g., colon cancer, melanoma), gene analysis, V600 variant(s)
81212	BRCA1 (BRCA1, DNA repair associated), BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; 185delAG, 5385insC, 6174delT variants
81215	BRCA1 (BRCA1, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; known familial variant
81216	BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; full sequence analysis
81217	BRCA2 (BRCA2, DNA repair associated) (e.g., hereditary breast and ovarian cancer) gene analysis; known familial variant
81218	CEBPA (CCAAT/enhancer binding protein[C/EBP], alpha) (e.g., acute myeloid leukemia), gene analysis, full gene sequence
81219	CALR (calreticulin) (e.g., myeloproliferative disorders), gene analysis, common variants in exon 9
81220	CFTR (cystic fibrosis transmembrane conductance regulator) (e.g., cystic fibrosis) gene analysis; common variants (e.g., ACMG/ACOG guidelines)
81221	CFTR (cystic fibrosis transmembrane conductance regulator) (e.g., cystic fibrosis) gene analysis; known familial variants
81222	CFTR (cystic fibrosis transmembrane conductance regulator) (e.g., cystic fibrosis) gene analysis; duplication/deletion variants
81223	CFTR (cystic fibrosis transmembrane conductance regulator) (e.g., cystic fibrosis) gene analysis; full gene sequence
81224	CFTR (cystic fibrosis transmembrane conductance regulator) (e.g., cystic fibrosis) gene analysis; intron 8 poly-T analysis (e.g., male infertility)
81225	CYP2C19 (cytochrome P450, family 2, subfamily C, polypeptide 19) (e.g., drug metabolism), gene analysis, common variants (e.g., *2, *3, *4, *8, *17)
81226	CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (e.g., drug metabolism), gene analysis, common variants (e.g., *2, *3, *4, *5, *6, *9, *10, *17, *19, *29, *35, *41, *1XN, *2XN, *4XN)
81227	CYP2C9 (Cytochrome P450, family 2, subfamily C, polypeptide 9) (e.g., drug metabolism), gene analysis, common variants (e.g., *2, *3, *5, *6)

81228	Cytogenetic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number variants (comparative genomic hybridization [CGH] microarray analysis)
81229	Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number and single nucleotide polymorphism (SNP) variants for comparative genomic hybridization (CGH) microarray analysis
81230	CYP3A4 (cytochrome P450 family 3 subfamily A member 4) (e.g., drug metabolism), gene analysis, common variant(s) (e.g., *2, *22)
81231	CYP3A5 (cytochrome P450 family 3 subfamily A member 5) (e.g., drug metabolism), gene analysis, common variants (e.g., *2, *3, *4, *5, *6, *7)
81232	DPYD (dihydropyrimidine dehydrogenase) (e.g., 5-fluorouracil/5-FU and capecitabine drug metabolism), gene analysis, common variant(s) (e.g., *2A, *4, *5, *6)
81233	BTK (Bruton's tyrosine kinase) (e.g., chronic lymphocytic leukemia) gene analysis, common variants (e.g., C481S, C481R, C481F)
81234	DMPK (DM1 protein kinase) (e.g., myotonic dystrophy type 1) gene analysis; evaluation to detect abnormal (expanded) alleles
81235	EGFR (epidermal growth factor receptor) (e.g., non-small cell lung cancer) gene analysis, common variants (e.g., exon 19 LREA deletion, L858R, T790M, G719A, G719S, L861Q)
81236	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (e.g., myelodysplastic syndrome, myeloproliferative neoplasms) gene analysis, full gene sequence
81237	EZH2 (enhancer of zeste 2 polycomb repressive complex 2 subunit) (e.g., diffuse large B-cell lymphoma) gene analysis, common variant(s) (e.g., codon 646)
81238	F9 (coagulation factor IX) (e.g., hemophilia B), full gene sequence
81239	DMPK (DM1 protein kinase) (e.g., myotonic dystrophy type 1) gene analysis; characterization of alleles (e.g., expanded size)
81240	F2 (prothrombin, coagulation factor II) (e.g., hereditary hypercoagulability) gene analysis, 20210G>A variant
81241	F5 (coagulation Factor V) (e.g., hereditary hypercoagulability) gene analysis, Leiden variant
81242	FANCC (Fanconi anemia, complementation group C) (e.g., Fanconi anemia, type C) gene analysis, common variant (e.g., IVS4+4A>T)
81243	FMR1 (fragile X mental retardation 1) (e.g., fragile X mental retardation) gene analysis; evaluation to detect abnormal (e.g., expanded) alleles
81244	FMR1 (fragile X mental retardation 1) (e.g., fragile X mental retardation) gene analysis; characterization of alleles (e.g., expanded size and promoter methylation status)
81245	FLT3 (fms-related tyrosine kinase 3) (e.g., acute myeloid leukemia), gene analysis, internal tandem duplication (ITD) variants (i.e., exons 14, 15)
81246	FLT3 (fms-related tyrosine kinase 3) (e.g., acute myeloid leukemia), gene analysis; tyrosine kinase domain (TKD) variants (e.g., D835, I836)
81247	G6PD (glucose-6-phosphate dehydrogenase) (e.g., hemolytic anemia, jaundice), gene analysis; common variant(s) (e.g., A, A-)
81248	G6PD (glucose-6-phosphate dehydrogenase) (e.g., hemolytic anemia, jaundice), gene analysis; known familial variant(s)
81249	G6PD (glucose-6-phosphate dehydrogenase) (e.g., hemolytic anemia, jaundice), gene analysis; full gene sequence
81250	G6PC (glucose-6-phosphatase, catalytic subunit) (e.g., Glycogen storage disease, Type 1a, von Gierke disease) gene analysis, common variants (e.g., R83C, Q347X)

81251	GBA (glucosidase, beta, acid) (e.g., Gaucher disease) gene analysis, common variants (e.g., N370S, 84GG, L444P, IVS2+1G>A)
81252	GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (e.g., nonsyndromic hearing loss) gene analysis; full gene sequence
81253	GJB2 (gap junction protein, beta 2, 26kDa; connexin 26) (e.g., nonsyndromic hearing loss) gene analysis; known familial variants
81254	GJB6 (gas junction protein, beta 6, 30kDa, connexin 30) (e.g., nonsyndromic hearing loss) gene analysis, common variants (e.g., 309kb [del(GJB6-D13S1830)] and 232kb [del(GJB6-D13S1854)])
81255	HEXA (hexosaminidase A [alpha polypeptide]) (e.g., Tay-Sachs disease) gene analysis, common variants (e.g., 1278insTATC, 1421+1G>C, G269S)
81256	HFE (hemochromatosis) (e.g., hereditary hemochromatosis) gene analysis, common variants (e.g., C282Y, H63D)
81257	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (e.g., alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; common deletions or variant (e.g., Southeast Asian, Thai, Filipino, Mediterranean, alpha3.7, alpha4.2, alpha20.5, Constant Spring)
81258	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (e.g., alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; known familial variant
81259	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (e.g., alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; full gene sequence
81260	IKBKAP (inhibitor of kappa light polypeptide gene enhancer in B-cells, kinase complex-associated protein) (e.g., familial dysautonomia) gene analysis, common variants (e.g., 2507+6T>C, R696P)
81261	IGH@ (Immunoglobulin heavy chain locus) (e.g., leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); amplified methodology (e.g., polymerase chain reaction)
81262	IGH@ (Immunoglobulin heavy chain locus) (e.g., leukemias and lymphomas, B-cell), gene rearrangement analysis to detect abnormal clonal population(s); direct probe methodology (e.g., Southern blot)
81263	IGH@ (Immunoglobulin heavy chain locus) (e.g., leukemia and lymphoma, B-cell), variable region somatic mutation analysis
81264	IGK@ (Immunoglobulin kappa light chain locus) (e.g., leukemia and lymphoma, B-cell), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)
81265	Comparative analysis using Short Tandem Repeat (STR) markers; patient and comparative specimen (e.g., pre-transplant recipient and donor germline testing, post-transplant non-hematopoietic recipient germline [e.g., buccal swab or other germline tissue sample]
81266	Comparative analysis using Short Tandem Repeat (STR) markers; each additional specimen (e.g., additional cord blood donor, additional fetal samples from different cultures, or additional zygosity in multiple birth pregnancies) (List separately in addition t
81269	HBA1/HBA2 (alpha globin 1 and alpha globin 2) (e.g., alpha thalassemia, Hb Bart hydrops fetalis syndrome, HbH disease), gene analysis; duplication/deletion variants
81270	JAK2 (Janus kinase 2) (e.g., myeloproliferative disorder) gene analysis, p.Val617Phe (V617F) variant
81271	HTT (huntingtin) (e.g., Huntington disease) gene analysis; evaluation to detect abnormal (e.g., expanded) alleles

81272	KIT (v-kit-Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (e.g., gastrointestinal stromal tumor [GIST], acute myeloid leukemia, melanoma), gene analysis, targeted sequence analysis (e.g., exons 8,11,13,17,18)
81273	KIT(v-kit-Hardy-Zuckerman 4 feline sarcoma viral oncogene homolog) (e.g., mastocytosis), gene analysis, D816 variant(s)
81274	HTT (huntingtin) (e.g., Huntington disease) gene analysis; characterization of alleles (e.g., expanded size)
81275	KRAS (Kirsten rat sarcoma viral oncogene homolog) (e.g., carcinoma) gene analysis, variants in exon 2 (e.g., codons 12 And 13)
81276	KRAS (V-Ki-ras2 Kirsten rat sarcoma viral oncogene) (e.g., carcinoma) gene analysis, variants in codons 12 And 13; additional variants(s) (e.g., codon 61, codon 146)
81277	Cytogenomic neoplasia (genome-wide) microarray analysis, interrogation of genomic regions for copy number and loss-of-heterozygosity variants for chromosomal abnormalities
81278	IGH@/BCL2 (t(14;18)) (e.g., follicular lymphoma) translocation analysis, major breakpoint region (MBR) and minor cluster region (mcr) breakpoints, qualitative or quantitative
81279	JAK2 (Janus kinase 2) (e.g., myeloproliferative disorder) targeted sequence analysis (e.g., exons 12 and 13)
81283	IFNL3 (interferon, lambda 3) (e.g., drug response), gene analysis, rs12979860 variant
81284	HTT (huntingtin) (e.g., Huntington disease) gene analysis; characterization of alleles (e.g., expanded size)
81285	FXN (frataxin) (e.g., Friedreich ataxia) gene analysis; characterization of alleles (e.g., expanded size)
81286	FXN (frataxin) (e.g., Friedreich ataxia) gene analysis; full gene sequence
81287	MGMT (O-6-methylguanine-DNA methyltransferase) (e.g., glioblastoma multiforme), promoter methylation analysis
81288	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; promoter methylation analysis
81289	FXN (frataxin) (e.g., Friedreich ataxia) gene analysis; full gene sequence
81290	MCOLN1 (mucolipin 1) (e.g., Mucolipidosis, type IV) gene analysis, common variants (e.g., IVS3-2A>G, del6.4kb)
81291	MTHFR (5,10-methylenetetrahydrofolate reductase) (e.g., hereditary hypercoagulability) gene analysis, common variants (e.g., 677T, 1298C)
81292	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
81293	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
81294	MLH1 (mutL homolog 1, colon cancer, nonpolyposis type 2) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
81295	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
81296	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
81297	MSH2 (mutS homolog 2, colon cancer, nonpolyposis type 1) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
81298	MSH6 (mutS homolog 6 [E. coli]) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis

81299	MSH6 (mutS homolog 6 [E. coli]) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
81300	MSH6 (mutS homolog 6 [E. coli]) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
81301	Microsatellite instability analysis (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) of markers for mismatch repair deficiency (e.g., BAT25, BAT26), includes comparison of neoplastic and normal tissue, if performed
81302	MECP2 (methyl CpG binding protein 2) (e.g., Rett syndrome) gene analysis; full sequence analysis
81303	MECP2 (methyl CpG binding protein 2) (e.g., Rett syndrome) gene analysis; known familial variant
81304	MECP2 (methyl CpG binding protein 2) (e.g., Rett syndrome) gene analysis; duplication/deletion variants
81305	MYD88 (myeloid differentiation primary response 88) (e.g., Waldenstrom's macroglobulinemia, lymphoplasmacytic leukemia) gene analysis, p.Leu265Pro (L265P) variant
81306	NUDT15 (nudix hydrolase 15) (e.g., drug metabolism) gene analysis, common variant(s) (e.g., *2, *3, *4, *5, *6)
81307	PALB2 (partner and localizer of BRCA2) (e.g., breast and pancreatic cancer) gene analysis; full gene sequence
81308	PALB2 (partner and localizer of BRCA2) (e.g., breast and pancreatic cancer) gene analysis; known familial variant
81309	PIK3CA (phosphatidylinositol-4, 5-biphosphate 3-kinase, catalytic subunit alpha) (e.g., colorectal and breast cancer) gene analysis, targeted sequence analysis (e.g., exons 7, 9, 20)
81310	NPM1 (nucleophosmin) (e.g., acute myeloid leukemia) gene analysis, exon 12 variants
81311	NRAS (Neuroblastoma RAS viral[v-ras] oncogene homolog) (e.g., colorectal carcinoma), gene analysis, variants in exon 2 (e.g., codons 12 and 13) and exon 3 (e.g., codon 61)
81312	PABPN1 (poly[A] binding protein nuclear 1) (e.g., oculopharyngeal muscular dystrophy) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81313	PCA3/KLK3 (prostate cancer antigen 3 [non-protein coding]/kallikrein-related peptidase 3 [prostate specific antigen]) ratio (e.g., prostate cancer)
81314	PDGFRA (platelet-derived growth factor receptor, alpha polypeptide) (e.g., gastrointestinal stromal tumor[GIST]), gene analysis, targeted sequence analysis (e.g., exons 12,18)
81315	PML/RARalpha, (t[15;17]), (promyelocytic leukemia/retinoic acid receptor alpha) (e.g., promyelocytic leukemia) translocation analysis; common breakpoints (e.g., intron 3 and intron 6), qualitative or quantitative
81316	PML/RARalpha, (t[15;17]), (promyelocytic leukemia/retinoic acid receptor alpha) (e.g., promyelocytic leukemia) translocation analysis; single breakpoint (e.g., intron 3, intron 6 or exon 6), qualitative or quantitative
81317	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; full sequence analysis
81318	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; known familial variants
81319	PMS2 (postmeiotic segregation increased 2 [S. cerevisiae]) (e.g., hereditary non-polyposis colorectal cancer, Lynch syndrome) gene analysis; duplication/deletion variants
81320	PLCG2 (phospholipase C gamma 2) (e.g., chronic lymphocytic leukemia) gene analysis, common variants (e.g., R665W, S707F, L845F)

81321	PTEN (phosphatase and tensin homolog) (e.g., Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; full sequence analysis
81322	PTEN (phosphatase and tensin homolog) (e.g., Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; known familial variant
81323	PTEN (phosphatase and tensin homolog) (e.g., Cowden syndrome, PTEN hamartoma tumor syndrome) gene analysis; duplication/deletion variant
81324	PMP22 (peripheral myelin protein 22) (e.g., Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; duplication/deletion analysis
81325	PMP22 (peripheral myelin protein 22) (e.g., Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; full sequence analysis
81326	PMP22 (peripheral myelin protein 22) (e.g., Charcot-Marie-Tooth, hereditary neuropathy with liability to pressure palsies) gene analysis; known familial variant
81327	SEPT9 (Septin9) (e.g., colorectal cancer) promoter methylation analysis
81328	SLCO1B1 (solute carrier organic anion transporter family, member 1B1) (e.g., adverse drug reaction), gene analysis, common variant(s) (e.g., *5)
81329	SMN1 (survival of motor neuron 1, telomeric) (e.g., spinal muscular atrophy) gene analysis; dosage/deletion analysis (e.g., carrier testing), includes SMN2 (survival of motor neuron 2, centromeric) analysis, if performed
81330	SMPD1(sphingomyelin phosphodiesterase 1, acid lysosomal) (e.g., Niemann-Pick disease, Type A) gene analysis, common variants (e.g., R496L, L302P, FsP330)
81331	SNRPN/UBE3A (small nuclear ribonucleoprotein polypeptide N and ubiquitin protein ligase E3A) (e.g., Prader-Willi syndrome and/or Angelman syndrome), methylation analysis
81332	SERPINA1 (serpin peptidase inhibitor, clade A, alpha-1 antiproteinase, antitrypsin, member 1) (e.g., alpha-1-antitrypsin deficiency), gene analysis, common variants (e.g., *S and *Z)
81333	TGFBI (transforming growth factor beta-induced) (e.g., corneal dystrophy) gene analysis, common variants (e.g., R124H, R124C, R124L, R555W, R555Q)
81334	RUNX1 (runt related transcription factor 1) (e.g., acute myeloid leukemia, familial platelet disorder with associated myeloid malignancy), gene analysis, targeted sequence analysis (e.g., exons 3-8)
81335	TPMT (thiopurine S-methyltransferase) (e.g., drug metabolism), gene analysis, common variants (e.g., *2, *3)
81336	SMN1 (survival of motor neuron 1, telomeric) (e.g., spinal muscular atrophy) gene analysis; full gene sequence
81337	SMN1 (survival of motor neuron 1, telomeric) (e.g., spinal muscular atrophy) gene analysis; known familial sequence variant(s)
81338	MPL (MPL proto-oncogene, thrombopoietin receptor) (e.g., myeloproliferative disorder) gene analysis; common variants (e.g., W515A, W515K, W515L, W515R)
81339	MPL (MPL proto-oncogene, thrombopoietin receptor) (e.g., myeloproliferative disorder) gene analysis; sequence analysis, exon 10
81340	TRB@ (T cell antigen receptor, beta) (e.g., leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using amplification methodology (e.g., polymerase chain reaction)
81341	TRB@ (T cell antigen receptor, beta) (e.g., leukemia and lymphoma), gene rearrangement analysis to detect abnormal clonal population(s); using direct probe methodology (e.g., Southern blot)

81342	TRG@ (T cell antigen receptor, gamma) (e.g., leukemia and lymphoma), gene rearrangement analysis, evaluation to detect abnormal clonal population(s)
81343	PPP2R2B (protein phosphatase 2 regulatory subunit Bbeta) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81344	TBP (TATA box binding protein) (e.g., spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (e.g., expanded) alleles
81345	TERT (telomerase reverse transcriptase) (e.g., thyroid carcinoma, glioblastoma multiforme) gene analysis, targeted sequence analysis (e.g., promoter region)
81346	TYMS (thymidylate synthetase) (e.g., 5-fluorouracil/5-FU drug metabolism), gene analysis, common variant(s) (e.g., tandem repeat variant)
81347	SF3B1 (splicing factor [3b] subunit B1) (e.g., myelodysplastic syndrome/acute myeloid leukemia) gene analysis, common variants (e.g., A672T, E622D, L833F, R625C, R625L)
81348	SRSF2 (serine and arginine-rich splicing factor 2) (e.g., myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variants (e.g., P95H, P95L)
81349	Cytogenomic (genome-wide) analysis for constitutional chromosomal abnormalities; interrogation of genomic regions for copy number and loss-of-heterozygosity variants, low-pass sequencing analysis
81350	UGT1A1 (UDP glucuronosyltransferase 1 family, polypeptide A1) (e.g., irinotecan metabolism), gene analysis, common variants (e.g., *28, *36, *37)
81351	TP53 (tumor protein 53) (e.g., Li-Fraumeni syndrome) gene analysis; full gene sequence
81352	TP53 (tumor protein 53) (e.g., Li-Fraumeni syndrome) gene analysis; targeted sequence analysis (e.g., 4 oncology)
81353	TP53 (tumor protein 53) (e.g., Li-Fraumeni syndrome) gene analysis; known familial variant
81355	VKORC1 (vitamin K epoxide reductase complex, subunit 1) (e.g., warfarin metabolism), gene analysis, common variants (e.g., -1639G>A, c.173+1000C>T)
81357	U2AF1 (U2 small nuclear RNA auxiliary factor 1) (e.g., myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variants (e.g., S34F, S34Y, Q157R, Q157P)
81360	ZRSR2 (zinc finger CCCH-type, RNA binding motif and serine/arginine-rich 2) (e.g., myelodysplastic syndrome, acute myeloid leukemia) gene analysis, common variant(s) (e.g., E65fs, E122fs, R448fs)
81361	HBB (hemoglobin, subunit beta) (e.g., sickle cell anemia, beta thalassemia, hemoglobinopathy); common variant(s) (e.g., HbS, HbC, HbE)
81362	HBB (hemoglobin, subunit beta) (e.g., sickle cell anemia, beta thalassemia, hemoglobinopathy); known familial variant(s)
81363	HBB (hemoglobin, subunit beta) (e.g., sickle cell anemia, beta thalassemia, hemoglobinopathy); duplication/deletion variant(s)
81364	HBB (hemoglobin, subunit beta) (e.g., sickle cell anemia, beta thalassemia, hemoglobinopathy); full gene sequence
81400	Molecular pathology procedure, Level 1 (e.g., identification of single germline variant [e.g., SNP] by techniques such as restriction enzyme digestion or melt curve analysis)
81401	Molecular pathology procedure, Level 2 (e.g., 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using non-sequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat)
81402	Molecular pathology procedure, Level 3 (e.g., >10 SNPs, 2-10 methylated variants, or 2-10 somatic variants [typically using non-sequencing target variant analysis], immunoglobulin and T-cell receptor gene rearrangements, duplication/deletion variants 1 exon, loss of heterozygosity [LOH], uniparental disomy [UPD])

81403	Molecular pathology procedure, Level 4 (e.g., analysis of single exon by DNA sequence analysis, analysis of >10 amplicons using multiplex PCR in 2 or more independent reactions, mutation scanning or duplication/deletion variants of 2-5 exons)
81404	Molecular pathology procedure, Level 5 (e.g., analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)
81405	Molecular pathology procedure, Level 6 (e.g., analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons), regionally targeted cytogenomic array analysis
81406	Molecular pathology procedure, Level 7 (e.g., analysis of 11-25 exons By DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic array analysis for neoplasia)
81407	Molecular pathology procedure, Level 8 (e.g., analysis Of 26-50 exons By DNA sequence analysis, mutation scanning or duplication/deletion variants Of >50 exons, sequence analysis of multiple genes on one platform)
81408	Molecular pathology procedure, Level 9 (e.g., analysis Of >50 exons in a single gene By DNA sequence analysis)
81410	Aortic dysfunction or dilation (e.g., Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); genomic sequence analysis panel, must include sequencing of at least 9 genes, including FBN1, TGFBR1, TGFBR2, COL3A1, MYH11, ACTA2, SLC2A10, SMAD3, and MYLK
81411	Aortic dysfunction or dilation (e.g., Marfan syndrome, Loeys Dietz syndrome, Ehler Danlos syndrome type IV, arterial tortuosity syndrome); duplication/deletion analysis panel, must include analyses for TGFBR1, TGFBR2, MYH11, and COL3A1
81412	Ashkenazi Jewish associated disorders (e.g., Bloom syndrome, Canavan disease, cystic fibrosis, familial dysautonomia, Franconi anemia group C, Gaucher disease, Tay-Sachs disease), genomic sequence analysis panel, must include sequencing of at least 9 genes, including ASPA, BLM, CFTR, FANCC, GBA, HEXA, IKBKAP, MCOLN1, and SMPD1
81413	Cardiac ion channelopathies (e.g., Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); genomic sequence analysis panel, must include sequencing of at least 10 genes, including ANK2, CASQ2, CAV3, KCNE1, KCNE2, KCNH2, KCNJ2, KCNQ1, RYR2, and SCN5A
81414	Cardiac ion channelopathies (e.g., Brugada syndrome, long QT syndrome, short QT syndrome, catecholaminergic polymorphic ventricular tachycardia); duplication/deletion gene analysis panel, must include analysis of at least 2 genes, including KCNH2 and KCNQ1
81415	Exome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis
81416	Exome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator exome (e.g., parents, siblings) (List separately in addition to code for primary procedure)
81417	Exome (e.g., unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained exome sequence (e.g., updated knowledge or unrelated condition/syndrome)
81419	Epilepsy genomic sequence analysis panel, must include analyses for ALDH7A1, CACNA1A, CDKL5, CHD2, GABRG2, GRIN2A, KCNQ2, MECP2, PCDH19, POLG, PRRT2, SCN1A, SCN1B, SCN2A, SCN8A, SLC2A1, SLC9A6, STXBP1, SYNGAP1, TCF4, TPP1, TSC1, TSC2, and ZEB2

81420	Fetal chromosomal aneuploidy (e.g., trisomy 21, monosomy X) genomic sequence analysis panel, circulating cell-free fetal DNA in maternal blood, must include analysis of chromosomes 13, 18, and 21
81422	Fetal chromosomal microdeletion(s) genomic sequence analysis (e.g., DiGeorge syndrome, Cri-du-chat syndrome), circulating cell-free fetal DNA in maternal blood
81425	Genome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis
81426	Genome (e.g., unexplained constitutional or heritable disorder or syndrome); sequence analysis, each comparator genome (e.g., parents, siblings) (List separately in addition to code for primary procedure)
81427	Genome (e.g., unexplained constitutional or heritable disorder or syndrome); re-evaluation of previously obtained genome sequence (e.g., updated knowledge or unrelated condition/syndrome)
81430	Hearing loss (e.g., nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); genomic sequence analysis panel, must include sequencing of at least 60 genes, including CDH23, CLRN1, GJB2, GPR98, MTRNR1, MYO7A, MYO15A, PCDH15, OTOF, SLC26A4, TMC1, TMPRSS3, USH1C, USH1G, USH2A, and WFS1
81431	Hearing loss (e.g., nonsyndromic hearing loss, Usher syndrome, Pendred syndrome); duplication/deletion analysis panel, must include copy number analyses for STRC and DFNB1 deletions in GJB2 and GJB6 genes
81432	Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); genomic sequence analysis panel, must include sequencing of at least 10 genes, always including BRCA1, BRCA2, CDH1, MLH1, MSH2, MSH6, PALB2, PTEN, STK11, and TP53
81433	Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer); duplication/deletion analysis panel, must include analyses for BRCA1, BRCA2, MLH1, MSH2, and STK11
81434	Hereditary retinal disorders (e.g., retinitis pigmentosa, Leber congenital amaurosis, cone-rod dystrophy), genomic sequence analysis panel, must include sequencing of at least 15 genes, including ABCA4, CNGA1, CRB1, EYS, PDE6A, PDE6B, PRPF31, PRPH2, RDH12, RHO, RP1, RP2, RPE65, RPGR, and USH2A
81435	Hereditary colon cancer disorders (e.g., Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); genomic sequence analysis panel, must include sequencing of at least 10 genes, including APC, BMPR1A, CDH1, MLH1, MSH2, MSH6, MUTYH, PTEN, SMAD4, and STK11
81436	Hereditary colon cancer disorders (e.g., Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis); duplication/deletion analysis panel, must include analysis of at least 5 genes, including MLH1, MSH2, EPCAM, SMAD4, and STK11
81437	Hereditary neuroendocrine tumor disorders (e.g., medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paragaglioma), genomic sequence analysis panel, must include sequencing of at least 6 genes, including MAX,SDHB,SDHC,SDHD,TMEM127 and VHL
81438	Hereditary neuroendocrine tumor disorders (e.g., medullary thyroid carcinoma, parathyroid carcinoma, malignant pheochromocytoma or paragaglioma), genomic sequence analysis panel, must include sequencing of at least 6 genes, including MAX,SDHB,SDHC,SDHD,TMEM127 and VHL; duplication/deletion analysis panel, must include analyses for SDHB, SDHC,SDHD and VHL

81439	Inherited cardiomyopathy (e.g., hypertrophic cardiomyopathy, dilated arrhythmogenic right ventricular cardiomyopathy), genomic sequence analysis panel, must include sequencing of at least 5 cardiomyopathy-related genes (e.g. DSG2, MYBPC3, MYH7, PKP2, and TTN)
81440	Nuclear encoded mitochondrial genes (e.g., neurologic or myopathic phenotypes), genomic sequence panel, must include analysis of at least 100 genes, including BCS1L, C10orf2, COQ2, COX10, DGUOK, MPV17, OPA1, PDSS2, POLG, POLG2, RRM2B, SCO1, SCO2, SLC25A4, SUCLA2, SUCLG1, TAZ, TK2, and TYMP
81442	Noonan spectrum disorders (e.g., Noonan Syndrome, cardio-facio-cutaneous syndrome, Costello Syndrome, LEOPARD syndrome, Noonan-like syndrome), genomic sequence analysis panel, must include sequencing of at least 12 genes, including BRAF,CBL,HRAS,KRAS,MAP2K1, MAP2K2, NRAS, PTPN11, RAF1, RIT1, SHOC2 and SOS1
81443	Genetic testing for severe inherited conditions (e.g., cystic fibrosis, Ashkenazi Jewish-associated disorders [e.g., Bloom syndrome, Canavan disease, Fanconi anemia type C, mucolipidosis type VI, Gaucher disease, Tay-Sachs disease], beta hemoglobinopathies, phenylketonuria, galactosemia), genomic sequence analysis panel, must include sequencing of at least 15 genes (e.g., ACADM, ARSA, ASPA, ATP7B, BCKDHA, BCKDHB, BLM, CFTR, DHCR7, FANCC, G6PC, GAA, GALT, GBA, GBE1, HBB, HEXA, IKBKAP, MCOLN1, PAH)
81445	Targeted genomic sequence analysis panel, solid organ neoplasm, DNA analysis, 5-50 genes (e.g., ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, NRAS, MET, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants or rearrangements, if performed
81448	Hereditary peripheral neuropathies (e.g., Charcot-Marie-Tooth, spastic paraplegia), genomic sequence analysis panel, must include sequencing of at least 5 peripheral neuropathy-related genes (e.g., BSCL2, GJB1, MFN2, MPZ, REEP1, SPAST, SPG11, SPTLC1)
81450	Targeted genomic sequence analysis panel, hematolymphoid neoplasm or disorder, DNA analysis, and RNA analysis when performed, 5-50 genes (e.g., BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KRAS, KIT, MLL, NRAS, NPM1, NOTCH1), interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed
81455	Targeted genomic sequence analysis panel, solid organ neoplasm or hematolymphoid neoplasm, DNA analysis, and RNA analysis when performed, 51 or greater genes (e.g., ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, NRAS, MLL,NPM1, NRAS, MET,NOTCH1, PDGFRA, PDGFRB, PGR,PIK3CA, PTEN, RET), interrogation for sequence variants, and copy number variants or rearrangements, if performed
81460	Whole mitochondrial genome (e.g., Leigh syndrome, mitochondrial encephalomyopathy, lactic acidosis, and stroke-like episodes [MELAS], myoclonic epilepsy with ragged-red fibers [MERFF], neuropathy, ataxia, and retinitis pigmentosa [NARP], Leber hereditary optic neuropathy [LHON]), genomic sequence, must include sequence analysis of entire mitochondrial genome with heteroplasmy detection
81465	Whole mitochondrial genome large deletion analysis panel (e.g., Kearns-Sayre syndrome, chronic progressive external ophthalmoplegia), including heteroplasmy detection, if performed
81470	X-linked intellectual disability (XLID) (e.g., syndromic and non-syndromic XLID); genomic sequence analysis panel, must include sequencing of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, RPS6KA3, and SLC16A2

81471	X-linked intellectual disability (XLID) (e.g., syndromic and non-syndromic XLID); duplication/deletion gene analysis, must include analysis of at least 60 genes, including ARX, ATRX, CDKL5, FGD1, FMR1, HUWE1, IL1RAPL, KDM5C, L1CAM, MECP2, MED12, MID1, OCRL, RPS6KA3, and SLC16A2
81479	Unlisted molecular pathology procedure
81493	Coronary artery disease, mRNA, gene expression profiling by real-time RT-PCR of 23 genes, utilizing whole peripheral blood, algorithm reported as a risk score
81504	Oncology (tissue of origin), microarray gene expression profiling of > 2000 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as tissue similarity scores
81507	Fetal aneuploidy (trisomy 21, 18, and 13) DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score of each trisomy
81518	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 11 genes (7 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithms reported as percentage risk for metastatic recurrence and likelihood of benefit from extended endocrine therapy
81519	Oncology (breast), mRNA, gene expression profiling by real-time RT-PCR of 21 genes, utilizing formalin-fixed paraffin embedded tissue, algorithm reported as recurrence score
81520	Oncology (breast), mRNA gene expression profiling by hybrid capture of 58 genes (50 content and 8 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence risk score
81521	Oncology (breast), mRNA, microarray gene expression profiling of 70 content genes and 465 housekeeping genes, utilizing fresh frozen or formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk of distant metastasis
81522	Oncology (breast), mRNA, gene expression profiling by RT-PCR of 12 genes (8 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk score
81523	Oncology (breast), mRNA, next-generation sequencing gene expression profiling of 70 content genes and 31 housekeeping genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as index related to risk to distant metastasis
81525	Oncology (colon), mRNA, gene expression profiling by real-time RT-PCR of 12 genes (7 content and 5 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a recurrence score
81529	Oncology (cutaneous melanoma), mRNA, gene expression profiling by real-time RT-PCR of 31 genes (28 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk, including likelihood of sentinel lymph node metastasis
81540	Oncology (tumor of unknown origin). mRNA, gene expression profiling by real-time RT-PCR of 92 genes (87 content and 5 housekeeping) to classify tumor into main cancer type and subtype, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a probability of a predicted main cancer type and subtype
81541	Oncology (prostate), mRNA gene expression profiling by real-time RT-PCR of 46 genes (31 content and 15 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a disease-specific mortality risk score
81542	Oncology (prostate), mRNA, microarray gene expression profiling of 22 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score
81546	Oncology (thyroid), mRNA, gene expression analysis of 10,196 genes, utilizing fine needle aspirate, algorithm reported as a categorical result (e.g., benign or suspicious)

81551	Oncology (prostate), promoter methylation profiling by real-time PCR of 3 genes (GSTP1, APC, RASSF1), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a likelihood of prostate cancer detection on repeat biopsy
81552	Oncology (uveal melanoma), mRNA, gene expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of metastasis
81554	Pulmonary disease (idiopathic pulmonary fibrosis [IPF]), mRNA, gene expression analysis of 190 genes, utilizing transbronchial biopsies, diagnostic algorithm reported as categorical result (e.g., positive or negative for high probability of usual interstitial pneumonia [UIP])
81595	Cardiology (heart transplant), mRNA, gene expression profiling by real-time quantitative PCR of 20 genes (11 content and 9 housekeeping), utilizing sub fraction of peripheral blood, algorithm reported as a rejection risk score

HCPCS Codes	Code Descriptions
G9143	Warfarin responsiveness testing by genetic technique using any method, any number of specimen(s)
G9840	KRAS gene mutation testing performed before initiation of anti-EGFR MoAb
G9841	KRAS gene mutation testing not performed before initiation of anti-EGFR MoAb
S3800	Genetic testing for amyotrophic lateral sclerosis (ALS)
S3840	DNA analysis for germline mutations of the RET proto-oncogene for susceptibility to multiple endocrine neoplasia type 2
S3841	Genetic testing for retinoblastoma
S3842	Genetic testing for Von Hippel-Lindau disease
S3844	DNA analysis of the connexin 26 gene (GJB2) for susceptibility to congenital, profound deafness
S3845	Genetic testing for alpha-thalassemia
S3846	Genetic testing for hemoglobin E beta-thalassemia
S3849	Genetic testing for Niemann-Pick disease
S3850	Genetic testing for sickle cell anemia
S3852	DNA analysis for APOE epsilon 4 allele for susceptibility to Alzheimer's disease
S3853	Genetic testing for myotonic muscular dystrophy
S3854	Gene expression profiling panel for use in the management of breast cancer treatment
S3861	Genetic testing, sodium channel, voltage-gated, type V, alpha subunit (SCN5A) and variants for suspected Brugada Syndrome
S3865	Comprehensive gene sequence analysis for hypertrophic cardiomyopathy
S3866	Genetic analysis for a specific gene mutation for hypertrophic cardiomyopathy (HCM) in an individual with a known HCM mutation in the family
S3870	Comparative genomic hybridization (CGD) microarray testing for developmental delay, autism spectrum disorder and/or intellectual disability

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Next Review Date

Not applicable

Retired Date

11/01/22

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by

Regulatory Approval: N/A Internal Approval: 08/17/11: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 09/28/11: Quality Improvement Committee (QIC)	12/01/11 Version 1	Director of Medical Policy as Chair of MPCTAC	MPCTAC and QIC

*Effective Date for QHP Commercial Product: 01/01/12
*Effective Date for New Hampshire Medicaid Product: 01/01/13
*Effective Date for Senior Care Options Product: 01/01/16
*Effective Date for New Hampshire Medicare Advantage HMO Product: 01/01/22

Note: Policy title was *Genetic Testing Guidelines and Pharmacogenetics* until 09/30/18; effective 10/01/18 the policy title has been changed to *Genetic/Genomic Testing and Pharmacogenetics*. Policy retired and service managed by AIM Specialty Health as of 11/01/22.

Policy Revisions History

Review Date	Summary of Revisions	Revision Effective Date and Version Number	Approved by
07/29/12	Off cycle review for Well Sense Health Plan, reformatted Medical Policy Statement, added Applicable Coding language and code list, deleted references to other products and associated limitations.	Version 2	08/03/12: MPCTAC 09/13/12: QIC
09/01/12	Review for effective date 01/01/13. Added applicable code list, revised language in Applicable Coding section, added newborn screening as a type of genetic testing to Description of Item or Service section (from Clinical Background Information section). Added reference to *Experimental and Investigational Treatment* policy and *Medically Necessary* policy. Removed duplicate text from Clinical Background Information section.	01/01/13 Version 3	09/19/12: MPCTAC 10/24/12: QIC
10/01/13 and 11/01/13	Review for effective date 03/01/14. Revised Summary, Medical Policy Statement, Limitations, Clinical Background Information, and References sections. Updated list of applicable codes. Summarized CPT code descriptions for CPT codes 81400-81408 and added Plan note.	03/01/14 Version 4	10/16/13: MPCTAC 11/20/13: MPCTAC 12/19/13: QIC
01/30/14	Review for effective date 04/01/14. Added ICD10 diagnosis code equivalents of existing ICD9 diagnosis codes.	04/01/14 Version 5	01/27/14: MPCTAC 01/30/14: QIC

07/01/14	Review for effective 10/01/14. Updated Summary section. Added CPT code 81507 and HCPCS code S3870 to the applicable code list.	10/01/14 Version 6	07/21/14: MPCTAC (electronic vote) 07/24/14: QIC (electronic vote)
11/01/14 and 12/01/14	Review for effective date 03/01/15. Revised Summary, Description of Item or Service, Definitions, and References sections. Revised criteria in the Medical Policy Statement and Limitations section. Updated applicable code list.	03/01/15 Version 7	11/19/14: MPCTAC 12/02/14: MPCTAC (electronic vote) 12/10/14: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Revised language related to applicable products in the Limitations section without changing criteria. Revised language in the Applicable Coding section.	01/01/16 Version 8	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
01/01/16	Review for effective date 05/01/16. Revised language and list of waived pregnancy diagnosis codes and corresponding procedure codes in the Applicable Coding section. Revised list of procedure codes according to industry-standard 2016 code changes. Updated Summary, Description of Item or Service, Definitions, Clinical Background Information, and References sections. Revised criteria in the Medical Policy Statement and Limitations sections.	05/01/16 Version 9	01/20/16: MPCTAC 02/10/16: QIC
09/01/16 and 09/28/16	Review for effective date 11/01/16. Administrative changes made to the Summary, Description of Item or Service, Medical Policy Statement, and Applicable Coding sections to clarify the types of genetic testing that require Plan prior authorization. No changes made to the criteria and/or the applicable code list. Administrative changes made to clarify language related to gender. Added definitions.	11/01/16 Version 10	09/21/16: MPCTAC 09/30/16: MPCTAC (electronic vote) 10/12/16: QIC
12/05/16	Industry-wide code change with the addition of 2017 applicable codes effective 01/01/17.	01/01/17 Version 11	Not applicable because industry-wide code revisions
01/01/17	Review for effective date 05/01/17. Revised ICD-10 pregnancy diagnosis codes and updated CPT codes in the Applicable Coding section. Updated criteria in the Medical Policy Statement and Limitations sections. Revised Summary, Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Added Plan notes to Applicable Coding section.	05/01/17 Version 12	01/18/17: MPCTAC 02/08/17: QIC
06/01/17	Review for effective date 07/01/17. Industry-wide code changes made to the Applicable Coding section. Administrative changes made to the Summary, Applicable Coding, and References sections. Updated Limitations section to be consistent with industry-wide code addition.	07/01/17 Version 13	06/21/17: MPCTAC.

08/09/17 and 09/08/17	Revision effective 10/01/17. Industry-wide updates to the ICD-10 diagnosis and HCPCS codes included in the Applicable Coding section.	10/01/17 Version 14	Not applicable because CMS industry wide changes to HCPCS and ICD10 diagnosis codes
09/20/17	Review for effective date 12/01/17. Revised criteria in the Limitations section. Updated Policy Summary, Description of Item or Service, References, and Other Applicable Policies sections. Revised the applicable code list and administrative changes made to the Applicable Coding section.	12/01/17 Version 15	09/20/17: MPCTAC
12/01/17	Review for effective 01/01/18. Industry-wide updates to codes included in the Applicable Coding section.	01/01/18 Version 16	Not applicable because industry-wide code changes
01/01/18	Review for effective date 04/01/18. Revised Summary, Definitions, Clinical Background Information, and References sections. Updated Medical Policy Statement, Limitations, and Applicable Coding sections.	04/01/18 Version 17	01/17/18: MPCTAC
06/01/18	Review for effective date 09/01/18. Criteria updated in the Limitations section. Administrative change made to the References and Other Applicable Policies sections.	09/01/18 Version 18	06/20/18: MPCTAC
06/25/18	Review for effective date 09/01/18. Revised criteria in the Medical Policy Statement section. Updated References section.	09/01/18 Version 19	06/25/18: MPCTAC (electronic vote)
09/01/18	Review for effective date 10/01/18. Revised the policy title. Administrative changes made to the Policy Summary, Description of Item or Service, Medical Policy Statement, References, and Other Applicable Policies sections. Industry-wide code changes and Plan notes added to Applicable Coding section.	10/01/18 Version 20	Not applicable because industry-wide code changes
09/19/18	Review for effective date 12/01/18. Revised criteria in the Limitations section.	12/01/18 Version 21	09/19/18: MPCTAC
01/01/19	Review for effective date 04/01/19. Revised criteria in the Medical Policy Statement and Limitations sections. Administrative changes made to the Policy Summary, Definitions, Clinical Background Information, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections. Industry-wide code updates and Plan notes revised in the Applicable Coding section.	04/01/19 Version 22	01/16/19: MPCTAC
02/01/19	Review for effective date 05/01/19. Administrative changes made to the Policy Summary, Definitions, References, and Other Applicable Policies sections.	05/01/19 Version 23	02/20/19: MPCTAC

	Criteria revised in the Medical Policy Statement and Limitations sections.		
03/01/19	Review for effective date 05/01/19. Administrative changes made to the Applicable Coding section to be consistent with the criteria revisions approved in version 23.	05/01/19 Version 24	03/20/19: MPCTAC
02/01/19	Review for effective date 06/01/19. Updated the code list in the Applicable Coding section.	06/01/19 Version 25 (formerly Version 24)	02/20/19: MPCTAC
03/01/19	Review for effective date 06/01/19. Administrative changes made to the Applicable Coding section to make consistent with the criteria revisions approved in version 23.	06/01/19 Version 26	03/20/19: MPCTAC
06/01/19	Review for effective date 07/01/19. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections. Industry-wide code additions and Plan notes included in the Applicable Coding section. Revised language in the Policy Summary, Medical Policy Statement, and Applicable Coding section to clarify that the prior authorization waiver for the specified primary pregnancy diagnosis codes only applies to genetic tests ordered, administered, and processed by participating providers and participating laboratories.	07/01/19 Version 27	06/19/19: MPCTAC
07/01/19	Review for effective date 10/01/19. Adopted InterQual® criteria for genetic testing unless specified otherwise in a Plan medical policy. Revised criteria in the Medical Policy Statement and Limitations sections by including medical necessity criteria for genetic testing for indeterminate thyroid nodules and papillary thyroid carcinoma, criteria for targeted genetic testing when indication not specified as medically necessary in Plan-adopted InterQual® criteria or a Plan medical policy, and criteria for multigene panel testing (rather than targeted genetic testing) when Plan-adopted InterQual® criteria are not met or not available. Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, and Other Applicable Policies sections. Maintained diagnosis code list for prior authorization pregnancy waiver and updated applicable procedure code list.	10/01/19 Version 28	07/17/19: MPCTAC
09/01/19	Review for effective 12/01/19. Updated the list of procedure codes and added high-risk diagnosis code in the Applicable coding section.	12/01/19 Version 29	09/18/19: MPCTAC

12/01/19	Review for effective date 01/01/20. Industry-wide code updates made in the Applicable Coding section. Administrative changes made to the Policy Summary, Medical Policy Statement, Applicable Coding, Definitions, and References sections.	01/01/20 Version 30	12/18/19: MPCTAC
01/01/20	Review for effective date 04/01/20. Administrative changes made to the Policy Summary, References, and Reference to Applicable Laws and Regulations sections. Plan notes revised in the Applicable Coding section. Criteria revised in the Medical Policy Statement and Limitations sections.	04/01/20 Version 31	01/15/20: MPCTAC
04/01/20	Review for effective date 05/01/20. Industry-wide code additions and Plan notes included in the Applicable Coding section.	05/01/20 Version 32	04/15/20: MPCTAC
06/01/20	Review for effective date 07/01/20. Industry-wide coding and pertinent Plan notes added to the Applicable Coding section.	07/01/20 Version 33	Not applicable because industry-wide code changes; 06/17/20: MPCTAC review
09/01/20	Review for effective date 12/01/20. Industry-wide coding and pertinent Plan notes added to the Applicable Coding section. Plan notes added to the Applicable Coding section. Administrative changes made to the Policy Summary, Description of Item or Service, Clinical Background Information, and References sections. Criteria revised in the Medical Policy Statement and Limitations sections.	12/01/20 Version 34	09/16/20: MPCTAC
12/01/20	Review for effective date 01/01/21. Industry-wide updates to coding in the Applicable Coding section.	01/01/21 Version 35	Not applicable because industry-wide code changes; 12/16/20: MPCTAC review
02/01/21	Review for effective date 06/01/21. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, Clinical Background Information, References, and Other Applicable Policies sections. Code-specific prior authorization requirements revised in the Applicable Coding section.	06/01/21 Version 36 Not implemented - replaced with Version 37	02/17/21: MPCTAC
03/22/21	Review for effective 06/01/21. Industry-wide updates to coding in the Applicable Coding section and revisions approved in version 36 implemented.	06/01/21 Version 37	Not applicable because industry-wide code changes
04/01/21	Review for effective date 07/01/21. Criteria revised in the Limitation section. Plan note added in the Applicable Coding section and updated References section.	07/01/21 Version 38 Not implemented -	04/21/21: MPCTAC

		replaced with Version 39	
06/01/21	Review for an effective date 07/01/21. Industry-wide code updates made in the Applicable Coding section. Revisions approved in version 38 implemented. Updated References section.	07/01/21 Version 39	Not applicable because industry-wide code changes; 06/16/21: MPCTAC review
10/01/21	Review for effective date 01/01/22. Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and the Limitations section renamed Limitations and Exclusions section. Added New Hampshire Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, and References sections. Industry-wide code updates and other code additions made to the Applicable Coding section. Revised criteria in the Limitations and Exclusions section.	01/01/22 Version 40	10/20/21: MPCTAC
01/01/22	Review for effective date 04/01/22. Policy Summary and References sections updated. Industry-wide code updates and other code additions made to the Applicable Coding section. ICD-10 diagnosis code added for carrier screening for female members (one per lifetime) for CF and SMA. Added male and female carrier screening criteria to the Clinical Criteria section.	04/01/22 Version 41	01/19/22: MPCTAC
04/01/22	Review for effective date 05/01/22. Administrative changes made to the Limitations and Exclusions and Applicable Coding sections. Industry-wide code updates made to the Applicable Coding section.	05/01/22 Version 42	04/20/22: MPCTAC
07/01/22	Review for effective date 08/01/22. Industry-wide code updates made to the Applicable Coding section. Administrative changes made to the Policy Summary, Limitations and Exclusions, and References sections.	08/01/22 Version 43	07/25/22: MPCTAC (electronic vote)
08/01/22	Review for policy retired date 11/01/22. Revised the Policy Summary, Clinical Criteria, Limitations and Exclusions, and Applicable Coding sections. InterQual medical necessity criteria and medical policy retired on 11/01/22. Plan prior authorization waivers removed after 10/31/22. AIM medical necessity criteria adopted for genetic testing on 11/01/22. Plan prior authorization waivers removed after 10/31/22. AIM prior authorization is required for genetic testing as of 11/01/22, even when applicable codes are not listed in this Plan policy.	11/01/22 Version 44	08/26/22: MPCTAC (electronic vote)

Medical Policy – Policy with InterQual Criteria Retired and AIM Criteria Adopted as of 11/01/22

Genetic Testing for Fragile X-Associated Disorders

Policy Number: OCA 3.571
Version Number: 26
Policy Retired Date: 11/01/22

Impacted Products

- ☒ **All Products**
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☒ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

Genetic testing for a fragile X-associated disorder is considered medically necessary for the diagnosis of an adult or pediatric member with unexplained intellectual disability, developmental delay, and/or symptoms or findings consistent with an autism spectrum disorder when AIM clinical appropriateness guidelines are met. Prior authorization from AIM Specialty Health is required for genetic testing.

Clinical Criteria

No medical policy criteria.

Limitations and Exclusions

None.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for the Plan's Senior Care Options (SCO) members and New Hampshire Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, NCD 190.3 includes guidelines for the use of cytogenetic studies. Verify CMS guidelines in effect on

the date of the prior authorization request. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. The list of applicable codes included in this policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization from AIM for genetic testing, even if an applicable code appropriately describing the service is not included in this policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Codes	Code Descriptions
81171	AFF2 (AF4/FMR2 family, member 2 [FMR2]) (e.g., fragile X mental retardation 2 [FRAXE]) gene analysis; evaluation to detect abnormal (e.g., expanded) alleles
81172	AFF2 (AF4/FMR2 family, member 2 [FMR2]) (e.g., fragile X mental retardation 2 [FRAXE]) gene analysis; characterization of alleles (e.g., expanded size and methylation status)
81243	FMR1 (Fragile X mental retardation 1) (e.g., fragile X mental retardation) gene analysis; evaluation to detect abnormal (e.g., expanded) alleles
81244	FMR1 (Fragile X mental retardation 1) (e.g., fragile X mental retardation) gene analysis; characterization of alleles (e.g., expanded size and promoter methylation status)
81401	Molecular pathology procedure, Level 2 (e.g., 2-10 SNPs, 1 methylated variant, or 1 somatic variant [typically using non-sequencing target variant analysis], or detection of a dynamic mutation disorder/triplet repeat) AFF2 (AF4/FMR2 family, member 2 [FMR2]) (e.g., fragile X mental retardation 2 {FRAXE]), evaluation to detect abnormal (e.g., expanded) alleles
81404	Molecular pathology procedure, Level 5 (e.g., analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis) NLGN4X (neuroligin 4, X-linked) (e.g., autism spectrum disorders), duplication/deletion analysis
81405	Molecular pathology procedure, Level 6 (e.g., analysis of 6-10 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 11-25 exons), regionally targeted cytogenomic array analysis

	NLGN4X (neuroligin 4, X-linked) (e.g., autism spectrum disorders), full gene sequence

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Next Review Date

Not applicable

Retired Date

11/01/22

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 05/18/11: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 06/30/11: Quality Improvement Committee (QIC)	03/01/14 Version 1	Director of Medical Policy as Chair of MPCTAC	MPCTAC and QIC

*Effective date for QHP commercial product: 01/01/12
*Effective date for NH Medicaid product: 01/01/13
*Effective date for Senior Care Options product: 01/01/16
*Effective date for NH Medicare Advantage HMO product: 01/01/22

Policy retired and service managed by AIM Specialty Health as of 11/01/22.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
01/01/20	Review for effective date 02/01/20. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections.	02/01/20 Version 15	01/15/20: MPCTAC
02/01/21	Review for effective date 03/01/21. Updated the Policy Statement and References sections. Administrative changes made to the Applicable Coding section.	03/01/21 Version 16	02/17/21: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, the Medical Policy Statement section renamed the Clinical Criteria section, and the Limitations section renamed the Limitations and Exclusions section. Added NH Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and	12/01/21 Version 17	11/17/21: MPCTAC

	Exclusions, Applicable Coding, and References sections.		
12/01/21	Review for effective date 01/01/22. Industry-wide code revision made to the Applicable Coding section.	01/01/22 Version 18	Not applicable because industry-wide code revision; 12/15/21: MPCTAC review
01/01/22	Review for effective date 02/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, and References sections.	02/01/22 Version 19	01/19/22: MPCTAC
12/01/11	Added new 2012 codes.	Version 2	12/01/11: MPCTAC 12/01/11: QIC
05/01/12	References updated, applicable CPT codes added, and clinical guidelines revised to clarify that a first degree relative is a biological parent, biological child, or biological sibling (rather than parent, child, or sibling).	Version 3	05/16/12: MPCTAC 06/27/12: QIC
07/30/12	Off cycle review for Well Sense Health Plan. Revised Summary, Medical Policy Statement, and Definitions sections.	Version 4	08/03/12: MPCTAC 09/05/12: QIC
09/01/12	References updated and referenced *Experimental and Investigational Treatment* and the *Preimplantation Genetic Testing* policies.	Version 5	09/19/12: MPCTAC 10/24/12: QIC
08/14/13 and 08/15/13	Off cycle review for Well Sense Health Plan and merged policy format. Incorporate policy revisions dated 09/01/12 (as specified above) for the Well Sense Health Plan product; these policy revisions were approved by MPCTAC on 09/19/12 and QIC on 10/24/12 for applicable Plan products.	Version 6	08/14/13: MPCTAC (electronic vote) 08/15/13: QIC
10/01/13 and 11/01/13	Review for effective date 03/01/14. Updated Summary, Description of Item or Service, Definitions, Clinical Background Information, and References sections. Revised criteria in Medical Policy Statement section. Revised language in Applicable Coding section and revised applicable code list.	03/01/14 Version 7	10/16/13: MPCTAC 11/20/13: MPCTAC 12/19/13: QIC
01/30/14	Review for effective date 04/01/14. Added ICD10 diagnosis code equivalents of existing ICD9 diagnosis codes.	04/01/14 Version 8	01/27/14: MPCTAC 01/30/14: QIC
07/01/14	Review for effective date 10/01/14. Updated Summary section and introductory paragraph in the Applicable Coding section. Added CPT	10/01/14 Version 9	07/21/14: MPCTAC (electronic vote) 07/24/14: QIC (electronic vote)

	codes 81404, 81405, and 88248 to the applicable code list.		
11/01/14	Review for effective date 03/01/15. Added CPT code 81401 as an applicable code. Updated criteria in the Medical Policy Statement and Limitations sections. Revised Summary, Definitions, Clinical Background Information, and References sections. Changed review calendar.	03/01/15 Version 10	11/19/14: MPCTAC 12/10/14: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Revised language in the Applicable Coding section.	01/01/16 Version 11	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
01/01/16	Review for effective date 05/01/16. Revised language in the Applicable Coding section and updated list of waived pregnancy diagnosis codes and corresponding procedure codes. Updated Summary, Definitions, Clinical Background Information, and References sections. Revised criteria in the Medical Policy Statement and Limitations sections.	05/01/16 Version 12	01/20/16: MPCTAC 02/10/16: QIC
09/28/16	Review for effective date 11/01/16. Administrative changes made to clarify language related to gender. Added definitions.	11/01/16 Version 13	09/30/16: MPCTAC (electronic vote) 10/12/16: QIC
01/01/17	Review for effective date 05/01/17. Revised ICD-10 pregnancy diagnosis codes in the Applicable Coding section. Updated criteria in the Limitations section. Revised Summary, Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Administrative changes made to the Medical Policy Statement section.	05/01/17 Version 14	01/18/17: MPCTAC 02/08/17: QIC
08/09/17	Revision effective 10/01/17. Industry-wide updates to the ICD-10 diagnosis codes included in the Applicable Coding section.	10/01/17 Version 15	Not applicable because industry-wide updates to ICD-10 diagnosis codes.
01/01/18	Review for effective date 02/01/18. Updated Summary, References, and Reference to Applicable Laws and Regulations sections. Administrative changes made to the Medical Policy Statement and Applicable Coding sections.	02/01/18 Version 16	01/17/18: MPCTAC
01/01/19	Review for effective date 04/01/19. Industry-wide code updates made in the Applicable Coding section with revised Plan notes.	04/01/19 Version 17	01/16/19: MPCTAC

	Administrative changes made to the Policy Summary, Limitations, Definitions, Clinical Background Information, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections. Criteria revised in the Medical Policy Statement section.		
02/01/19	Review fore effective date 04/01/19. Administrative changes made to the Medical Policy Statement section to clarify guidelines. Updated Plan notes in the Applicable Coding section (without revising the applicable code list). Revised the Policy Summary and Other Applicable Policies sections.	04/01/19 Version 18	02/20/19: MPCTAC
06/01/19	Review for effective date 07/01/19. Revised language in the Policy Summary, Medical Policy Statement, and Applicable Coding section to clarify that the prior authorization waiver for the specified primary pregnancy diagnosis codes only applies to genetic tests ordered, administered, and processed by participating providers and participating laboratories.	07/01/19 Version 19	06/19/19: MPCTAC
07/01/19	Review for effective date 10/01/19. Medical policy criteria retired and applicable InterQual® criteria adopted. Administrative changes made to the Policy Summary, Description of Item or Service, and Other Applicable Policies sections. Updated Plan notes in the Applicable Coding section. Maintained diagnosis code list for prior authorization pregnancy waiver and updated corresponding procedure code list.	10/01/19 Version 20	07/17/19: MPCTAC
09/01/19	Review for effective date 12/01/19. Added high-risk diagnosis code in the Applicable Coding section.	12/01/19 Version 21	09/18/19: MPCTAC
01/01/20	Review for effective date 02/01/20. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections.	02/01/20 Version 22	01/15/20: MPCTAC
02/01/21	Review for effective date 03/01/21. Updated the Policy Statement and References sections. Administrative changes made to the Applicable Coding section.	03/01/21 Version 23	02/17/21: MPCTAC

11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, the Medical Policy Statement section renamed the Clinical Criteria section, and the Limitations section renamed the Limitations and Exclusions section. Added Well Sense Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Applicable Coding, and References sections.	12/01/21 Version 24	11/17/21: MPCTAC
01/01/22	Review for effective date 02/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, and References sections.	02/01/22 Version 25	01/19/22: MPCTAC
08/01/22	Review for policy retired date 11/01/22. Revised the Policy Summary, Clinical Criteria, Limitations and Exclusions, and Applicable Coding sections. InterQual medical necessity criteria and medical policy retired on 11/01/22. Plan prior authorization waivers removed after 10/31/22. AIM medical necessity criteria adopted for genetic testing on 11/01/22. Plan prior authorization waivers removed after 10/31/22. AIM prior authorization is required for genetic testing as of 11/01/22, even when applicable codes are not listed in this Plan policy.	11/01/22 Version 26	08/26/22: MPCTAC (electronic vote)

Medical Policy – Policy Retired and AIM Criteria Adopted as of 11/01/22

Genetic Testing for Hereditary Thrombophilia

Policy Number: OCA 3.728
Version Number: 14
Policy Retired Date: 11/01/22

Impacted Products

- ☒ **All Products**
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☒ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers genetic testing for hereditary thrombophilia to be medically necessary to identify predisposition to thrombosis if AIM clinical appropriateness guidelines are met. Prior authorization from AIM Specialty Health is required for genetic testing.

Clinical Criteria

No medical policy criteria.

Limitations and Exclusions

None.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for the Plan's Senior Care Options (SCO) members and New Hampshire Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, NCD 190.3 includes guidelines for the use of cytogenetic studies. Verify CMS guidelines in effect on the date of the prior authorization request. When there is no guidance from CMS for the requested

service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. The list of applicable codes included in this policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization from AIM for genetic testing, even if an applicable code appropriately describing the service is not included in this policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Codes	Code Descriptions
81240	F2 (prothrombin, coagulation factor II) (e.g., hereditary hypercoagulability) gene analysis, 20210G>A variant
81241	F5 (coagulation factor V) (e.g., hereditary hypercoagulability) gene analysis, Leiden variant

References

Abu-Asab NS, Ayesh SK, Ateeq RO, Nassar SM, El-Sharif WA. Association of Inherited Thrombophilia with Recurrent Pregnancy Loss in Palestinian Women. Obstet Gynecol Int. 2011;2011:689684. doi: 10.1155/2011/689684. PMID: 21765836.

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Next Review Date

Not applicable

Retired Date

11/01/22

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:
Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 11/20/13: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 12/03/13: MPCTAC (electronic vote) 12/19/13: Quality Improvement Committee (QIC)	03/01/14 Version 1	Director of Medical Policy as Chair of MPCTAC	MPCTAC and QIC

*Effective Date for QHP Commercial Product: 01/01/12
*Effective Date for NH Medicaid Product: 01/01/13
*Effective Date for Senior Care Options Product: 01/01/16
*Effective Date for NH Medicare Advantage HMO Product: 01/01/22
* Effective date for NH Medicare Advantage HMO product: 01/01/22

Policy retired and service managed by AIM Specialty Health as of 11/01/22.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
11/01/14	Review for effective date 03/01/15. Revised criteria in the Medical Policy Statement and Limitations sections. Updated Summary, Definitions, and References sections. Changed review calendar.	03/0/15 Version 2	11/19/14: MPCTAC 12/10/14: QIC
11/01/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Updated Summary and language in the Applicable Coding section without changing criteria or the applicable code list.	01/01/16 Version 3	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
01/01/16	Review for effective date 05/01/16. Updated Description of Item or Service, Definitions, Clinical Background Information, and References sections. Revised criteria in the Limitations section.	05/01/16 Version 4	01/20/16: MPCTAC 02/10/16: QIC
09/28/16	Review for effective date 11/01/16. Administrative changes to clarify language related to gender.	11/01/16 Version 5	09/30/16: MPCTAC (electronic vote) 10/12/16: QIC

01/01/17	Review for effective date 05/01/17. Updated Summary, Definitions, Clinical Background Information, References, and References to Applicable Laws and Regulations sections. Revised criteria in the Medical Policy Statement and Limitations sections.	05/01/17 Version 6	01/18/17: MPCTAC 02/08/17: QIC
01/01/18	Review for effective date 04/01/18. Updated Definitions and References sections. Revised Medical Policy Statement and Limitations sections. Updated Plan note in the Applicable Coding section.	04/01/18 Version 7	01/17/18: MPCTAC
01/01/19	Review for effective date 04/01/19. Administrative changes made to the Policy Summary, Limitations, Definitions, Applicable Coding, Clinical Background Information, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections. Criteria revised in the Medical Policy Statement section.	04/01/19 Version 8	01/16/19: MPCTAC
07/01/19	Review for effective 10/01/19. Administrative changes made to the Policy Summary, Limitations, Applicable Coding, References, and Other Applicable Policies sections.	10/01/19 Version 9	07/17/19: MPCTAC
01/01/20	Review for effective date 04/01/20. Criteria revised in the Limitations section. Administrative changes made to the Medical Policy Statement, Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections.	04/01/20 Version 10	01/15/20: MPCTAC
02/01/21	Review for effective date 03/01/21. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, Definitions, Clinical Background Information, and References sections.	03/01/21 Version 11	02/17/21: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and Limitations section renamed Limitation and Exclusions section. Added NH Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections.	12/01/21 Version 12	11/17/21: MPCTAC

01/01/22	Review for effective date 02/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, and References sections.	02/01/22 Version 13	01/19/22: MPCTAC
08/01/22	Review for policy retired date 11/01/22. Revised the Policy Summary, Clinical Criteria, Limitations and Exclusions, and Applicable Coding sections. Medical policy retired on 11/01/22. AIM medical necessity criteria adopted for genetic testing on 11/01/22. AIM prior authorization is required for genetic testing as of 11/01/22, even when applicable codes are not listed in this Plan policy.	11/01/22 Version 27	08/26/22: MPCTAC (electronic vote)

Medical Policy – Policy Retired and AIM Criteria Adopted as of 11/01/22

Minimally Invasive Procedures and Associated Devices used to Treat Back Pain (Including Thermal Intradiscal Procedures, Interspinous Spacers, Interlaminar Stabilization Devices, Facet Arthroplasty, Lysis of Epidural Adhesions, and Minimally Invasive Surgical Procedures for Spinal Fusion and/or to Remove Disc Material)

Policy Number: OCA 3.713
Version Number: 23
Policy Retired Date: 11/01/22

Impacted Products

- ☒ **All Products**
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☒ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

Effective 11/01/22, the Plan will use AIM clinical appropriateness guidelines to determine the medical necessity of musculoskeletal procedures and interventional pain management services. Prior authorization from AIM Specialty Health is required for these services.

Clinical Criteria

No medical policy criteria.

Limitations and Exclusions

The Plan does NOT reimburse for a minimally invasive procedure (and related devices that include but are not limited to interbody cages, screws, spacers, and/or other fixation devices) when used as a

stand-alone surgical treatment of pain associated with disc disease, back pain, and/or for any other indication because the clinical utility and clinical validity of these procedures have not been sufficiently established. The Plan does NOT reimburse additionally for these unproven minimally invasive procedures/techniques (and associated devices) when used with a standard, open spinal procedure and/or with established conservative, nonsurgical treatment(s) because these minimally invasive procedures and devices are considered experimental and investigation or NOT medically necessary by the Plan.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for the Plan's Senior Care Options (SCO) members and New Hampshire Medicare Advantage HMO members, including but not limited to national coverage determinations (NCCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, NCD 150.11 and NCD 150.13 include guidelines for minimally invasive procedures for the treatment of back pain. Verify CMS criteria in effect for the requested service on the date of the prior authorization request for a SCO or New Hampshire Medicare Advantage HMO member. When there is no guidance from CMS for the requested service for the specified indication on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. The list of applicable codes included in this policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization from AIM for musculoskeletal procedures and interventional pain management services, even if an applicable code appropriately describing the service is not included in this policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Codes	Code Descriptions
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [e.g., spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure
63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [e.g., spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)

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Next Review Date

Not applicable

Retired Date

11/01/22

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 05/26/09: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 05/26/09: Utilization Management Committee (UMC) 06/24/09: Quality Improvement Committee (QIC)	09/01/09 Version 1	Director of Medical Policy as Chair of MPCTAC	MPCTAC, QIC, and UMC

*Effective Date for QHP Commercial Product: 01/01/12
*Effective Date for New Hampshire Medicaid Product: 01/01/13
*Effective Date for Senior Care Options Product: 01/01/16
*Effective Date for New Hampshire Medicare Advantage HMO Product: 01/01/22

Policy Title:

1. Effective 09/01/09, this policy replaced the IDET policy. Policy title from 09/01/09 to 05/31/16 was Thermal Intradiscal and Other Minimally Invasive Surgical Treatments for Back Pain.
2. Policy renamed *Minimally Invasive Procedures for Back Pain (Including Thermal Intradiscal Procedures, Interspinous Spacers, Interlaminar Stabilization Devices, and Minimally Invasive Surgical Procedures to Remove Disc Material)* as of 06/01/16.
3. Policy title from 03/01/17 to 05/31/21 was *Minimally Invasive Procedures and Associated Devices used to Treat Back Pain (Including Thermal Intradiscal Procedures, Interspinous Spacers, Interlaminar Stabilization Devices, and Minimally Invasive Surgical Procedures for Spinal Fusion and/or to Remove Disc Material).*
4. From 06/01/21 to 10/31/22, policy tile was *Minimally Invasive Procedures and Associated Devices used to Treat Back Pain (Including Thermal Intradiscal Procedures, Interspinous Spacers, Interlaminar Stabilization Devices, Facet Arthroplasty, Lysis of Epidural Adhesions, and Minimally Invasive Surgical Procedures for Spinal Fusion and/or to Remove Disc Material).* Policy retired as of 11/01/22.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
04/01/10	Annual review. Updated references.	Version 2	04/27/10: MPCTAC 05/26/10: QIC
04/01/11	Annual review. No changes to criteria. Updated references.	Version 3	04/20/11: MPCTAC 05/25/11: QIC

04/01/12	Annual review. Updated criteria, updated coding, updated references.	Version 4	04/18/12: MPCTAC 06/27/12: QIC
07/29/12	Off cycle review for NH product. Revised Summary statement, revised Medical Policy Statement, revised language in Applicable Coding section, revised Limitations.	Version 5	08/03/12: MPCTAC 09/05/12: QIC
02/01/13	Annual review for effective date 06/01/13. References updated, updated code definitions, revised introductory paragraph in Applicable Coding section, revised Summary section and referenced *Experimental and Investigational Treatment* policy, reformatted Description of Item or Service section, revised the Medical Policy Statement section (formerly named the Clinical Guideline Statement section) and Limitations section, moved list of experimental and investigation procedures from the Medical Policy Statement section to the Limitations section and added procedures, added definition for nociceptors, changed name of policy category from "Clinical Coverage Guidelines" to "Medical Policy."	06/01/13 Version 6	02/20/13: MPCTAC 03/21/13: QIC
08/14/13 and 08/15/13	Off cycle review for NH product and merged policy format. Incorporate policy revisions dated 02/01/13 (as specified above) for the NH Medicaid product; these policy revisions were approved by MPCTAC on 02/20/13 and QIC on 03/21/13 for applicable Plan products.	Version 7	08/14/13: MPCTAC (electronic vote) 08/15/13: QIC
02/01/14	Annual review for effective 03/01/14. Added arthroscopic microdiscectomy (AMD) and examples of percutaneous discectomy devices to the Description of Item or Service section. Updated references.	03/01/14 Version 8	02/19/14: MPCTAC 02/26/14: QIC
02/01/15	Annual review for effective date 04/01/15. Updated references. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available.	04/01/15 Version 9	02/18/15: MPCTAC 03/11/15: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Revised language in the Applicable Coding section.	01/01/16 Version 10	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC

02/01/16	Review for effective date 06/01/16. Updated Summary, Description of Item or Service, Limitations, Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Added experimental and investigational codes to the applicable code list and revised the policy title.	06/01/16 Version 11	02/17/16: MPCTAC 03/09/16: QIC
12/01/16	Review for effective date 04/01/17. Revised title. Updated Summary, Description of Item or Service, Definitions, Clinical Background Information, and References sections. Revised criteria in the Medical Policy Statement and Limitations sections. Revised the language and code list in the Applicable Coding section.	03/01/17 Version 12	12/21/16: MPCTAC 01/11/17: QIC
03/01/17	Review for effective date 06/07/17. Updated Summary, References, and Other Applicable Policies sections. Administrative changes made to the Medical Policy Statement section. Updated applicable code list and added Plan notes to the Applicable Coding section.	06/07/17 Version 13	03/15/17: MPCTAC
02/01/18	Review for effective date 03/01/18. Updated References and Other Applicable Policies sections.	03/01/18 Version 14	02/21/18: MPCTAC
02/01/19	Review for effective date 03/01/19. Administrative changes made to the Policy Summary, Description of Item or Service, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.	03/01/19 Version 15	02/20/19: MPCTAC
02/01/20	Review for effective date 05/01/20. Administrative changes made to the Description of Item or Service, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Code added and Plan notes revised in the Applicable Coding section.	05/01/20 Version 16	02/19/20: MPCTAC
03/01/21	Review for effective date 06/01/21. Administrative changes made to the Policy Summary, Description of Item or Service, Medical Policy Statement, and References sections. Revised the policy title. Criteria revised in the Limitations section. Coding updated in the Applicable Coding section.	06/01/21 Version 17	03/17/21: MPCTAC

06/01/21	Review for effective date 09/01/21. Codes removed from Applicable Coding section when InterQual criteria used to determine medical necessity. Administrative changes made to the Policy Summary, Description of Item or Service, Medical Policy Statement, Limitations, References, and Other Applicable Policies sections. Updated medical necessity criteria with the use of applicable InterQual criteria, when available.	09/01/21 Version 18	06/16/21: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and Limitations section renamed Limitation and Exclusions section. Added NH Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections.	12/01/21 Version 19	11/17/21: MPCTAC
12/01/21	Review for effective date 01/01/22. Industry-wide code updates made in the Applicable Coding section.	01/01/22 Version 20	Not applicable because industry-wide code changes. 12/15/21: MPCTAC review
02/01/22	Review for effective date 03/01/22. Administrative changes made to the Policy Summary, Applicable Coding, and References sections.	03/01/22 Version 21	02/16/22: MPCTAC
05/01/22	Review for effective date 08/01/22. Codes added to the Applicable Coding section.	08/01/22 Version 22	05/11/22: MPCTAC (electronic vote)
08/01/22	Review for policy retired date 11/01/22. The Plan will adopt on 11/01/22 the AIM clinical appropriateness guidelines for musculoskeletal services, including joint surgery, spine surgery, and interventional pain management services; AIM prior authorization is required for those services as of 11/01/22, even when applicable codes are not listed in this Plan policy. Criteria revised in the Clinical Criteria and Limitations and Exclusions sections. Administrative changes made to the Policy Summary section. Coding revised in the Applicable Coding section.	11/01/22 Version 23	08/26/22: MPCTAC (electronic vote)

Medical Policy

Non-Emergency Transportation Services

Policy Number: OCA 3.191
Version Number: 23
Version Effective Date: 11/01/22

Impacted Products

- ☐ **All Products**
- ☒ NH Medicaid
- ☐ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☐ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers non-emergency transportation services medically necessary when Plan criteria are met according to applicable state regulations and benefit coverage. Prior authorization is required. The Plan does NOT require prior authorization for emergency ambulance transportation (including ground, air, and/or sea emergency transport) and/or ground ambulance transport when a member is transported between two (2) inpatient facilities where the admission to each inpatient facility is authorized by the Plan.

Coordinated Transportation Solutions, Inc. (CTS) manages the travel arrangements for non-emergent sea transport, non-emergent air transport, and non-emergent ground transportation for NH Medicaid members, SCO members, and NH Medicare Advantage HMO members. CTS may be contacted directly at 1-844-909-RIDE for NH Medicaid members and 1-844-458-6226 for NH Medicare Advantage members. When requesting transportation services for a MA Senior Care Options member, call 1-855-833-8125. Hearing impaired members may dial 711 to be connected to an operator who will then connect the member to CTS. Review the following notification guidelines:

1. MA MassHealth Members:

    a. Non-Emergency Transportation Services Managed Directly by MassHealth: Non-emergency transport by land transport, chair car, taxi, and common carriers that generally

are pre-arranged to transport a member to and from covered medical care in Massachusetts or within 50 miles or less of the Massachusetts border are covered directly by MassHealth (rather than the Plan) and may require authorization directly from MassHealth; this includes ground ambulance transport when a member is transported between two (2) inpatient facilities. The Plan will assist in the coordination of these services. (This MassHealth coverage guideline does NOT apply to SCO members with MassHealth benefits.)

b. Non-Emergency Transportation Services Managed by the Plan: All other types of covered non-emergency transportation services that require prior authorization are managed by the Plan (i.e., transportation greater than 50 miles outside of the Massachusetts border). Verify member benefits and eligibility for the type of non-emergency transportation requested (and corresponding services) in addition to obtaining prior authorization for services. When a code is NOT payable by the Plan for a MassHealth member, contact MassHealth rather than the Plan for coverage guidelines.

2. MA Qualified Health Plans (QHP) Members: Non-emergency transportation services are NOT routinely covered for QHP members. Benefit exceptions do require Plan prior authorization and may include requests for non-emergency sea and/or non-emergency air transportation according to standard medical necessity criteria used for all Plan products. The Plan does cover transportation services when a QHP member is transported between two (2) inpatient facilities where the admission to each inpatient facility is authorized by the Plan.

3. MA Senior Care Options (SCO) Members: CTS will manage the travel arrangements for non-emergency transportation services for SCO members.

4. NH Medicaid Members: Contact CTS directly rather than the Plan for requests for non-emergent sea transport, non-emergent air transport, non-emergent chair car/wheelchair van transport, non-emergent ground transport, and/or medically necessary general transportation services for the Plan's NH Medicaid members, including both member and provider requests for service. This includes all non-emergent transportation and associated transportation services (even if the corresponding code are not listed in this policy's Applicable Coding section). Transportation services are not covered outside the United States and its territories.

5. NH Medicare Advantage HMO Members: Prior authorization is NOT required for covered non-emergency transportation services provided to NH Medicare Advantage members as a supplemental benefit. Review the member's benefit documents for coverage guidelines and maximum number of trips included in the transportation supplemental benefit. Benefit exceptions do require Plan prior authorization.

Clinical Criteria for MA MassHealth Product

Contact the Plan for requests for non-emergency transportation services. Applicable medical necessity criteria must be met in EITHER item 1 or item 2:

1. Non-Emergent Sea Transportation or Non-Emergent Air Transportation:

   BOTH criteria must be met in item a and item b:

   a. Transport is to a contracted or Plan authorized medically appropriate acute care medical facility predetermined and authorized by the Plan; AND

      Note: Commercial airline charges may be authorized for the member in lieu of air transportation services only when the Plan determines that the member could be safely and less expensively transported on a commercial airline accompanied by necessary medical attendants.

   b. ANY criteria is met in items (1) through (3):

      (1) Member's medical condition requires medical attention during transport and EITHER:

         (a) The use of ground transportation is contraindicated; OR

         (b) Ground transportation is inappropriate to ensure the member's safe transfer; OR

      (2) An ill or injured member who received urgent or emergent care outside the service area is determined to be medically stable for transport back to the Plan service area but requires medical attention during transport to ensure a safe return; OR

      (3) The time needed to provide transport for a patient by land, or the instability of transportation by land, poses a threat to the member's condition or survival; OR

2. Other Types of Plan Authorized Non-Emergency Transportation:

   Criteria are met in either item a or item b:

   a. Non-Emergent Chair Car or Non-Emergent Wheelchair Van Transportation: ±

      ALL criteria are met in items (1) through (4):

      (1) Member requires transportation to and/or from a covered medical, dental, and/or behavioral health service (including transport from an inpatient facility when the Plan has authorized the admission unless the reason for the transport is that the originating facility does not have the medically necessary diagnostic or therapeutic service); AND

      (2) Member's medical condition prevents safe transportation by any other means and this method of transportation is the least intensive, medically necessary method; AND

(3) Member is unable to safely transfer from a wheelchair to a vehicle with or without assistance; AND

(4) Member is unable to ambulate with or without assistance or a device; OR

b. Non-Emergent Ground Transportation:

ALL criteria are met in items (1) through (3):

(1) Member requires transportation to and/or from a covered medical, dental, or behavioral health service (including transport from an inpatient facility when the Plan has authorized the admission unless the reason for the transport is that the originating facility does not have the medically necessary diagnostic or therapeutic service); AND

(2) Member's medical condition prevents safe transport by any other means and this method of transportation is the least intensive, medically necessary method; AND

(3) ANY criteria are met in items (a) through (h):

(a) Member is bed confined (defined as unable to get out of bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair); OR

(b) Member cannot safely sit upright while seated in a wheelchair; OR

(c) Member can tolerate a wheelchair but is medically unstable; OR

(d) Member requires oxygen and oxygen saturation level monitoring, in the absence of a portable oxygen system, to treat hypoxemia, syncope, airway obstruction and/or chest pain; OR

(e) Member requires isolation due to communicable disease or hazardous material exposure; OR

(f) Member has a major orthopedic device that specifically precludes the member from sitting in a wheelchair van or chair car; examples may include backboard, halo-traction, Spica cast, use of pins and traction; OR

(g) Member requires special positioning to prevent further injury (i.e., decubiti or other wound, contracture, post-op hip fracture, severe pain, or the member's size and/or medical condition is such that more than one person is needed for transfer); OR

(h) Member is at risk of harming him/herself or others.

Clinical Criteria for MA Senior Care Options (SCO) Product

Contact the Plan for requests for non-emergency transportation services. After Plan approval, CTS may serve as the Plan's designee to coordinate travel arrangements for covered non-emergent transport and general transport services. The requested transportation must be a component of the member's individualized care plan and applicable medical necessity criteria must be met in EITHER item 1 or item 2:

1. Non-Emergent Sea Transportation or Non-Emergent Air Transportation:

   BOTH criteria must be met in item a and item b:

   a. Non-emergent sea transportation or non-emergent air transportation is prescribed by the member's primary care provider or treating provider; AND

   b. Ground transportation is contraindicated, inappropriate to ensure the member's safe transfer, or cannot be used to access the member; OR

2. Other Types of Plan Authorized Non-Emergency Transportation:

   ANY criteria must be met in items a through c:

   a. Non-Emergent Chair Car or Non-Emergent Wheelchair Van Transportation:

      ALL criteria must be met in items (1) through (4):

      (1) Member requires non-emergent chair care or non-emergent wheelchair van transportation to a covered medical, dental, or behavioral health service, and/or transport to a pharmacy when it is a covered destination according to the CMS Medicare Benefit Policy Manual in effect at the time of the prior authorization request, or the transportation service is authorized by the Plan for care management and integration of medically necessary services for the member's individualized care plan; AND

      (2) Member's medical condition prevents safe transportation by any other means and this method of transportation is the least intensive, medically necessary method; AND

      (3) Member is unable to safely transfer from a wheelchair to a vehicle with or without assistance; AND

      (4) Member is unable to ambulate with or without assistance or a device; OR

   b. Non-Emergent Ground Ambulance Transportation:

      BOTH criteria must be met in items (1) and (2):

(1) Member's medical condition prevents safe transportation by any other means and this method of transportation is the least intensive, medically necessary method; AND

(2) Member meets ANY criteria in items (a) through (i):

(a) Member requires non-emergent ground transportation to a covered medical, dental, or behavioral health service and/or transport to a pharmacy when it is a covered destination according to the CMS Medicare Benefit Policy Manual in effect at the time of the prior authorization request, or the transportation service is authorized by the Plan for care management and integration of medically necessary services for the member's individualized care plan; OR

(b) Member is bed confined (defined as unable to get out of bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair); OR

(c) Member cannot safely sit upright while seated in a wheelchair; OR

(d) Member can tolerate a wheelchair but is medically unstable; OR

(e) Member requires oxygen and oxygen saturation level monitoring, in the absence of a portable oxygen system, to treat hypoxemia, syncope, airway obstruction and/or chest pain; OR

(f) Member requires isolation due to communicable disease or hazardous material exposure; OR

(g) Member has a major orthopedic device that specifically precludes the member from sitting in a wheelchair van or chair car; examples may include backboard, halo-traction, Spica cast, use of pins and traction; OR

(h) Member requires special positioning to prevent further injury (i.e., decubiti or other wound, contracture, post-op hip fracture, severe pain, or the member's size and/or medical condition is such that more than one person is needed for transfer); OR

(i) Member is at risk of harming him/herself or others; OR

c. General Transportation:

Member requires general transportation services (excluding coverage for private transportation services that may include but are not limited to a taxi service, private car service, and/or transportation provided by a member, family member, friend, volunteer, and/or significant other) to a covered medical, dental, or behavioral health service and/or transport to a pharmacy when it is a covered destination according to the CMS Medicare

Benefit Policy Manual in effect at the time of the prior authorization request, or the transportation service is authorized by the Plan for care management and integration of medically necessary services for the member's individualized care plan. General transportation services must be authorized by the Plan for the mode of transportation and indication for transport, arrangements are coordinated by the Plan's Care Management staff (or CTS as the Plan's designee), and the transportation service is covered.

Clinical Criteria for NH Medicaid Product

Contact CTS directly rather than the Plan for requests for covered non-emergent transport and/or medically necessary general transportation services for NH Medicaid members. CTS will coordinate covered and medically necessary transportation on behalf of Plan members (and will direct requests to the Plan's Care Management staff for medically necessary non-emergent transportation requests over 100 miles one way for a NH Medicaid member).

Applicable medical necessity criteria must be met in EITHER item 1 or item 2:

1. Non-Emergent Sea Transportation or Non-Emergent Air Transportation:

   Non-emergent sea transport or non-emergent air transport to and/or from medically necessary care is covered when BOTH criteria are met in item a and item b:

   a. Transport is to a contracted or Plan authorized medically appropriate acute care medical facility predetermined and authorized by the Plan; AND

   b. ANY criteria is met in items (1) through (4):

      (1) Member's medical condition requires medical attention during transport and ANY criteria is met in item (a) or item (b):

         (a) The use of ground transportation is contraindicated; OR

         (b) Ground transportation is inappropriate to ensure the member's safe transfer; OR

      (2) An ill or injured member who received urgent or emergent care outside the service area is determined to be medically stable for transport back to the Plan service area but requires medical attention during transport to ensure a safe return; OR

      (3) The time needed to provide transport for a patient by land, or the instability of transportation by land, poses a threat to the member's condition or survival; OR

      (4) The non-emergent sea transportation or non-emergent air transportation is prescribed by the member's primary care provider or treating provider and ground transportation is contraindicated, inappropriate to ensure the member's safe transfer, or cannot be used to access the member; OR

Note: Commercial airline charges may be authorized for the member in lieu of air transportation services only when the Plan determines that the member could be safely and less expensively transported on a commercial airline accompanied by necessary medical attendants. Coverage for transportation services complies with applicable New Hampshire regulations (including He-W 572).

2. Other Types of Plan Authorized Non-Emergent Transportation:

   ANY criteria must be met in items a through c:

   a. Non-Emergent Chair Car or Non-Emergent Wheelchair Van Transportation:

      ALL criteria must be met in items (1) through (4):

      (1) Member requires transportation to and/or from a covered medical, dental, or behavioral health service (including transport from an inpatient facility when the Plan has authorized the admission unless the reason for the transport is that the originating facility does not have the medically necessary diagnostic and/or therapeutic service), with coverage according to the member's benefit document and applicable New Hampshire regulations (including He-W 572); AND

      (2) Member's medical condition prevents safe transportation by any other means and this method of transportation is the least intensive, medically necessary method; AND

      (3) Member is unable to safely transfer from a wheelchair to a vehicle with or without assistance; AND

      (4) Member is unable to ambulate with or without assistance or a device; OR

   b. Non-Emergent Ground Transportation:

      ALL criteria must be met in items (1) through (3):

      (1) Member requires transportation to and/or from a covered medical, dental, or behavioral health service (including transport from an inpatient facility when the Plan has authorized the admission unless the reason for the transport is that the originating facility does not have the medically necessary diagnostic and/or therapeutic service), with coverage according to the member's benefit document and applicable New Hampshire regulations (including He-W 572and He-W 574); AND

      (2) Member's medical condition prevents safe transportation by any other means and this method of transportation is the least intensive, medically necessary method; AND

      (3) Member meets ANY criteria in items (a) through (k):

(a) The non-emergent ground transportation is prescribed by the member's primary care provider or treating provider; OR

(b) Member is bed confined (defined as unable to get out of bed without assistance, unable to ambulate, and unable to sit in a chair or wheelchair); OR

(c) Member cannot safely sit upright while seated in a wheelchair and must be transported in a supine position; OR

(d) Member can tolerate a wheelchair but is medically unstable; OR

(e) Member requires oxygen and oxygen saturation level monitoring, in the absence of a portable oxygen system, to treat hypoxemia, syncope, airway obstruction and/or chest pain; OR

(f) Member requires isolation due to communicable disease or hazardous material exposure; OR

(g) Member has a major orthopedic device that specifically precludes the member from sitting in a wheelchair van or chair car; examples may include backboard, halo-traction, Spica cast, use of pins and traction; OR

(h) Member requires special positioning to prevent further injury (i.e., decubiti or other wound, contracture, post-op hip fracture, severe pain, or the member's size and/or medical condition is such that more than one person is needed for transfer); OR

(i) Member is at risk of harming him/herself or others and requires restraints during transport; OR

(j) Member requires skilled/trained monitoring with life support equipment during transport, which may include but is not limited to a member with ANY conditions in items I through vi:

i. Member is comatose; OR

ii. Member requires airway monitoring; OR

iii. Member requires cardiac monitoring; OR

iv. Member is dependent on a ventilator; OR

v. Member requires suctioning; OR

vi. Member requires the supply and/or regulation of oxygen; OR

(k) Member requires skilled/trained monitoring during transport for ANY conditions in items i through vi:

i. Member is comatose; OR

ii. Member requires airway monitoring; OR

iii. Member requires cardiac monitoring; OR

iv. Member is dependent on a ventilator; OR

v. Member requires suctioning; OR

vi. Member requires the supply and/or regulation of oxygen; OR

c. General Transportation:

General transportation services are covered and consider medically necessary when the Plan's NH Medicaid member requires general transportation services to a covered medical, dental, or behavioral health service, and/or transport to a pharmacy (if the pharmacy does not provide free delivery services to the member's home) ONLY when the transportation is authorized by CTS (as the Plan's designee) in advance. Requests for transportation services must be submitted to CTS at least 48 hours before the member's non-urgent appointment time. CTS will accept an urgent request for transportation services with less than 48-hour notification when the treating provider's office has validated that that the member requires an urgent appointment. CTS must prospectively authorize the mode of transportation and indication for transport, and arrangements must be coordinated by CTS. General transportation services are covered for a NH Medicaid member for healthcare services when the member is not able to obtain free transportation (or not eligible for transportation from another agency), as specified in the member's applicable benefit document and according to applicable New Hampshire regulations (including He-W 572 and He-W 574). The member is responsible for submitting prior authorization requests in advance to CTS for general transportation services, and the member must comply with all reimbursement guidelines. Covered general transportation services may include public transportation (including bus and/or train) and transportation provided by a CTS provider authorized to transport the member (with mileage reimbursement for the driver according to CTS guidelines). See the New Hampshire Medicaid Member Handbook rather than this policy for Plan rules for transportation coordination and reimbursement for the Friends and Family Mileage Reimbursement Program and Request a Ride Program.

Limitations and Exclusions

The following transportation services are NOT covered:

1. Transportation to and/or from medical appointments, dental appointments, behavioral health appointments, and/or transport to a pharmacy EXCEPT when the specific transportation service is covered and authorized by the Plan or CTS as the Plan's designee.

2. Private transportation services (such as taxi service, private car service, and/or transportation provided by a member, family member, friend, volunteer, and/or significant other) UNLESS authorized by the Plan or CTS as the Plan's designee as a medically necessary service and a component of the member's individualized treatment plan.

3. Public transportation UNLESS authorized by the Plan or CTS as the Plan's designee as a medically necessary service and component of the member's individualized treatment plan.

4. Transport, non-emergent chair car or non-emergent wheelchair van transportation, or covered general transportation solely for the convenience or preference of a member or the member's family member (unless authorized by the Plan as a medically necessary service and a component of the member's individualized treatment plan).

5. Transport, non-emergent chair car or non-emergent wheelchair van transportation when an alternative method of transportation is available and can be utilized without endangering the member's health status unless authorized by the Plan or CTS as the Plan's designee as a medically necessary service and a component of the member's individualized treatment plan.

6. Transport for the purpose of seeking a non-covered service unless authorized by the Plan or CTS as the Plan's designee as a medically necessary service and a component of the member's individualized treatment plan.

7. Transport for any purpose other than to receive covered healthcare services from a network provider.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for the Plan's Senior Care Options (SCO) members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, no applicable clinical guidelines were found from CMS. Verify CMS criteria in effect for the requested service on the date of the prior authorization request for a SCO member. When there is no guidance from CMS for the requested service for the specified indication on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification

of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. Since these codes may be updated at different intervals than the medical policy review cycle, the list of applicable codes included in a policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of a medical policy, even if an applicable code appropriately describing the service is not included in the policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

HCPCS Codes	**Description: The following transportation codes REQUIRE prior authorization**. Contact CTS for all non-emergency transport for SCO and NH Medicaid members.
A0021	Ambulance service, outside state per mile, transport (Medicaid only) Plan note: Code is NOT payable for the Plan's SCO members.
A0100	Nonemergency transportation; taxi
A0110	Nonemergency transportation and bus, intra- or interstate carrier
A0120	Nonemergency transportation: mini-bus, mountain area transports, or other transportation systems
A0130	Nonemergency transportation: wheelchair van
A0170	Transportation ancillary: parking fees, tolls, other Plan note: Payable by the Plan for NH Medicaid and SCO members if related to emergency ambulance services and is dependent on the primary transportation code.
A0426	Ambulance service, advanced life support, non-emergency transport, level 1 (ALS 1)
A0428	Ambulance service, basic life support, non-emergency transport (BLS) Plan note: Ground ambulance transport is covered and does NOT require prior authorization when a member is transported between two (2) inpatient facilities where the admission to each inpatient facility is authorized by the Plan.
A0998	Ambulance response and treatment, no transport
A0999	Unlisted ambulance service
S0215	Non-emergency transportation; mileage, per mile Plan note: Code is NOT payable for members with MassHealth Family Assistance coverage.
T2001	Nonemergency transportation; patient attendant/escort Plan note: Code is NOT payable for members with MassHealth Family Assistance coverage.
T2005	Non-emergency transportation; stretcher van
T2049	Non-emergency transportation; stretcher van, mileage; per mile

References

American College of Emergency Physicians. EMTALA Main Points.

Centers for Medicare & Medicaid Services (CMS). Ambulances Services Center.

Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual. Publication Number 100-02. Transmittal 130. Change Request 7058. Definition of Ambulance Services. 2010 Jul 29.

Centers for Medicare & Medicaid Services (CMS). Medicare Benefit Policy Manual. Publication Number 100-02. Chapter 10 – Ambulance Services.

Centers for Medicare & Medicaid Services (CMS). Transmittals.

Centers for Medicare & Medicaid Services (CMS). Welcome to the Medicare Coverage Database.

Commonwealth of Massachusetts. Division of Insurance (DOI) Bulletins.

Commonwealth of Massachusetts. MassHealth Provider Bulletins.

Commonwealth of Massachusetts. MassHealth Provider Manuals.

Commonwealth of Massachusetts. MassHealth Transmittal Letters.

New Hampshire Department of Health and Human Services. Billing Manuals.

New Hampshire Department of Health and Human Services. Provider Notices.

Next Review Date

03/01/23

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 06/29/11: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 07/27/11: Quality Improvement Committee (QIC)	01/01/12 Version 1	Director of Medical Policy as Chair of MPCTAC	MPCTAC and QIC

* Effective Date for QHP and MassHealth Products: 01/01/12.
* Effective Date for NH Medicaid Product: 07/01/14.
* Effective Date for SCO Product: 01/01/16.

Effective 06/01/22 policy title changed from Emergency Transportation Services to *Non-Emergent Transportation Services* until 05/31/22. As of 06/01/22, policy title changed to *Non-Emergency Transportation Services*.

Transportation Vendor:
- From 06/01/20 to 06/30/22, One Call Government Solutions, LLC (One Call) managed the travel arrangements for non-emergent sea transport, non-emergent air transport, and non-emergent ground transportation for New Hampshire Medicaid members and Senior Care Options members.
- Prior to 06/01/20 and as of 07/01/22, Coordinated Transportation Solutions, Inc. (CTS) manages the travel arrangements for non-emergent sea transport, non-emergent air transport, and non-emergent ground transportation for New Hampshire Medicaid and Senior Care Options members.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
07/01/12	Updated reference, revised language in Applicable Code section, included list of applicable codes, added detail on the when to reference the Plan's *Reimbursement Guidelines: Transportation* policy. Included clarification on limitations on the use of ambulance transport (i.e., limitation when ambulance transport is solely for convenience, when another alternative is safe and available, and/or use with non-covered services).	Version 2	06/20/12: MPCTAC 07/18/12: MPCTAC 08/22/12: QIC

Policy Revisions History			
11/01/12	Added Commonwealth Care to list of applicable products (to comply with EOC), removed "Guidelines" from title, updated Summary and References sections, reformatted Medical Policy Statement section, added references to sea ambulance (as appropriate).	Version 3	11/21/12: MPCTAC 12/20/12: QIC
03/01/13	Review, deleted redundant text in the Summary section, revised Description of Item or Service section, moved medical criteria from the Summary section to the Medical Policy Statement section (formerly named Clinical Guideline Statement section), updated applicable code list and references, and changed name of policy category from "Clinical Coverage Guidelines" to "Medical Policy."	Version 4	03/20/13: MPCTAC 04/18/13: QIC
03/01/14	Review for effective date 07/01/14. Added New Hampshire Medicaid as an applicable product for this policy and included criteria for New Hampshire Medicaid product. Updated references, applicable code list (adding HCPCS codes S9960 and S9961), and revised language in the Applicable Coding section. Revised Summary section and added note to policy header. Added reference to Coordinated Transportation Solutions, Inc. (CTS), the Plan's external partner who manages the travel arrangements for non-emergent sea transport, non-emergent air transport, and non-emergent ground transportation for New Hampshire Medicaid members. Reformatted and revised criteria for BMC HealthNet Plan products, allowing the approval of transport to a Plan authorized acute care medical facility (as well as a contracted facility).	07/01/14 Version 5	03/19/14: MPCTAC 04/16/14: QIC
06/30/14	Off cycle review for effective date 10/01/14. Removed the following codes from the applicable code list: A0425, A0430, A0431, A0434, A0435, and A0436 (since these codes may be used with emergency transport and Plan prior authorization will not be required).	10/01/14 Version 6	06/30/14: MPCTAC (electronic vote) 07/09/14: QIC

Policy Revisions History			
10/31/14	Off cycle review for effective date 12/01/14. Added MassHealth as an applicable product. Updated Summary, Medical Policy Statement, and Limitations sections without changing criteria.	12/01/14 Version 7	10/31/14: MPCTAC (electronic vote) 11/12/14: QIC
03/01/15	Review for effective date 05/01/15. Updated references. Revised the Limitations section to reference the member's applicable benefit document without changing the service limitations. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available.	05/01/15 Version 8	03/18/15: MPCTAC 04/08/15: QIC
11/01/15	Review for effective date 0 1/01/16. Updated product applicability template and note. Administrative changes made to the Summary, Limitations, and BMC HealthNet Plan Medical Policy Statement sections to reference the Senior Care Options (SCO) product and interface with Coordinated Transportation Solutions, Inc. (CTS) to manage the travel arrangements for covered non-emergent transport for SCO members. Revised language in the Applicable Coding section.	01/01/16 Version 9	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
05/01/16	Review for effective date 09/01/16. Updated Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Administrative changes made to the Summary, Description of Item or Service, Applicable Coding, and Definitions sections. Criteria changes made in the Medical Policy Statement and Limitations sections. Updated applicable code list.	09/01/16 Version 10	05/31/16: MPCTAC (electronic vote) 06/08/16: QIC
04/01/17	Review for effective date 07/08/17. Updated Summary section. Administrative changes made to the Medical Policy Statement section. Revised the code list, revised Plan notes for applicable codes, and administrative changes made to the Applicable Coding section.	07/08/17 Version 11	04/28/17: MPCTAC
02/01/18	Review for effective date 05/01/18. Administrative changes made to the Policy Summary and Other Applicable Policies sections. Updated criteria in the Medical	05/01/18 Version 12	02/21/18: MPCTAC

Policy Revisions History			
	Policy Statement and Limitations sections. Revised applicable code list.		
04/01/18	Review for effective date 05/01/18. Updated Plan notes (administrative changes only) in the Applicable Coding section.	05/01/18 Version 13	04/18/18: MPCTAC
09/01/18	Review for effective date 12/01/18. Revised criteria in the Medical Policy Statement for BMC HealthNet Plan Product, Senior Care Options Product, and New Hampshire Medicaid Product sections. Updated the Definitions and the Other Applicable Policies sections.	12/01/18 Version 14	09/19/18: MPCTAC
03/01/19	Review for effective date 04/01/19. Administrative changes made to the Medical Policy Statement for New Hampshire Medicaid Product section and the Limitations section. Updated the Plan notes in the Applicable Coding section and revised the Other Applicable Policies section and the Applicable Laws and Regulations section.	04/01/19 Version 15	03/20/19: MPCTAC
11/01/19	Review for effective date 01/01/20. Plan note effective 01/01/20 added to the Applicable Coding section. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections.	01/01/20 Version 16	11/20/19: MPCTAC
04/01/20	Review for effective date 06/01/20. The Plan has partnered with the non-emergency medical transportation vendor, One Call Government Solutions, LLC (One Call). One Call replaces Coordinated Transportation Solutions, Inc. (CTS) effective 06/01/20 as the manager of travel arrangements for non-emergent sea transport, non-emergent air transport, and non-emergent ground transportation for members enrolled in the Plan's New Hampshire Medicaid product or the Senior Care Options product. Administrative changes made to the Policy Summary, Medical Policy Statement for Senior Care Options Products, Medical Policy Statement for New Hampshire Medicaid Product, Limitations, and Applicable Coding sections.	06/01/20 Version 17	04/15/20: MPCTAC
01/01/21	Review for effective date 04/01/21. Plan notes and coding revised in the Applicable	04/01/21 Version 18	01/19/21: MPCTAC (electronic vote)

Policy Revisions History			
	Coding section. Administrative change made to the Other Applicable Policies section.		
02/01/21	Review for effective date 05/01/21. Revised the coding in the Applicable Coding section.	05/01/21 Version 19	02/17/21: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, the Medical Policy Statement section renamed the Clinical Criteria section, and the Limitations section renamed the Limitations and Exclusions section. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections.	12/01/21 Version 20	11/30/21: MPCTAC (electronic vote)
04/01/22	Review for effective date 05/01/22. Emergency transportation and facility-to-facility transport do not require prior authorization so services removed from the Clinical Criteria for MassHealth Product and Clinical Criteria for New Hampshire Medicaid Product sections. Administrative changes made to the Policy Summary, Applicable Coding, and References sections. QHP was removed as an applicable product from the policy but no material changes to coverage. Revised the policy title.	05/01/22 Version 21	04/20/22: MPCTAC
06/01/22	Review for effective date 07/01/22. Administrative changes made to the Policy Summary, Clinical Criteria for MA Senior Care Options Product, Clinical Criteria for NH Medicaid Product, Limitations and Exclusions, and Applicable Coding sections.	07/01/22 Version 22	06/15/22: MPCTAC
08/01/22	Review for effective date 11/01/22. Removed CPT code A0434 from the Applicable Coding section.	11/01/22 Version 23	08/26/22: MPCTAC (electronic vote)

Medical Policy – Policy with InterQual Criteria Retired and AIM Criteria Adopted as of 11/01/22

Occupational Therapy in the Outpatient Setting

Policy Number: OCA 3.543
Version Number: 25
Policy Retired Date: 11/01/22

Impacted Products

- ☐ **All Products**
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☐ MA MassHealth ACO
- ☐ MA MassHealth MCO
- ☐ MA Qualified Health Plans/Employer Choice Direct
- ☐ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers outpatient occupational therapy (OT) medically necessary, including habilitative services and/or rehabilitative services, when AIM clinical appropriateness guidelines are met for an adult or pediatric member or are required EPSDT services for a member age 20 or younger on the date of service. Prior authorization from AIM Specialty Health is required for outpatient OT after the initial evaluation. OT must be provided within the scope of practice of the treating professional and/or paraprofessional and follow all applicable state licensing and supervisory requirements.

Clinical Criteria

No medical policy criteria.

Limitations and Exclusions

None.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for NH Medicare Advantage members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's

most recent policy review, LCD L34427 includes medically necessary indications for occupational therapy. Verify CMS guidelines in in effect on the date of the prior authorization request. When there is no guidance from CMS on the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. The list of applicable codes included in this policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization from AIM for occupational therapy, even if an applicable code appropriately describing the service is not included in this policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Codes	Code Descriptions
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	Application of a modality to 1 or more areas; traction, mechanical
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (e.g., microwave)
97026	Application of a modality to 1 or more areas; infrared
97028	Application of a modality to 1 or more areas; ultraviolet
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)
97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)

97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97168	Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; an update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and a revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living [ADL] and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes by provider, each 15 minutes
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
97755	Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes
97761	Prosthetic training, upper and/or lower extremity(ies), initial prosthetic(s) encounter each 15 minutes

97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

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Hayes. Health Technology Assessment. Cognitive Rehabilitation Therapy for Traumatic Brain Injury (TBI). Dallas, TX: Hayes; 2017 Sep 26. Annual Review 2021 Feb 8.

Hayes. Health Technology Assessment. Occupational Therapy for Attention-Deficit/Hyperactivity Disorder (ADHD). Dallas, TX: Hayes; 2017 Mar 16. Annual Review 2021 May 12.

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New Hampshire Department of Health and Human Services. Provider Notices

New Hampshire Medicaid. Therapies. Physical, Occupational, Speech. Provider Manual. Volume II. 2017 Dec 1.

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Next Review Date

Not applicable

Retired Date

11/01/22

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 09/16/05	10/16/05 Version 1	Director of Medical Policy as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	Quality and Clinical Management Committee (Q&CMC)

*Effective Date for NH Medicaid Product: 01/01/13
*Effective Date for NH Medicare Advantage HMO Product: 01/01/22

Policy retired and service managed by AIM Specialty Health as of 11/01/22.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
02/07/06	Added definitions for modality and visit. Defined coverage for visits, evaluations and units billed.	Version 2	02/07/06: Q&CMC
07/06/06	Removed verbiage regarding reimbursement for evaluation and modality services.	Version 3	07/06/06: Q&CMC
03/27/07	Policy archived.	Not applicable	Not specified
10/14/08	Policy reviewed and clinical criteria updated, effective date of revised policy is 12/16/08.	12/16/08 Version 4	11/10/08: MPCTAC 12/16/08: Quality Improvement Committee (QIC)
09/22/09	No changes.	Version 5	09/22/09: MPCTAC 10/28/09: QIC
10/01/10	Updated template and references, no changes to criteria	Version 6	10/20/10: MPCTAC 11/22/10: QIC
10/01/11	Added Commercial benefit limitations, updated references and coding.	Version 7	10/19/11: MPCTAC 11/29/11: QIC
08/01/12	Off cycle review for the NH Medicaid product, revised Summary statement, reformatted Medical Policy Statement, revised Applicable Coding introductory paragraph, updated code list, revised limitations, deleted references to contracts and EOCs that are not applicable.	Version 8	08/13/12: MPCTAC 09/06/12: QIC
11/01/12	Review for effective date 03/01/13. Updated references and revised Summary section.	03/01/13 Version 9	11/21/12: MPCTAC 12/20/12: QIC

	Moved medical criteria from Summary section to Clinical Guidelines Statement section. Moved services not considered medically necessary from the Clinical Guidelines Statement section to the Limitations section. Updated applicable coding list and references. Removed duplicate text in the Clinical Background Information section. Referenced Plan reimbursement policy 4.609 for occupational therapy reimbursement guidelines. Updated language in introductory paragraph of Applicable Coding section. Removed "Guideline" from title.		
08/14/13 and 08/15/13	Off cycle review for the NH Medicaid product and merged policy format. Incorporate policy revisions dated 11/01/12 (as specified above) for the NH Medicaid product; these policy revisions were approved by MPCTAC on 11/21/12 and QIC on 12/20/12 for applicable Plan products.	Version 10	08/14/13: MPCTAC (electronic vote) 08/15/13: QIC
11/01/13, 12/01/13, 01/01/14, and 02/01/14	Review for effective date 05/01/14. Updated code definitions, introductory paragraph in Applicable Coding section, and the applicable code lists for the MA products and the NH Medicaid product. Updated references. Removed prior authorization waiver for the first 32 units of OT for the NH Medicaid product. Add criterion in the Medical Policy Statement sections for the MA products and NH Medicaid product requiring an updated physician prescription and supporting clinical documentation after 20 OT visits per treatment episode. Revised Limitations.	05/01/14 Version 11	02/11/14: MPCTAC 02/18/14: QIC
09/08/14	For NH Medicaid product only, waived prior authorization of first eight (8) 15-minute treatment units per member per servicing provider per calendar year.	10/01/14 Version 11 Addendum A	09/17/14: MPCTAC 09/301/14: QIC
11/04/14 and 11/19/14	Review for effective date 01/11/15. Summary and Medical Policy Statement sections updated with guidelines specified in version 11, addendum A. Policy renumbered OCA 3.543 to include occupational therapy in the outpatient setting for NH Medicaid members age 21 or older. Summary, Limitations, and References sections updated. (OT services formerly included in policy number OCA 3.53 for all adult and pediatric members.) Change in review calendar.	01/11/15 Version 12	11/06/14: MPCTAC (electronic vote) 11/11/14: QIC (electronic vote) 11/19/14: MPCTAC 12/10/14: QIC

12/03/15	Review for effective date 01/01/16. Updated template and Summary section. Administrative changes made to the Medical Policy Statement section and Limitations sections without changing criteria. Revised language in the Applicable Coding section. Added definitions.	01/01/16 Version 13	12/03/15: MPCTAC (electronic vote) 12/09/15: QIC
12/01/16	Review for effective date 02/01/17. Industry-wide revisions of applicable codes. Clarified existing criteria in the Medical Policy Statement section.	02/01/17 Version 14	12/21/16: MPCTAC 01/11/17: QIC
12/01/17	Review for effective 01/01/18. Industry-wide updates to codes included in the Applicable Coding section. Annual review of policy with administrative changes made to the Definitions and Reference sections.	01/01/18 Version 15	12/20/17: MPCTAC
02/01/18	Review for effective date 03/01/18. Administrative changes made to the Policy Summary and Limitations sections.	03/01/18 Version 16	02/21/18: MPCTAC
11/01/18	Review for effective date 12/01/18. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, Definitions, Applicable Coding, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.	12/01/18 Version 17	11/21/18: MPCTAC
03/01/19	Review for effective date 07/01/19. Criteria and prior authorization guidelines revised in the Medical Policy Statement section. Administrative changes made to the Limitations and Reference to Applicable Laws and Regulations sections.	07/01/19 Version 18	03/20/19: MPCTAC
12/01/19	Review for effective date 01/01/20. Industry-wide updates to codes included in the Applicable Coding section.	01/01/20 Version 19	Not applicable because industry-wide code changes
11/01/19	Review for effective date 02/01/20. Revised criteria in the Medical Policy Statement and Limitations sections. Administrative changes made to the References Reference to Applicable Laws and Regulations sections.	02/01/20 Version 20 Renumbered to version 20 to implement industry-wide code updates effective 01/01/20 in version 19	11/20/19: MPCTAC

12/01/19	Review for effective 02/01/20. Industry-wide updates to codes effective 01/01/20 included in the Applicable Coding section of the policy version 20 effective 02/01/20.	02/01/20 Version 21	Not applicable because industry-wide code changes
12/01/19	Review for effective date 03/01/20. Revised in the Medical Policy Statement section the definition of a servicing OT provider for the prior authorization waiver.	03/01/20 Version 22	12/18/19: MPCTAC
11/01/20	Review for effective date 12/01/20. Updated the References section. Administrative change made to the Applicable Coding section.	12/01/20 Version 23	11/18/20: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and Limitations section renamed Limitations and Exclusions section. Added NH Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary and References sections. Criteria revised in the Clinical Criteria and Limitations and Exclusions sections. Medical policy criteria retired and InterQual criteria will continue to be used to determine medical necessity.	12/01/21 Version 24	11/17/21: MPCTAC
08/01/22	Review for effective date 11/01/22. Administrative changes made to the Policy Summary and Applicable Coding sections. InterQual medical necessity criteria and medical policy guidelines in the Clinical Criteria and Limitations and Exclusions sections retired on 11/01/22. AIM criteria adopted for outpatient OT on 11/01/22. Plan prior authorization waivers removed after 10/31/22. AIM prior authorization is required for outpatient OT after the initial evaluation as of 11/01/22, even when applicable codes are not listed in this Plan policy.	11/01/22 Version 25	08/26/22: MPCTAC (electronic vote)

Medical Policy – Policy Retired and AIM Criteria Adopted as of 11/01/22

Osteochondral Treatments for Defects of the Knee, Talus, or Other Joints

Policy Number: OCA 3.965
Version Number: 19
Policy Retired Date: 11/01/22

Impacted Products

- ☒ **All Products**
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☒ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers autologous chondrocyte implantation (ACI)/matrix-induced autologous chondrocyte implantation (MACI), osteochondral autograft transplantation (OATS/autologous mosaicplasty), and osteochondral allograft transplantation procedures medically necessary for the treatment of osteochondral defects when AIM clinical appropriateness guidelines are met. Prior authorization from AIM Specialty Health is required for musculoskeletal procedures and interventional pain management services.

Clinical Criteria

No medical policy criteria.

Limitations and Exclusions

None.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and NH Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, no applicable clinical guidelines were found from CMS. Verify CMS criteria in effect for the requested service on the date of the prior authorization request for a SCO or NH Medicare Advantage HMO member. When there is no guidance from CMS for the requested service for the specified indication on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. The list of applicable codes included in this policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization from AIM for this service, even if an applicable code appropriately describing the service is not included in this policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT/HCPCS Codes	Code Descriptions
27412	Autologous chondrocyte implantation, knee
27415	Osteochondral allograft, knee, open
27416	Osteochondral autograft(s), knee, open (e.g., mosaicplasty) (includes harvesting of autograft[s])
28446	Open osteochondral autograft, talus (includes obtaining grafts[s])
29866	Arthroscopy, knee, surgical; osteochondral autograft(s) (e.g., mosaicplasty) (includes harvesting of the autograft[s])
29867	Arthroscopy, knee, surgical; osteochondral allograft (e.g., mosaicplasty)
J7330	Autologous cultured chondrocytes, implant
S2112	Arthroscopy, knee, surgical for harvesting of cartilage (chondrocyte cells)

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Next Review Date

Not applicable

Retired Date

11/01/22

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:
Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 07/08/08: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 07/22/08: Utilization Management Committee (UMC) 08/13/08: Quality Improvement Committee (QIC)	11/01/08 Version 1	Director of Medical Policy as Chair of MPCTAC	MPCTAC, QIC, and UMC

*Effective Date for QHP Commercial Product: 01/01/12
*Effective Date for New Hampshire Medicaid Product: 01/01/13
*Effective Date for Senior Care Options Product: 01/01/16
*Effective Date for NH Medicare Advantage HMO Product: 01/01/22

Policy title was *Osteochondral Treatments for Defects of the Knee* until 05/31/19. As of 06/01/19, policy title changed to *Osteochondral Treatments for Defects of the Knee, Talus, or Other Joint*. Policy retired and service managed by AIM Specialty Health as of 11/01/22.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
07/28/09	No changes except updated references.	Version 2	07/28/09: MPCTAC 07/28/09: UMC 08/26/09: QIC
07/01/10	No changes except updated references.	Version 3	08/18/10: MPCTAC 09/22/10: QIC
07/01/11	No changes except updated references.	Version 4	08/17/11: MPCTAC 09/28/11: QIC
07/01/12	Updated references. No change made to applicable code list. Revised list of conservative treatment options. Added language in clinical criteria that states "acute trauma may result from falls, sports, and other sources of impact while repetitive trauma may include overuse." Changed criteria for all three procedure types	Version 5	07/18/12: MPCTAC 08/22/12: QIC

	from "no history of bone cancer in the affected limb" to "no history of cancer in the bone, cartilage, fat, or muscle of the treated limb." Added note in Description of Item or Service with recommendations on age and BMI of member seeking surgical procedure. Added language in Applicable Code section.		
07/30/12	Off cycle review for New Hampshire Medicaid product. Revised Summary statement, reformatted Medical Policy Statement section, deleted reference to Carticel product.	Version 6	08/03/12: MPCTAC 09/05/12: QIC
07/01/13	Review for effective date 11/01/13. Revised text in Description of Item or Service section. Removed duplicate text in the Clinical Background Information section and added information on Carticel®, minced cartilage repair, and synthetic resorbable polymers. Moved medical guidelines (related to skeletal maturing and BMI) from Description of Item or Service to the Medical Policy Statement section. Added medical criteria, limitations, and definition of Outerbridge Grading System. Updated references.	11/01/13 Version 7	07/17/13: MPCTAC 08/15/13: QIC
04/01/14	Review for effective date 08/01/14. Revised Summary, Description of Item or Service, Definitions, and References sections. Revised criteria in the Medical Policy Statement section.	08/01/14 Version 8	04/16/14: MPCTAC 05/14/14: QIC
03/01/15	Review for effective date 05/01/15. Updated references. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available. Administrative changes made to Medical Policy Statement section and Limitation section to clarify criteria.	05/01/15 Version 9	03/18/15: MPCTAC 04/08/15: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Revised language in the Applicable Coding section.	01/01/16 Version 10	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
04/01/16	Review for effective date 06/01/16. Updated Clinical Background Information, References, and Reference to Applicable Laws and Regulations.	06/01/16 Version 11	04/20/16: MPCTAC 05/23/16: QIC
03/01/17	Review for effective date 06/07/17. Updated criteria in the Medical Policy Statement and Limitations sections. Updated References	06/07/17 Version 12	03/15/17: MPCTAC

	section. Plan note added to the Applicable Coding section.		
02/01/18	Review for effective date 03/01/18. Updated Description of Item or Service, Definitions, References, and Other Applicable Policies sections.	03/01/18 Version 13	02/21/18: MPCTAC
03/01/19	Review for effective date 06/01/19. Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, Clinical Background Information, References, Other Applicable Policies, and References to Applicable Laws and Regulations sections. Revised Plan notes in the Applicable Coding section without revising code list. Criteria revised in the Medical Policy Statement and Limitations sections. Revised the policy title.	06/01/19 Version 14	03/20/19: MPCTAC
02/01/20	Review for effective date 05/01/20. Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Criteria revised in the Medical Policy Statement and Limitations sections.	05/01/20 Version 15	02/19/20: MPCTAC
02/01/21	Review for effective date 03/01/21. Administrative changes made to the References section.	03/01/21 Version 16	02/17/21: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, the Medical Policy Statement section renamed the Clinical Criteria section, and the Limitations section renamed the Limitations and Exclusions section. Added NH Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections.	12/01/21 Version 17	11/17/21: MPCTAC
02/01/22	Review for effective date 03/01/22. Administrative changes made to the References section. Non-material changes made to the Clinical Criteria section (removing Outerbridge Grade criteria).	03/01/22 Version 18	02/16/22: MPCTAC
08/01/2	Review for effective date 11/01/22. The Plan will adopt on 11/01/22 the AIM clinical	11/01/22 Version 19	08/26/22: MPCTAC

	appropriateness guidelines for musculoskeletal services, including joint surgery, spine surgery, and interventional pain management services; AIM prior authorization is required for those services as of 11/01/22, even when applicable codes are not listed in this Plan policy. Criteria revised in the Clinical Criteria and Limitations and Exclusions sections. Administrative changes made to the Policy Summary section.		(electronic vote)

Medical Policy – Policy Retired and AIM Criteria Adopted as of 11/01/22

Pelvic Floor Stimulation for the Treatment of Incontinence and/or Overactive Bladder

Policy Number: OCA 3.561
Version Number: 25
Policy Retired Date: 11/01/22

Impacted Products

- ☒ **All Products**
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☒ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

AIM clinical appropriateness criteria will be used to determine if non-implantable pelvic floor stimulation is considered medically necessary for the treatment of overactive bladder, urinary incontinence and/or fecal continence; this includes pelvic floor electrical stimulation (PFES) and/or pelvic floor magnetic stimulation. Prior authorization from AIM Specialty Health is required.

Clinical Criteria

No medical policy criteria.

Limitations and Exclusions

None.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and NH Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, CMS NCD 230.8 8 includes medically necessary indications for the use of a non-implantable pelvic floor electrical stimulator. No

CMS clinical criteria were identified for pelvic floor magnetic stimulation for urinary incontinence or fecal incontinence or the use of pelvic floor electrical stimulation (PFES) for fecal incontinence. Verify CMS guidelines in effect on the date of the prior authorization request. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. The list of applicable codes included in a policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization for this services, even if an applicable code appropriately describing the service is not included in this policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT/HCPCS Codes	Code Descriptions
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended) Note: Supervised. The application of a modality that does not require direct, one-on-one, patient contact by the provider. Plan note: Code is NOT payable for the Senior Care Options and NH Medicare Advantage HMO products.
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
E0740	Non-implanted pelvic floor electrical stimulator, complete system
G0283	Electrical stimulation (unattended), to one or more areas for indication(s) other than wound care, as part of a therapy plan of care

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Next Review Date

Not applicable

Retired Date

11/01/22

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity;

utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 10/03/06	12/03/06 Version 1	Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	Quality and Clinical Management Committee (Q&CMC)

*Effective Date for QHP Commercial Product: 01/01/12
*Effective Date for New Hampshire Medicaid Product: 01/01/13
*Effective Date for Senior Care Options Product: 01/01/16
*Effective Date for New Hampshire Medicare Advantage HMO Product: 01/01/22

This policy replaced P*elvic Floor/Sacral Nerve Stimulation for Urinary Incontinence* medical policy, policy number OCA 3.56, as of 05/01/13 for criteria related to pelvic floor stimulation for the treatment of incontinence. The policy was titled *Non-Implantable Pelvic Floor Electrical Stimulation for Urinary Incontinence* from 05/01/13 to 01/31/16. The policy title was *Pelvic Floor Stimulation for the Treatment of Incontinence* from 02/01/16 to 02/28/19. Effective 03/01/19, the policy title has been changed to *Pelvic Floor Stimulation for the Treatment of Incontinence and/or Overactive Bladder*. Policy retired and service managed by AIM Specialty Health as of 11/01/22.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
09/11/07	Updated template, added coding, approved by MPCTAC.	Version 2	09/11/07: MPCTAC 09/25/07: Utilization Management Committee (UMC) 10/15/07: Quality Improvement Committee (QIC)
09/09/08	No changes.	Version 3	09/09/08: MPCTAC 09/30/08: UMC 10/22/08: QIC
09/22/09	Updated references, no changes to criteria.	Version 4	09/22/09: MPCTAC 10/28/09: QIC
09/01/10	Updated template and references, no changes to criteria.	Version 5	10/20/10: MPCTAC 11/22/10: QIC

10/01/11	Updated limitations to include that sacral nerve stimulation for the treatment of fecal incontinence and posterior tibial nerve stimulation for the treatment of symptoms associated with overactive bladder are considered experimental and investigational. Updated references and coding.	Version 6	10/19/11: MPCTAC 11/29/11: QIC
07/20/12	Off cycle review for Well Sense Health Plan: Updated title, revised Summary statement, added posterior tibial stimulation to Description of Item or Service, reformatted Medical Policy Statement, updated Definitions, revised language in Applicable Coding section, updated code list.	Version 7	08/13/12: MPCTAC 09/13/12: QIC
12/01/12	Separated pelvic floor electrical stimulation, sacral nerve stimulation, and posterior tibial nerve stimulation into three separate policies; policy formerly titled *Pelvic Floor/Sacral Nerve Stimulation for Urinary Incontinence* (formerly policy number OCA: 3.65). Revised title and re-numbered policy. Updated language in Summary, Description of Item or Service, Definitions, Applicable Coding, and Clinical Background Information sections. Referenced *Posterior Tibial Nerve Stimulation*, *Sacral Nerve Stimulation (Including Peripheral Nerve Stimulation Test and Two-Stage Tined Lead Procedure) for Incontinence and Urinary Conditions, Biofeedback for Urinary Incontinence, Experimental and Investigation Treatment,* and *Medically Necessary* policies. Reformatted and added criteria in Medical Policy Statement section, updated and added references, and added limitations. Revised applicable code list.	Version 8	12/19/12: MPCTAC 01/31/13: QIC
12/01/13	Review for effective date 02/01/14. Updated references.	02/01/14 Version 9	12/18/13: MPCTAC 01/21/14: QIC
12/01/14	Review for effective date 05/01/15. Updated references. Added ICD9/ICD10 diagnosis codes for urinary incontinence to the Applicable Coding section. Updated introductory paragraph in the Applicable Coding section.	05/01/15 Version 10	12/17/14: MPCTAC 01/14/15: QIC
10/01/15	Review for effective date 12/01/15. Updated template with list of applicable products and corresponding notes.	12/01/15 Version 11	10/21/15: MPCTAC 11/11/15: QIC
10/21/15	Review for effective date 02/01/16. Updated Summary, Description of Item or Service, Definitions, Clinical Background Information,	02/01/16 Version 12	10/21/15: MPCTAC 11/11/15: QIC

	and References sections. Updated criteria in the Medical Policy Statement and Limitations sections. Revised the title of the policy.		
11/25/15	Review for effective date 02/01/16. Revised language in the Applicable Coding section. Plan note added to HCPCS code G0283.	02/01/16 Version 13	11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
10/01/16	Review for effective date 12/01/16. Updated Summary, Definitions, Clinical Background Information, References, and References to Applicable Laws and Regulations sections. Administrative changes made to the Medical Policy Statement and Limitations sections; no change to criteria. Removed ICD-9 diagnosis codes and Plan notes added to applicable codes.	12/01/16 Version 14	10/19/16: MPCTAC 11/09/16: QIC
12/01/16	Industry-wide change to applicable code description (HCPCS code E0740) effective 01/01/17.	01/01/17 Version 15	Not applicable because industry-wide change in code description.
10/01/17	Review for effective date 01/01/18. Revised criteria in the Medical Policy Statement and Limitations sections (designating service experimental and investigational for the treatment of urinary incontinence and/or fecal incontinence). Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, Clinical Background Information, References, and Other Applicable Policies sections. Plan notes updated in the Applicable Coding section and revised code list; diagnosis codes added for fecal incontinence and applicable procedure codes considered experimental and investigational for specified indications.	01/01/18 Version 16	10/18/17: MPCTAC
10/01/18	Review for effective date 11/01/18. Administrative changes made to the Policy Summary, References, and Other Applicable Policies sections. Administrative change made to the Applicable Coding section (using ICD-10 diagnosis code range rather than individual diagnosis codes without changing the code list).	11/01/18 Version 17	10/17/18: MPCTAC
12/01/18	Review for effective date 03/01/19. Revised the policy title. Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, and References sections. Criteria updated in the Medical Policy Statement and Limitations sections. Revised the diagnosis	03/01/19 Version 18	12/19/18: MPCTAC

	codes and Plan notes in the Applicable Coding section.		
07/01/19	Review for effective date 08/01/19. Updated the Plan notes in the Applicable Coding section.	08/01/19 Version 19	07/17/19: MPCTAC
09/01/19	Review for effective date 10/01/19. Administrative changes made to the Other Applicable Policies, References, and Reference to Applicable Laws and Regulations sections.	10/01/19 Version 20	09/18/19: MPCTAC
09/01/20	Review for effective date 10/01/20. Administrative changes made to the References and Other Applicable Policies sections.	10/01/20 Version 21	09/16/20: MPCTAC
05/01/21	Review for effective date 06/01/21. Plan note revised in the Applicable Coding section. Administrative changes made to the Policy Summary, Description of Item or Service, Medical Policy Statement, and Limitations sections.	06/01/21 Version 22	05/19/21: MPCTAC
10/01/21	Review for effective date 11/01/21. Adopted new medical policy template; removed administrative sections and the Medical Policy Statement section renamed the Clinical Criteria section. Added NH Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Applicable Coding, and References sections. Removed the Limitations section.	11/01/21 Version 23	10/20/21: MPCTAC
08/01/22	Review for effective date 09/01/22. Administrative changes made to the Clinical Criteria and References sections.	09/01/22 Version 24	08/26/22: MPCTAC (electronic vote)
08/01/22	Review for policy retired date 11/01/22. Administrative changes made to the Policy Summary and Applicable Coding sections. Medical policy criteria revised in the Clinical Criteria and Limitations and Exclusions sections. Service will be managed by AIM Specialty Health as of 11/01/22 with AIM prior authorization required.	11/01/22 Version 25	08/26/22: MPCTAC (electronic vote)

Medical Policy – Policy with InterQual Criteria Retired and AIM Criteria Adopted as of 11/01/22

Physical Therapy in the Outpatient Setting

Policy Number: OCA 3.544
Version Number: 25
Policy Retired Date: 11/01/22

Impacted Products

- ☐ **All Products**
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☐ MA MassHealth ACO
- ☐ MA MassHealth MCO
- ☐ MA Qualified Health Plans/Employer Choice Direct
- ☐ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers outpatient physical therapy (PT) medically necessary, including habilitative services and/or rehabilitative services, when AIM clinical appropriateness guidelines are met for an adult or pediatric member or are required EPSDT services for a member age 20 or younger on the date of service. Prior authorization from AIM Specialty Health is required for outpatient PT after the initial evaluation. PT must be provided within the scope of practice of the treating professional and/or paraprofessional and follow all applicable state licensing and supervisory requirements.

Clinical Criteria

No medical policy criteria.

Limitations and Exclusions

None.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for NH Medicare Advantage members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's

most recent policy review, no applicable clinical guidelines were found from CMS. Verify CMS criteria in effect for the requested service on the date of the prior authorization request for a SCO or NH Medicare Advantage HMO member. When there is no guidance from CMS for the requested service for the specified indication on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. The list of applicable codes included in this policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization from AIM for physical therapy, even if an applicable code appropriately describing the service is not included in this policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Codes	Code Descriptions
97010	Application of a modality to 1 or more areas; hot or cold packs
97012	Application of a modality to 1 or more areas; traction, mechanical
97014	Application of a modality to 1 or more areas; electrical stimulation (unattended)
97016	Application of a modality to 1 or more areas; vasopneumatic devices
97018	Application of a modality to 1 or more areas; paraffin bath
97022	Application of a modality to 1 or more areas; whirlpool
97024	Application of a modality to 1 or more areas; diathermy (e.g., microwave)
97026	Application of a modality to 1 or more areas; infrared
97028	Application of a modality to 1 or more areas; ultraviolet
97032	Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes
97033	Application of a modality to 1 or more areas; iontophoresis, each 15 minutes
97034	Application of a modality to 1 or more areas; contrast baths, each 15 minutes
97035	Application of a modality to 1 or more areas; ultrasound, each 15 minutes
97036	Application of a modality to 1 or more areas; Hubbard tank, each 15 minutes
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97113	Therapeutic procedure, 1 or more areas, each 15 minutes; aquatic therapy with therapeutic exercises
97116	Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing)

97124	Therapeutic procedure, 1 or more areas, each 15 minutes; massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)
97140	Manual therapy techniques (e.g., mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals)
97164	Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family.
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
97533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
97535	Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes
97537	Community/work reintegration training (e.g., shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes
97545	Work hardening/conditioning; initial 2 hours
97546	Work hardening/conditioning; each additional hour (List separately in addition to code for primary procedure)
97750	Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes
97755	Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes

97761	Prosthetic training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes

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Next Review Date

Not applicable

Retired Date

11/01/22

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:
Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 09/16/05	09/16/05 Version 1	Director of Medical Policy as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	Quality and Clinical Management Committee (Q&CMC)

*Effective Date for NH Medicaid Product: 01/01/13
*Effective Date for NH Medicare Advantage HMO Product: 01/01/22

Physical Therapy policy renumbered OCA 3.544 for physical therapy provided to NH Medicaid members age 21 or older in the outpatient setting as of 01/11/15. (Policy formerly numbered OCA 3.54 for physical therapy in the outpatient setting for all adult and pediatric NH Medicaid members from 01/01/13 to 01/10/15.) Policy title changed to *Physical Therapy in the Outpatient Setting* as of 12/01/21.

Policy retired and service managed by AIM Specialty Health as of 11/01/22.

Policy Revisions History

Review Date	Summary of Revisions	Revision Effective Date and Version Number	Approved by
02/07/06	Added definitions for modality and visit. Defined coverage for visits, evaluations and units billed.	Version 2	02/07/06: Q&CMC
07/06/06	Removed verbiage regarding reimbursement for evaluation and modality services.	Version 3	07/06/06: Q&CMC
03/27/07	Policy archived.	Not applicable	Not specified
10/14/08	Reviewed policy and updated clinical criteria, effective date of the revised policy is 12/16/08.	12/16/08 Version 4	11/10/08: MPTAC 12/16/08: Quality Improvement Committee (QIC)
09/22/09	No changes.	Version 5	09/22/09: MPCTAC 10/28/09: QIC
10/01/10	Updated template and references.	Version 6	10/20/10: MPCTAC 11/22/10: QIC
10/01/11	Added Commercial benefit limitations, updated coding and references.	Version 7	10/19/11: MPCTAC 11/29/11: QIC
08/01/12	Off cycle review for WellSense New Hampshire Medicaid product, revised Summary statement, reformatted Medical Policy Statement, revised	Version 8	08/13/12: MPCTAC 09/06/12: QIC

	Applicable Coding introductory paragraph, updated code list, revised Limitations section, and revised references.		
11/01/12	Review for effective date 03/01/13. Updated references. Revised Summary section. Clarified text in Medical Policy Statement section. Revised language in introductory paragraph in Applicable Coding section and updated applicable code list. Clinical criteria moved from Clinical Background and Summary sections to Medical Policy Statement section. Moved services not considered medically necessary from the Medical Policy Statement section to the Limitations section. Removed duplicate text from Clinical Background Information section. Referenced Plan reimbursement policy 4.609 for physical therapy reimbursement guidelines. Removed "Guideline" from title.	03/01/13 Version 9	11/21/12: MPCTAC 12/20/12: QIC
08/14/13 and 08/15/13:	Off cycle review for the NH Medicaid product and merged policy format. Incorporate policy revisions dated 11/01/12 (as specified above) for the NH Medicaid product; these policy revisions were approved by MPCTAC on 11/21/12 and QIC on 12/20/12 for applicable Plan products.	Version 10	08/14/13: MPCTAC (electronic vote) 08/15/13: QIC
11/01/13, 12/01/13, 01/01/14, and 02/01/14	Review for effective date 05/01/14. Updated code definitions, introductory paragraph in Applicable Coding section, and the applicable code lists for the MA products and the NH Medicaid product. Updated references. Removed prior authorization waiver for the first 32 units of PT for the NH Medicaid product. Add criterion in the Medical Policy Statement sections for the MA products and NH Medicaid product requiring an updated physician prescription and supporting clinical documentation after 20 OT visits per treatment episode. Revised Limitations sections.	05/01/14 Version 11	02/11/14: MPCTAC 02/18/14: QIC
09/08/14	For NH Medicaid product only, waived prior authorization of first eight (8) 15-minute treatment units per member per servicing provider per calendar year.	10/01/14 Version 11 Addendum A	09/17/14: MPCTAC 09/30/14: QIC
11/04/14 and 11/19/14	Review for effective date 01/11/15. Summary and Medical Policy Statement sections updated with guidelines specified in version 11, addendum A. Policy renumbered OCA 3.544 to include physical therapy in the outpatient setting for NH	01/11/15 Version 12	11/06/14: MPCTAC (electronic vote) 11/11/14: QIC (electronic vote) 11/19/14: MPCTAC

	Medicaid members age 21 or older on the date of service. Revised Limitations section. (PT services formerly included in policy number OCA 3.54 for all adult and pediatric members.) Revised review calendar.		12/10/14: QIC
11/01/15	Review for effective date 01/01/16. Updated template, Summary section, and References section. Administrative changes made to the Medical Policy Statement and Limitations section without changing criteria. Revised language in the Applicable Coding section. Added definitions.	01/01/16 Version 13	12/03/15: MPCTAC (electronic vote) 12/09/15: QIC
12/01/16	Review for effective date 02/01/17. Industry-wide revisions of applicable codes. Clarified existing criteria in the Medical Policy Statement section.	02/01/17 Version 14	12/21/16: MPCTAC 01/11/17: QIC
12/01/17	Review for effective 01/01/18. Industry-wide updates to codes included in the Applicable Coding section. Annual review of policy with administrative changes made to the Definitions and Reference sections.	01/01/18 Version 15	12/20/17: MPCTAC
02/01/18	Review for effective date 03/01/18. Administrative changes made to the Policy Summary and Limitations sections.	03/01/18 Version 16	02/21/18: MPCTAC
11/01/18	Review for effective date 12/01/18. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, Definitions, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.	12/01/18 Version 17	11/21/18: MPCTAC
03/01/19	Review for effective date 07/01/19. Administrative changes made to the Limitations and Reference to Applicable Laws and Regulations sections. Criteria revised in the Medical Policy Statement section.	07/01/19 Version 18	03/20/19: MPCTAC
12/01/19	Review for effective date 01/01/20. Industry-wide updates to codes included in the Applicable Coding section.	01/01/20 Version 19	Not applicable because industry-wide code changes
11/01/19	Review for effective date 02/01/20. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections. Revised criteria in the Medical Policy Statement and Limitations sections.	02/01/20 Version 20 Renumbered to version 20 to implement industry-wide code updates effective	11/20/19: MPCTAC

		01/01/20 included in version 19	
12/01/19	Review for effective 02/01/20. Industry-wide updates to codes effective 01/01/20 included in the Applicable Coding section of the policy version 20 effective 02/01/20.	02/01/20 Version 21	12/18/19: MPCTAC
12/01/19	Review for effective date 03/01/20. Revised in the Medical Policy Statement section the definition of a servicing PT provider for the prior authorization waiver.	03/01/20 Version 22	12/18/19: MPCTAC
11/01/20	Review for effective date 12/01/20. Updated the References section. Administrative change made to the Applicable Coding section.	12/01/20 Version 23	11/18/20: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and Limitations section renamed Limitations and Exclusions section. Administrative changes made to the Policy Summary, Applicable Coding, and References sections. Medical policy criteria retired and InterQual criteria will continue to be used to determine the medical necessity of services. Revised policy title because policy applies to adult and pediatric members as of 12/01/21.	12/01/21 Version 24	11/17/21: MPCTAC
08/01/22	Review for policy retired date 11/01/22. Administrative changes made to the Policy Summary and Applicable Coding sections. InterQual medical necessity criteria and medical policy guidelines in the Clinical Criteria and Limitations and Exclusions sections retired on 11/01/22. AIM criteria adopted for outpatient PT on 11/01/22. Plan prior authorization waivers removed after 10/31/22. AIM prior authorization is required for outpatient PT after the initial evaluation as of 11/01/22, even when applicable codes are not listed in this Plan policy.	11/01/22 Version 25	08/26/22: MPCTAC (electronic vote)

Medical Policy

Posterior Tibial Nerve Stimulation (Percutaneous or Transcutaneous)

Policy Number: OCA 3.562
Version Number: 21
Version Effective Date: 11/01/22

Impacted Products

- ☒ **All Products**
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☒ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

Posterior tibial nerve stimulation may include percutaneous tibial nerve stimulation (PTNS) and/or transcutaneous posterior tibial nerve stimulation (TPTNS, also known as transcutaneous electrical nerve stimulation/TENS). The Plan considers PTNS medically necessary for the treatment of non-neurogenic overactive bladder syndrome in adult members when Plan criteria are met. Plan prior authorization is required.

AIM clinical appropriateness criteria will be used to determine the medical necessity of therapeutic electrical stimulation (TENS) as part of a therapy plan of care. Prior authorization from AIM Specialty Health is required.

Clinical Criteria

The Plan will NOT approve more than 6 sessions of PTNS per prior authorization request. Criteria must be met in either item A (medical necessity criteria) or item B (Medical Director review required):

A. ALL criteria in items 1 through 8 must be met for PTNS:

1. Member is age 18 or older on the date of service; AND

2. Member is diagnosed with non-neurogenic overactive bladder (OAB) syndrome and the member has NOT received a course of treatment with PTNS sessions in the past for the treatment of OAB symptoms; AND

3. Member has consistently attempted for at least 8 to 12 weeks ALL behavioral therapies listed in items a through d but these conservative treatments have failed to manage member's symptoms of OAB:

    a. Bladder training; AND

    b. Bladder control strategies; AND

    c. Pelvic floor muscle training; AND

    d. Fluid management; AND

4. Member has failed second-line therapy with a trial of at least 2 anticholinergic agents (antimuscarinics) and Myrbetrig® (mirabegron), with each administered for a minimum of 4 weeks to treat the member's symptoms of OAB syndrome, unless this pharmacotherapy is NOT tolerated or is contraindicated for the member; AND

5. Device requested is FDA approved for the intended use; AND

6. Member does NOT have an implanted or planned implantation of a sacral nerve neurostimulator; AND

7. Each PTNS session will be 30 minutes in duration; AND

8. Member's first course of treatment is defined as first-time use of PTNS to treat one (1) or more urological symptoms per member regardless of treating provider and date of service. The Plan will authorize PTNS sessions ONLY when it is the member's first course of treatment with PTNS and ONE (1) of the applicable treatment frequency criteria in items a through c must be met:

    a. **6 Initial PTNS Sessions for First Course of Treatment**:

    BOTH criteria must be met in items (1) and item (2):

    (1) Treating provider will be objectively documenting the degree of improvement (e.g., member voiding diaries) of the member's symptoms after each PTNS session; AND

(2) Each of the 6 initial PTNS sessions will occur once a week for 6 consecutive weeks; OR

b. **PTNS Sessions Number 7 Through 12 for First Course of Treatment**:

BOTH criteria must be met in item (1) and item (2):

(1) Treating provider has objectively documented the degree of improvement (e.g., member voiding diaries) of the member's symptoms after each of the initial sessions 1 through 6 and will continue to objectively document improvement after each of the PTNS sessions number 7 through 12; AND

(2) Each of PTNS sessions number 7 through 12 will occur once a week for ALL consecutive weeks; OR

c. **PTNS After 12 Sessions for First Course of Treatment**

ALL criteria must be met in items (1) through (3): ∞

(1) Additional PTNS sessions will occur no more frequently than monthly for the first 6 months of treatment (with the first 6 months of treatment defined as 6 consecutive calendar months from the date of the initial PTNS session for the member regardless of treating provider); AND

(2) Treating provider has objectively documented (e.g., member voiding diaries) that the member has consistently experienced 50% or greater improvement in voiding symptoms for at least 48 hours after each PTNS session – if this improvement threshold is not met or not documented, the PTNS treatment will be immediately discontinued (even if additional PTNS sessions are authorized by the Plan); AND

(3) PTNS sessions do not exceed 6 consecutive calendar months from the initial PTNS session for the member (regardless of treating provider). ∞

B. Plan Medical Director review is required for ANY condition listed in items 1 through 3:

1. Request for PTNS after 12 sessions when that the member has NOT experienced 50% or greater improvement in voiding symptoms for at least 48 hours; the efficacy of continued treatment with PTNS has NOT been established if the initial 12-week course of PTNS has failed to adequately manage the member's urological symptoms; OR

2. Request for PTNS for a member whose sessions will exceed 6 consecutive calendar months from the member's initial PTNS session (regardless of treating provider and dates of service) to determine if PTNS remains the most effective treatment option for the member (rather than

first-line therapy or a long-term treatment option such as implantable sacral nerve stimulation which has greater accuracy because the sacral nerve is directly stimulated); OR

3. Request for PTNS sessions more frequently than once a week.

Limitations and Exclusions

Contraindications for PTNS include ANY of the following conditions listed in items 1 through 7:

1. Neurogenic overactive bladder syndrome/neurogenic lower urinary tract dysfunction; OR
2. Pacemaker or implantable defibrillator; OR
3. Prone to excessive bleeding; OR
4. Nerve damage that could impact either percutaneous tibial nerve or pelvic floor function; OR
5. Pregnant or planning to become pregnant during the duration of the treatment; OR
6. Active infection in the area of the percutaneous puncture; OR
7. Unable to tolerate needle stick (e.g., phobia to needles).

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and NH Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, no NCD was found. LCD L33396 includes medical necessity criteria for posterior tibial nerve stimulation for voiding dysfunction. Verify CMS guidelines in effect on the date of the prior authorization request. When there is no guidance from CMS for the requested service, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. Since these codes may be updated at different intervals than the medical policy review cycle, the list of applicable codes included in a policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan

billing guidelines. Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of a medical policy, even if an applicable code appropriately describing the service is not included in the policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Code	Description: Code Considered Medically Necessary for PTNS for Non-Neurogenic Overactive Bladder Syndrome
64566	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming

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Next Review Date

09/01/22

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:
Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 10/03/06	12/03/06 Version 1	Director of Medical Policy as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	Quality and Clinical Management Committee (Q&CMC)

*Effective Date for QHP Commercial Product: 01/01/12
*Effective Date for New Hampshire Medicaid Product: 01/01/13
*Effective Date for Senior Care Options Product: 01/01/16
*Effective Date for NH Medicare Advantage HMO Product: 01/01/22

Notes: Effective 05/01/13, this policy replaced the P*elvic Floor/Sacral Nerve Stimulation for Urinary Incontinence* policy, policy number OCA: 3.56, for a service-specific policy for posterior tibial nerve stimulation. Policy title was *Posterior Tibial Nerve Stimulation* from 05/01/13 to 12/31/18. Effective 01/01/19, policy title changed to *Posterior Tibial Nerve Stimulation (Percutaneous or Transcutaneous)*.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
09/11/07	Updated template and added coding.	Version 2	09/11/07: MPCTAC 09/25/07: Utilization Management Committee (UMC) 10/15/07: Quality Improvement Committee (QIC)
09/09/08	No changes.	Version 3	09/09/08: MPCTAC 09/30/08: UMC 10/22/08: QIC
09/22/09	Updated references, no changes to criteria.	Version 4	09/22/09: MPCTAC 10/28/09: QIC
09/01/10	Updated template and references. No changes to criteria.	Version 5	10/20/10: MPCTAC 11/22/10: QIC
10/01/11	Updated limitations to include that sacral nerve stimulation for the treatment of fecal incontinence and posterior tibial nerve	Version 6	10/19/11: MPCTAC 11/29/11: QIC

	stimulation for the treatment of symptoms associated with overactive bladder are considered experimental and investigational. Updated references and coding.		
07/20/12	Off cycle review for Well Sense Health Plan: Updated title, revised Summary statement, added posterior tibial stimulation to Description of Item or Service, reformatted Medical Policy Statement, updated Definitions, revised language in Applicable Coding section, updated code list.	Version 7	08/13/12: MPCTAC 09/13/12: QIC
12/01/12	Review for effective date 05/01/13. Separated pelvic floor electrical stimulation, sacral nerve stimulation, and posterior tibial nerve stimulation into three separate policies; policy formerly titled *Pelvic Floor/Sacral Nerve Stimulation for Urinary Incontinence* (formerly policy number OCA: 3.65). Revised title and re-numbered policy. Updated language in Summary, Description of Item or Service, Medical Policy Statement, Definitions, Applicable Coding, and Clinical Background Information sections. Updated references and revised limitations. Revised applicable code list. Referenced the following policies: *Experimental and Investigational Treatment*, *Non-Implantable Pelvic Floor Electrical Stimulation for Urinary Incontinence*, *Sacral Nerve Stimulation (Including Peripheral Nerve Stimulation Test and Two-Stage Tined Lead Procedure) for Incontinence and Urinary Conditions,* and *Biofeedback for Urinary Incontinence*.	05/01/13 Version 8	12/19/12: MPCTAC 01/31/13: QIC
12/01/13	Review for effective date 02/01/14. Updated references.	02/01/14 Version 9	12/18/13: MPCTAC 01/21/14: QIC
12/01/14	Review for effective date 02/01/15. Updated references.	02/01/15 Version 10	12/17/14: MPCTAC 01/14/15: QIC
10/01/15	Review for effective date 12/01/15. Updated list of applicable products and corresponding notes. Updated Clinical Background Information and References sections.	12/01/15 Version 11	10/21/15: MPCTAC 11/11/15: QIC
11/25/15	Review for effective date 01/01/16. Revised language in the Applicable Coding section.	01/01/16 Version 12	11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
10/01/16	Review for effective date 12/01/16. Administrative changes made to the Summary, Medical Policy Statement, Definitions, Clinical	12/01/16 Version 13	10/19/16: MPCTAC 11/09/16: QIC

	Background Information, References, and References to Applicable Laws and Regulations sections. No change to criteria or the applicable code list.		
10/01/17	Review for effective date 11/01/17. Administrative changes made to the Policy Summary, Description of Item or Service, Limitations, Definitions, Clinical Background Information, References, and Other Applicable Policies sections. Percutaneous tibial nerve stimulation (PTNS) remains an experimental and investigational treatment.	11/01/17 Version 14	10/18/17: MPCTAC
10/01/18	Review for effective date 01/01/19. Revised policy title. Administrative changes made to the Policy Summary, Description of Item or Service, Definitions, Clinical Background Information, References, and Other Applicable Policies sections. Criteria revised in the Medical Policy Statement and Limitations sections (designating PTNS as medically necessary when applicable criteria are met and listing TPTNS as an experimental and investigational service). Revised code list in the Applicable Coding section.	01/01/19 Version 15	10/17/18: MPCTAC
12/01/18	Review for effective date 03/01/19. Revised the code list (including industry-wide code update) and Plan notes in the Applicable Coding section.	03/01/19 Version 16	12/19/18: MPCTAC
09/01/19	Review for effective date 12/01/19. Administrative changes made to the Other Applicable Policies, References, and Reference to Applicable Laws and Regulations sections. Administrative change made to the Plan notes in the Applicable Coding section. Revised criteria in the Limitations section.	12/01/19 Version 17	09/18/19: MPCTAC
09/01/20	Review for effective date 10/01/20. Administrative changes made to the References and Other Applicable Policies sections.	10/01/20 Version 18	09/16/20: MPCTAC
05/01/21	Review for effective date 06/01/21. Administrative changes made to the Applicable Coding and References sections.	06/01/21 Version 19	05/19/21: MPCTAC
10/01/21	Review for effective date 11/01/21. Adopted new medical policy template; removed administrative sections and the Medical Policy Statement section renamed the Clinical Criteria section, and the Limitations section renamed	11/01/21 Version 20	10/20/21: MPCTAC

	Limitations and Exclusions section. Added NH Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections.		
08/01/22	Review for effective date 11/01/22. Removed codes considered experimental and investigational for PTNS and made administrative changes to the language in the Applicable Coding section. Administrative changes made to the Policy Summary, Clinical Criteria, and Limitations and Exclusions sections.	11/01/22 Version 21	08/26/22: MPCTAC (electronic vote)

Medical Policy – Policy Retired and AIM Criteria Adopted as of 11/01/22

Sacroiliac Joint Injections

Policy Number: OCA 3.9642
Version Number: 22
Policy Retired Date: 11/01/22

Impacted Products

- ☒ **All Products**
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☒ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers diagnostic or therapeutic sacroiliac joint (SIJ) injections to be medically necessary when AIM clinical appropriateness guidelines are met. Prior authorization from AIM Specialty Health is required.

Clinical Criteria

No medical policy criteria.

Limitations and Exclusions

None.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and NH Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, no guidelines were found for sacroiliac joint injections. Verify CMS criteria in effect for the requested service on the date of the prior authorization request for a SCO or NH Medicare Advantage HMO member. When there is no

guidance from CMS for the requested service for the specified indication on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. The list of applicable codes included in this policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization from AIM for this service, even if an applicable code appropriately describing the service is not included in the policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Code	**Code Description**
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed Plan notes: This code should only be used for the professional component of the service. Code 27096 is a unilateral procedure; for bilateral procedure, use modifier 50.
HCPCS Code	**Code Description**
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography Plan notes: This code should only be used for the technical component of the service. Code is NOT payable for the MassHealth or Qualified Health Plan products.

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Next Review Date

Not applicable

Retired Date

11/01/22

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date*	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 06/10/08: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 06/24/08: Utilization Management Committee (UMC) 08/13/08: Quality Improvement Committee (QIC)	11/01/08 Version 1	Medical Policy Manager as Chair of MPCTAC	MPCTAC , UMC, and QIC

*Effective Date for the QHP Commercial Product: 01/01/12
*Effective Date for the New Hampshire Medicaid Product: 01/01/13
*Effective Date for the Senior Care Options Product: 01/01/16
*Effective Date for the New Hampshire Medicare Advantage HMO Product: 01/01/22

Effective 06/01/13, this policy replaced the *Facet Joint Nerve Injections and Sacroiliac Joint Injections for Chronic Neck Pain and Chronic Back Pain* policy (policy number OCA 3.964) which was effective from 11/01/08 to 05/31/13. Also, see Plan policy, *Facet Joint Nerve Injections for Chronic Back Pain and Chronic Neck Pain* (policy number OCA 3.9641) effective 06/01/13. Policy retired and service managed by AIM Specialty Health as of 11/01/22.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
06/23/09	Changed name of the policy, added additional criteria for SIJ injections and replaced the criteria for radiological findings negative for disc herniation and nerve root compression with: negative physical signs of radiculopathy or radicular pain, including negative straight leg raising or root tension signs, normal neurological examination, absence of signs of radiculopathy on any electrodiagnostic examinations. Updated the diagnostic clinical criteria to allow no more than 2 joint levels bilaterally or 3 joint levels unilaterally in a 7 to 14 day period to determine the origin of the patient's pain. For SIJ injections, no more than 2 procedures may be allowed in a 7 to 14 day period to determine	10/01/09 Version 2	06/23/09: MPCTAC 06/23/09: UMC 07/22/09: QIC

Policy Revisions History			
	the origin of the patient's pain. Updated references and coding sections. Effective date of changes is 10/01/09.		
06/01/10	No changes to criteria. Updated references and coding.	Version 3	06/30/10: MPCTAC 07/28/10: QIC
06/01/11	Updated clinical criteria to clarify that the absence of prior spinal fusion must be at the clinically suspect levels. Updated references.	Version 4	06/29/11: MPCTAC 07/27/11: QIC
07/01/12	Updated references and revised the introductory paragraph in Applicable Coding section. Code descriptions updated but no change to list of applicable codes. Revised policy title and text to specify the policy relates to chronic neck pain and chronic back pain. Added the following additional contraindication for procedures: 'Patient with a malignancy at the injection site.' Clinical criteria updated for facet joint nerve injections and sacroiliac joint injections. Definitions added for radiculopathy and straight leg raise test. For facet joint injections, added symptoms of axial pain and signs of facet disease. For sacroiliac joint injections, added types of tests used for a sacroiliac exam. Added definition of a comprehensive pain management program and referenced the Plan's *Medically Necessary* policy.	Version 5	06/20/12: MPCTAC 07/18/12: MPCTAC 08/22/12: QIC
08/01/12	Off cycle review for NH Medicaid product. No changes.	Version 6	08/13/12: MPCTAC 09/06/12: QIC
12/01/12	Revised sacroiliac joint injection frequency guidelines in Medical Policy Statement section.	Version 7	12/19/12: MPCTAC 12/20/12: QIC
02/01/13	Review for effective date 06/01/13. Separated facet joint nerve injections and sacroiliac joint injections into two separate policies; policy formerly titled *Facet Joint Nerve Injections and Sacroiliac Joint Injections for Chronic Neck Pain and Chronic Back Pain* (formerly policy number OCA 3.964). Revised title and re-numbered policy. Updated language in Summary, Description of Item or Service, and Clinical Background Information sections. Revised applicable code list, and updated references. Deleted definitions for radiculopathy and straight leg raise test in Definition section because not referenced in policy. Added the following definitions: Compression test, Fortin finger test, Gaenslen test, Gillet's test, Patrick test (or Faber maneuver), Piedallu seated flexion test,	06/01/13 Version 8	02/20/13: MPCTAC 03/21/13: QIC

Policy Revisions History			
	and Van Durson standing flexion test. Revised medical criteria in the Medical Policy Statement section (formerly named the Clinical Guideline Statement section).		
08/14/13	Off cycle review for NH Medicaid and merged policy format. Incorporate policy revisions dated 12/01/12 and 02/01/13 (as specified above) for the NH Medicaid product; these policy revisions were approved by MPCTAC (on 12/19/12 and 02/20/13) and QIC (on 12/20/12 and 03/21/13) for applicable Plan products.	Version 9	08/14/13: MPCTAC (electronic vote) 08/15/13: QIC
03/01/14	Review for effective date 07/01/14. Changed policy title from *Sacroiliac Joint Injections for Chronic Low Back Pain* to *Sacroiliac Joint Injections*. Revised Summary and References sections. Revised criteria in the Medical Policy Statement section and the Limitations section. Removed HCPCS code G0259 as an applicable code.	07/01/14 Version 10	03/19/14: MPCTAC 04/16/14: QIC
09/01/14	Review for effective date 11/01/14. Clarified in the Medical Policy Statement section that bilateral injections may be medically necessary for both the diagnostic phase and therapeutic phase when all Plan applicable criteria are met. Updated references.	11/01/14 Version 11	09/17/14: MPCTAC 10/08/14: QIC
02/01/15	Review for effective 06/01/15. Updated Definitions and References sections. Revised criteria in the Medical Policy Statement and Limitations sections. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available.	06/01/15 Version 12	02/27/15: MPCTAC (electronic vote) 03/11/15: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Revised language in the Applicable Coding section.	01/01/16 Version 13	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
02/01/16	Review for effective date 06/01/16. Updated criteria in the Medical Policy Statement section. Administrative changes made to the Applicable Coding section without changing the list of codes. Revised the Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections.	06/01/16 Version 14	02/17/16: MPCTAC 03/09/16: QIC
01/01/17	Review for effective date 05/01/17. Updated criteria in the Medical Policy Statement and Limitations sections. Updated Summary, Clinical	05/01/17 Version 15	01/18/17: MPCTAC 02/08/17: QIC

Policy Revisions History			
	Background Information, and References sections. Plan note added to Applicable Coding section (with no change to the applicable code list).		
02/01/18	Review for effective date 05/01/18. Administrative changes made to the Policy Summary, Limitations References, and Other Applicable Policies sections. Criteria revised in the Medical Policy Statement section.	05/01/18 Version 16	02/21/18: MPCTAC
02/01/19	Review for effective date 03/01/19. Administrative changes made to the Policy Summary, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.	03/01/19 Version 17	02/20/19: MPCTAC
02/01/20	Review for effective date 03/01/20. Administrative changes made to the Limitations, Applicable Coding, References, and Reference to Applicable Laws and Regulations sections.	03/01/20 Version 18	02/19/20: MPCTAC
02/01/21	Review for effective date 03/01/21. Administrative changes made to the References section.	03/01/21 Version 19	02/17/21: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and Limitations section renamed Limitation and Exclusions section. Added NH Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections.	12/01/21 Version 20	11/17/21: MPCTAC
02/01/22	Review for effective date 05/01/22. Administrate changes made to the References section. Updated criteria in the Clinical Criteria section (i.e., added neurological testing as criterion).	05/01/22 Version 21	02/16/22: MPCTAC
08/01/22	Review for policy retired date 11/01/22. Administrative changes made to the Policy Summary and Applicable Coding sections. Criteria revised in the Clinical Criteria and Limitations and Exclusions sections. AIM medical necessity criteria adopted for this service and AIM prior authorization is required as of 11/01/22, even when applicable codes are not listed in this Plan policy.	09/01/22 Version 22	08/26/22: MPCTAC (electronic vote)

Medical Policy – Policy with InterQual Criteria Retired and AIM Criteria Adopted as of 11/01/22

Speech Therapy, Language Therapy, Voice Therapy, or Auditory Rehabilitation in the Outpatient Setting

Policy Number: OCA 3.542
Version Number: 32
Policy Retired Date: 11/01/22

Impacted Products

- ☐ **All Products**
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☐ MA MassHealth ACO
- ☐ MA MassHealth MCO
- ☐ MA Qualified Health Plans/Employer Choice Direct
- ☐ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers outpatient speech therapy (i.e., speech and language therapy, swallowing therapy, feeding therapy, aural or auditory rehabilitation, and/or voice therapy) medically necessary, including habilitative services and/or rehabilitative services, when AIM clinical appropriateness guidelines are met for an adult or pediatric member or are required EPSDT services for a member age 20 or younger on the date of service. Prior authorization from AIM Specialty Health is required for outpatient speech therapy (ST) after the initial evaluation. ST must be provided within the scope of practice of the treating professional and/or paraprofessional and follow all applicable state licensing and supervisory requirements.

Clinical Criteria

No medical policy criteria.

Limitations and Exclusions

None.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Plan's New Hampshire Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, no applicable clinical guidelines were found from CMS. Verify CMS criteria in effect for the requested service on the date of the prior authorization request for a NH Medicare Advantage HMO member. When there is no guidance from CMS for the requested service for the specified indication on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. The list of applicable codes included in this policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization from AIM for speech therapy, even if an applicable code appropriately describing the service is not included in this policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

CPT Codes	Code Descriptions
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, two or more individuals
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92606	Therapeutic services for use of non-speech-generating device with programming
92609	Therapeutic services for use of speech-generating device with programming
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes
97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (List separately in addition to code for primary procedure)

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Next Review Date

Not applicable

Retired Date

11/01/22

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 03/16/11: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 04/27/11: Quality Improvement Committee (QIC)	07/01/11 Version 1	Director of Medical Policy as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC)	MPCTAC and QIC

* Effective Date for NH Medicaid Product: 01/01/13
* Effective Date for NH Medicare Advantage HMO Product: 01/01/22

Policy retired and service managed by AIM Specialty Health as of 11/01/22.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
03/19/12	Updated references.	Version 2	03/21/12: MPCTAC 04/25/12: QIC
08/01/12	Off cycle review. Revised Summary statement, reformatted Medical Policy Statement, revised Applicable Coding introductory paragraph, updated code list, revised Limitations, and updated references.	Version 3	08/13/12: MPCTAC 09/06/12: QIC
11/01/12	Review for effective date 03/01/13. Updated references. Revised title so policy applies to members age 22 or older (rather than members over the age of 21). Added language in Summary section to clarify text. Referenced Plan reimbursement policy 4.609 for therapy reimbursement guidelines. Reorganized clinical criteria in Medical Policy Statement section and referenced InterQual® criteria. Revised applicable code list.	03/01/13 Version 4	11/21/12: MPCTAC 12/20/12: QIC
08/14/13 and 08/15/13	Off cycle review. Incorporate policy revisions dated 11/01/12 (as specified above) for the Well Sense Health Plan product; these policy revisions were approved by MPCTAC on		08/14/13: MPCTAC (via electronic vote) 08/15/13: QIC

	11/21/12 and QIC on 12/20/12 for applicable Plan products. Additional review of policy conducted.		
11/01/13, 12/01/13, 01/01/14, and 02/01/14	Review for effective date 05/01/14. Revised Applicable Coding section by updating code definitions and Plan notes, introductory paragraph, and applicable codes for the Massachusetts and New Hampshire products. Reformatted Limitations section without changing criteria. Updated references.	05/01/14 Version 5	02/11/14: MPCTAC 02/18/14: QIC
09/08/14	For New Hampshire products only, waive prior authorization of first 2 treatment sessions per member per servicing provider per calendar year.	10/01/14 Version 11 Addendum A	09/17/14: MPCTAC 09/30/14: QIC
11/04/14 and 11/19/14	Review for effective date 01/11/15. Summary and Medical Policy Statement sections updated with guidelines specified in version 11, addendum A. Policy renumbered OCA 3.542 to include speech therapy (and associated therapies) for members age 21 or older in the outpatient setting for Well Sense Health Plan members. Revised language in the Applicable Coding section without changing the applicable code list. Age range changed from age 22 or older to age 21 or older for adult Well Sense members; ST services for adult members formerly in policy number OCA 3.551. Revised review calendar.	01/11/15 Version 12	11/06/14: MPCTAC (electronic vote) 11/11/14: QIC (electronic vote) 11/19/14: MPCTAC 12/10/14: QIC
12/03/15	Review for effective date 01/01/16. Updated template and Summary section. Administrative changes made to the Medical Policy Statement and Limitations sections without changing criteria. Revised language in the Applicable Coding section. Added definitions.	01/01/16 Version 13	12/03/15: MPCTAC (electronic vote) 12/09/15: QIC
12/01/16	Review for effective date 02/01/17. Clarified existing criteria in the Medical Policy Statement section. Updated references.	02/01/17 Version 14	12/21/16: MPCTAC 01/11/17: QIC
05/01/17	Review for effective date 08/01/17. Removed CPT code 92524 from the applicable code list because it is an initial evaluation code for voice and resonance.	08/01/17 Version 15	05/17/17: MPCTAC
12/01/17	Review for effective date 01/01/17. Updated Policy Summary section.	01/01/17 Version 16	12/20/17: MPCTAC
12/01/17	Review for effective date 01/01/18. Industry-wide updates to codes included in the Applicable Coding section. Annual review of	01/01/18 Version 17	12/20/17: MPCTAC

	policy with administrative changes made to the Medical Policy Statement, Definitions, and Reference sections.		
02/01/18	Review for effective date 03/01/18. Administrative changes made to the Policy Summary and Limitations sections.	03/01/18 Version 18	02/21/18: MPCTAC
11/01/18	Review for effective date 12/01/18. Administrative changes made to the Limitations, Definitions, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.	12/01/18 Version 19	11/21/18: MPCTAC
03/01/19	Review for effective date 07/01/19. Administrative changes made to the Limitations and Reference to Applicable Laws and Regulations sections. Criteria revised in the Medical Policy Statement section.	07/01/19 Version 20	03/20/19: MPCTAC
05/01/19	Review for effective date 08/01/19. Revised criteria in the Medical Policy Statement section. Administrative changes made to the References and Reference to Applicable Laws and Regulations sections.	05/15/19 Version 21	05/15/19: MPCTAC
12/01/19	Review for effective date 01/01/20. Industry-wide code deletion required revision to coding in the Applicable Coding section.	01/01/20 Version 22	Not applicable because industry-wide code changes.
11/01/19	Review for effective date 02/01/20. Administrative changes made to the Policy Summary, References and Reference to Applicable Laws and Regulations sections. Criteria revised in the Medical Policy Statement and Limitations sections.	02/01/20 Version 23 Renumbered to version 23 to implement industry-wide code updates effective 01/01/20 in version 22.	11/20/19: MPCTAC
12/01/19	Review for effective 02/01/20. Industry-wide code deletion required revision to coding in the Applicable Coding section of the policy version 23 effective 02/01/20.	02/01/20 Version 24	Not applicable because industry-wide code changes.
12/01/19	Review for effective date 03/01/20. Revised in the Medical Policy Statement section the definition of a servicing ST provider for the prior authorization waiver.	03/01/20 Version 25	12/18/19: MPCTAC
11/01/20	Review for effective date 02/01/21. Administrative changes made to the Definitions, Applicable Coding, and References sections.	02/01/21 Version 26	11/18/20: MPCTAC

	Revised criteria in the Medical Policy Statement section.		
05/01/21	Review for effective date 08/01/21. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, Definitions, and References sections. Codes added to the Applicable Coding section.	08/01/21 Version 27	05/19/21: MPCTAC
10/01/21	Review for effective date 01/01/22 Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and Limitations section renamed Limitations and Exclusions section. Administrative changes made to the Policy Summary, Limitations and Exclusions, Applicable Coding, and References sections. Added New Hampshire Medicare Advantage HMO as an applicable product effective 01/01/22. Added gender dysphoria as a medically necessary indication for voice therapy in the Criteria section.	01/01/22 Version 28	10/20/21: MPCTAC
02/01/22	Review for effective date 02/01/22. Administrative changes made to the Policy Summary. Revised policy title because policy will apply to adult and pediatric members. Adopted InterQual criteria to determine medical necessity and retired medical policy criteria. Gender dysphoria specified as a medically necessary indication for voice therapy in the *Gender Affirmation Services* medical policy, OCA 3.11, as of 01/01/22.	02/01/22 Version 29	11/17/21: MPCTAC
05/01/22	Review for effective date 06/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, and Applicable Coding sections.	06/01/22 Version 30	05/11/22: MPCTAC (electronic vote)
05/01/22	Review for effective date 08/01/22. Revised code list in the Applicable Coding section.	08/01/22 Version 31	05/11/22: MPCTAC
08/01/22	Review for policy retired date 11/01/22. Administrative changes made to the Policy Summary and Applicable Coding sections. InterQual medical necessity criteria and medical policy guidelines in the Clinical Criteria and Limitations and Exclusions sections retired on 11/01/22. AIM criteria adopted for outpatient ST on 11/01/22. Plan prior authorization waivers	11/01/22 Version 32	08/26/22: MPCTAC (electronic vote)

	removed after 10/31/22. AIM prior authorization is required for outpatient ST after the initial evaluation as of 11/01/22, even when applicable codes are not listed in this Plan policy.		

Medical Policy

Temporomandibular Joint Disorder Treatment

Policy Number: OCA 3.968
Version Number: 22
Version Effective Date: 11/01/22

Impacted Products

- ☒ **All Products**
- ☒ NH Medicaid
- ☒ NH Medicare Advantage
- ☒ MA MassHealth ACO
- ☒ MA MassHealth MCO
- ☒ MA Qualified Health Plans/Employer Choice Direct
- ☒ MA Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers medical and/or surgical (non-dental) treatment of a temporomandibular joint (TMJ) disorders to be medically necessary ONLY when the disorders are caused by, or results from a specific medical condition. Examples of specific medical conditions include jaw fractures and/or dislocations and degenerative arthritis. Plan prior authorization is required. Separate coverage is outlined in the member's benefit documents for dental services (if dental services are covered for the Plan member). This medical policy ONLY includes guidelines for TMJ disorders related to a medical condition for medical and/or surgical (non-dental) treatment.

Effective 11/01/22, the Plan uses AIM clinical appropriateness guidelines to determine the medical necessity of radiology services, musculoskeletal services (i.e., spine surgeries, joint surgeries, and interventional pain management treatments), genetic testing, and outpatient rehabilitation services (i.e., physical therapy, occupational therapy, and speech therapy). Prior authorization from AIM Specialty Health is required for these services.

Clinical Criteria

Criteria must be met in item A (medical necessity criteria) or item B (services that require Plan Medical Director review):

A. Criteria must be met in either item 1 or item 2:

1. Initial Medical Evaluation: Prior authorization is REQUIRED for the initial medical evaluation for a TMJ disorder ONLY when conducted by a provider who is NOT a participating oral and maxillofacial surgeon or participating otolaryngologist; OR

2. Treatment after the Initial Evaluation: All medical and/or surgical treatments for TMJ disorders REQUIRE prior authorization after the initial medical evaluation. ALL criteria must be met in items a through c:

    a. Medical condition eligible for treatment includes ANY of the following:

        (1) Jaw fracture or jaw dislocation (i.e., current fracture or acute dislocation); OR

        (2) Degenerative arthritis; AND

    b. Medical condition is confirmed by diagnostic x-rays or other generally accepted diagnostic procedures used to diagnose a jaw fracture, jaw dislocation, and/or degenerative arthritis, including but not limited to a CT scan, MRI, tomogram, or arthrogram; AND

    c. Based on the treatment plan determined by the treating provider, the member requires ANY treatment specified in item (1) or item (2):

        (1) Criteria for Non-Surgical Treatment: Covered first-line, conservative treatment may include diet and behavior modification and ANY combination of treatment listed below in items (a) through (e):

            (a) Pharmacologic therapy such as anti-inflammatory, muscle relaxants, and/or analgesics (according to guidelines included in the Plan's pharmacy policies and fomulary applicable for the member's benefit coverage); OR

            (b) Occupational therapy, speech therapy, and/or physical therapy (according to Plan-adopted medical necessity criteria); OR

            (c) Use of mandibular orthopedic repositioning appliances (MORA); OR

            (d) Therapeutic injections (e.g. local anesthetic or corticosteroids); OR

            (e) Manipulation for reduction of fracture or dislocation; OR

        (2) Criteria for Surgical Treatment: ANY criteria must be met in items (a) through (e):

            (a) Arthrocentesis (e.g., for acute closed lock); OR

            (b) Arthroscopic surgery (e.g., for arthritis); OR

(c) Intraoral vertical ramus osteotomy (IVRO) to correct internal derangements; OR

(d) Open surgical procedure such as open reduction, arthroplasty, condylectomy, meniscus or disc plication, or disc removal; OR

(e) TMJ arthroplasty will be performed with an FDA-approved prosthetic implant (only) according to the FDA-approved indication for the implantation.

B. Medical Director review is required for individual consideration when medical necessity criteria are NOT met and/or the disorder may be caused by a medical condition other than a jaw fracture, jaw dislocation, and/or degenerative arthritis.

Limitations and Exclusions

A. The treatment of TMJ disorders or TMJ syndrome that is NOT related to a medical condition would be considered a dental service rather than a medical benefit.

B. ANY of the following services is considered NOT medically necessary for the assessment and/or treatment of TMJ disorders or other TMJ-related indications:

1. Treatment of a TMJ disorder that is NOT proven to be caused by or to result in a specific medical condition; OR

2. Acupuncture (unless a covered benefit for the member for the specified indication); OR

3. Arthroscopy of the TMJ for diagnostic purposes only; OR

4. Biofeedback; OR

5. Dental or orthodontic services (including restorations, prostheses procedures, radiographic images, oral/facial photographic images, supplies) for TMJ-related indications and/or to adjust the height of teeth or other way restore occlusion, such as crowns, bridges, braces; OR

6. Devices/appliances such as mechanical stretching devices or devices to maintain range of motion, gain increased range of motion, and/or improve functioning of the TMJ, including but not limited to continuous passive motion (CPM) devices, passive rehabilitation therapy devices, mandibular orthopedic repositioning appliances (MORA); OR

7. Dry needling alone or in combination with a stretching regimen used to reduce pain and increase range of motion in patients with TMJ pain; OR

8. Electrical stimulation techniques such as:

a. Electrogalvanic stimulation; OR

b. Microcurrent electrical therapy (MET); OR

c. Percutaneous electrical stimulation (PENS); OR

d. Percutaneous neuromodulation therapy (e.g., the Percutaneous Neuromodulation Therapy™ by Vertis Neurosciences system or the Deepwave® Percutaneous Neuromodulation Pain Therapy System by Biowave Corp.); OR

e. Transcutaneous electrical nerve stimulation (TENS); OR

9. Electromyography (EMG); OR

10. Intra-articular injection of hyaluronic acid (viscosupplementation); OR

11. Iontophoresis using electricity to enhance the percutaneous absorption of a drug or chemical ions (e.g., lidocaine hydrochloride, dexamethasone sodium phosphate); OR

12. Jaw tracking devices, computerized jaw tracking technologies, and associated jaw tracking services using one or more technologies/services (e.g., TENS, 3D imaging/computerized mandibular scans, kinesiography, magnetic recording devices, electronic motion recording methods, and/or range of motion measurements); OR

13. Kinesiography; OR

14. Laser therapy; OR

15. Neuromuscular junction studies, range of motion measurements, and/or muscle testing; OR

16. Phonophoresis using ultrasound to enhance the delivery of topically applied drugs; OR

17. Somatosensory testing (also known as somatosensory evoked potentials test, SEPs, or SSEPs); OR

18. Thermography (including digital infrared thermal imaging, magnetic resonance thermography and temperature gradient studies); OR

19. Transcranial or lateral skull x-rays; OR

20. Ultrasonic Doppler auscultation/ultrasound imaging/sonogram for diagnosing disorders of the temporomandibular joint; OR

21. Use of a TMJ arthroplasty implant or device not FDA approved or not used according to FDA-approved indications.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for the Plan's Senior Care Options (SCO) members and New Hampshire Medicare Advantage HMO members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, no applicable clinical guidelines were found from CMS specifically for temporomandibular joint disorder, but CMS guidelines do exist for services that may be used for the diagnosis or treatment of TMJ. Verify CMS criteria in effect on the date of the prior authorization request. When there is no guidance from CMS for the requested service for the specified indication on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan utilizes up-to-date, industry-standard Current Procedural Terminology (CPT) codes, Health Care Common Procedure Coding System (HCPCS) codes, and International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes in the Plan's medical policies. Since these codes may be updated at different intervals than the medical policy review cycle, the list of applicable codes included in a policy is informational only and may not be all inclusive. Applicable codes are subject to change without prior notification and do not guarantee member coverage or provider reimbursement. Review the Plan's reimbursement policies for Plan billing guidelines. Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of a medical policy, even if an applicable code appropriately describing the service is not included in the policy's Applicable Coding section. Providers are expected to report all services using the most up-to-date, industry-standard procedures and diagnosis codes at the time of the service.

ICD-10 Diagnosis Codes	**Description: Diagnoses Requiring Prior Authorization for Any Treatment** Plan note: The initial medical evaluation does NOT require prior authorization when it is a component of a new patient office visit and conducted by a participating oral and maxillofacial surgeon or participating otolaryngologist and bills with one of the following diagnosis codes.
M26.601	Right temporomandibular joint disorder
M26.602	Left temporomandibular joint disorder
M26.603	Bilateral temporomandibular joint disorder
M26.609	Unspecified temporomandibular joint disorder
M26.611	Adhesions and ankylosis of right temporomandibular joint
M26.612	Adhesions and ankylosis of left temporomandibular joint
M26.613	Adhesions and ankylosis of bilateral temporomandibular joint
M26.619	Adhesions and ankylosis of temporomandibular joint, unspecified side

M26.621	Arthralgia of right temporomandibular joint
M26.622	Arthralgia of left temporomandibular joint
M26.623	Arthralgia of bilateral temporomandibular joint
M26.629	Arthralgia of temporomandibular joint
M26.631	Articular disc disorder of right temporomandibular joint
M26.632	Articular disc disorder of left temporomandibular joint
M26.633	Articular disc disorder of bilateral temporomandibular joint
M26.639	Articular disc disorder of temporomandibular joint, unspecified side
M26.641	Arthritis of right temporomandibular joint
M26.642	Arthritis of left temporomandibular joint
M26.643	Arthritis of bilateral temporomandibular joint
M26.649	Arthritis of unspecified temporomandibular joint
M26.651	Arthropathy of right temporomandibular joint
M26.652	Arthropathy of left temporomandibular joint
M26.653	Arthropathy of bilateral temporomandibular joint
M26.659	Arthropathy of unspecified temporomandibular joint
M26.69	Other specified disorders of temporomandibular joint

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Next Review Date

07/01/23

Authorizing Entity

MPCTAC

Appendix

Appendix: Policy History

Disclaimer Information:

Plan refers to Boston Medical Center Health Plan, Inc. which operates under the trade name WellSense Health Plan. Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity

definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

Appendix: Policy History

Original Approval Date	Original Effective Date* and Version	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 09/09/08: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 09/30/08: Utilization Management Committee (UMC) 10/22/08: Quality Improvement Committee (QIC)	01/01/09 Version 1	Director of Medical Policy as Chair of MPCTAC	MPCTAC, QIC, and UMC

*Effective Date for QHP Commercial Product: 01/01/12
*Effective Date for New Hampshire Medicaid Product: 01/01/13
*Effective Date for Senior Care Options Product: 01/01/16
*Effective Date for New Hampshire Medicare Advantage HMO Product: 01/01/22

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
09/22/09	No criteria changes. Updated references.	Version 2	09/22/09: MPCTAC 10/28/09: QIC
09/01/10	No changes to criteria. Updated references and coding.	Version 3	09/15/10: MPCTAC 11/22/10: QIC
09/01/11	Updated limitations and references.	Version 4	09/21/11: MPCTAC 10/26/11: QIC
07/01/12	References updated, revised language in the Applicable Coding section, and deleted four-digit diagnosis code 524.6.	Version 5	07/18/12: MPCTAC 08/22/12: QIC
07/01/13	Review for effective date 11/01/13. Updated references. Added criteria for medical evaluation of TMJ disorders. Reformatted, revised, and added examples in the Medical Policy Statement section. Added definition for temporomandibular joint syndrome. Deleted duplicate text in Clinical Background Information section.	11/01/13 Version 6	07/17/13: MPCTAC 08/15/13: QIC
07/29/12	Off cycle review for WellSense New Hampshire Medicaid product, revised Description of Item or Service section, reformatted the Medical Policy	Version 7	08/03/12: MPCTAC 09/05/12: QIC

	Statement section, and updated the References section.		
01/30/14	Off cycle review for effective date 04/01/14. Added ICD10 diagnosis code equivalents of existing ICD9 diagnosis codes.	Version 8	01/27/14: MPCTAC 01/30/14: QIC
09/01/14	Review for effective date 01/01/15. Revised language in the Limitations section related to benefit coverage. Revised medical criteria in the Medical Policy Statement and Limitations sections. Updated references.	01/01/15 Version 9	09/17/14: MPCTAC 10/08/14: QIC
09/01/15	Annual review for effective date 01/01/16. Revised the list of applicable products, including removing Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available. Revised criteria in the Medical Policy Statement and Limitations sections. Updated Clinical Background Information and References sections.	01/01/16 Version 10	09/16/15: MPCTAC 10/14/15: QIC
11/25/15	Review for effective date 01/14/16. Revised language in the Applicable Coding section.	01/14/16 Version 11	11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
09/01/16 and 09/28/16	Review for effective date 01/01/17. Removed ICD9 diagnosis codes. Updated Summary, Description of Item or Service, Definitions, Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections. Revised criteria in the Medical Policy Statement and Limitations sections. Administrative changes made to clarify language related to gender.	01/01/17 Version 12	09/21/16: MPCTAC 09/30/16: MPCTAC (electronic vote) 10/12/16: QIC
12/05/16	Industry-wide changes to applicable ICD-10 diagnosis codes for temporo-mandibular joint disorder effective 01/01/17.	01/01/17 Version 13	Not applicable because industry-wide revisions to ICD-10 diagnosis codes.
09/01/17	Review for effective date 12/01/17. Revised criteria in the Medical Policy Statement and Limitations sections. Updated the Policy Summary, Definitions, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.	12/01/17 Version 14	09/20/17: MPCTAC
09/01/18	Review for effective date 12/01/18. Updated the Clinical Background Information, References, and Other Applicable Policies sections. Criteria revised in the Medical Policy Statement and Limitations sections.	12/01/18 Version 15	09/19/18: MPCTAC
12/01/18	Review for effective date 01/01/19. Administrative change made to the Limitations	01/01/19 Version 16	12/19/18: MPCTAC

	section (removing the reference to the NH Health Protection Program).		
09/01/19	Review for effective date 12/01/19. Administrative changes made to the Policy Summary, Definitions, References, and Reference to Applicable Laws and Regulations sections. Revised criteria in the Limitations section.	12/01/19 Version 17	09/18/19: MPCTAC
07/01/20	Review for effective date 10/01/20 to be consistent with implementation date of industry-wide diagnosis code updates made to the Applicable Coding section. Administrative changes made to the Medical Policy Statement, References, and Other Applicable Policies sections.	10/01/20 Version 18	07/15/20: MPCTAC
08/01/21	Review for effective date 09/01/21. Administrative changes made to the Policy Summary, Medical Policy Statement, Limitations, and References sections.	09/01/21 Version 19	08/27/21: MPCTAC (electronic vote)
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, the Medical Policy Statement section renamed the Clinical Criteria section, and the Limitations section renamed the Limitations and Exclusions section. Added WellSense Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections.	12/01/21 Version 20	11/17/21: MPCTAC
07/01/22	Review for effective date 08/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections.	08/01/22 Version 21	07/25/22: MPCTAC (electronic vote)
08/01/22	Review for effective date 11/01/22. Administrative changes made to the Policy Summary section.	11/01/22 Version 22	08/26/22: MPCTAC (electronic vote)