BOSTON MEDICAL CENTER HEALTHNet PLAN

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Medical Policy

Photochemotherapy, Phototherapy, or Excimer Laser Therapy for Dermatological Conditions in the Outpatient Setting

Policy Number: OCA 3.39
Version Number: 22
Version Effective Date: 02/01/22

Product Applicability	☒ **All Plan+ Products**
WellSense Health Plan	**Boston Medical Center HealthNet Plan**
☒ NH Medicaid	☒ MassHealth
☒ NH Medicare Advantage	☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct
	☒ Senior Care Options

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

Policy Summary

The Plan considers photochemotherapy, phototherapy, or excimer laser therapy for specific dermatological disorders to be **medically necessary** when Plan criteria are met. Prior authorization is required for phototherapy or photochemotherapy provided in an outpatient setting (including office or clinic-based treatments) when used for ANY dermatological condition EXCEPT for phototherapy used for the treatment neonatal jaundice (i.e., neonate is a newborn infant under 28 days of age according to the World Health Organization). ALL requests for home phototherapy/home light therapy must be submitted to Northwood for review.

Clinical Criteria

Medically necessary photochemotherapy, phototherapy, and/or excimer laser treatment must be ordered by a treating provider knowledgeable about these modalities, and the treating provider has adequately informed the Plan member of the risks of treatment; associated staff must be sufficiently qualified and trained to administer the treatments, and the equipment must be FDA approved, safe,

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purpose-built, adequately maintained, and sufficiently monitored. The Plan considers phototherapy, photochemotherapy, or excimer laser therapy to be medically necessary when the following criteria are met and prior authorization is obtained for services provided in outpatient setting (including office or clinic-based treatments), as specified below in item A (for services that REQUIRE Plan prior authorization) and item B (for services that do NOT require Plan prior authorization). When the service requires Plan authorization, **continued treatment requires prior authorization every 3 months (unless otherwise specified); authorization for continued treatment requires documentation of improvement from the treatment in the member's medical record.**

A. **Services Requiring Prior Authorization:**

The following applicable criteria in items 1 through 3 must be met for the requested service:

1. **Photochemotherapy (PUVA)**: Office or clinic-based psoralens and ultraviolet A light (PUVA) treatments are considered medically necessary when ALL criteria are met in items a through c:

   a. Member is 10 years of age or older on the date of service; AND

   b. Member has failed or has a contraindication to a 4 week trail of conventional therapy which may have included but is not limited to topical corticosteroids, topical calcineurin inhibitors, systemic steroids, antihistamines, and/or immunomodulatory drugs such as methotrexate; AND

   c. The member has ANY of the conditions listed in items (1) through (17):

      (1) Chronic palmoplantar pustulosis; OR

      (2) Eosinophilic folliculitis and other pruritic eruptions of HIV infection; OR

      (3) Graft vs. host disease with or without cutaneous manifestations; OR

      (4) Granuloma annulare; OR

      (5) Morphea and localized skin lesions associated with scleroderma; OR

      (6) Mycosis fungoides (cutaneous T-cell lymphoma), all stages; OR

      (7) Necrobiosis lipoidica; OR

      (8) Photodermatoses; OR

      (9) Pityriasis lichenoides; OR

(10) Severe dyshidrotic eczema (with dyshidrotic eczema also known as dyshidrosis, acute palmoplantar eczema, vesicular palmoplantar eczema, acute and recurrent vesicular hand dermatitis, pompholyx, cheiropompholyx when affecting the hands, or podopompholyx when affecting the feet); OR

(11) Severe lichen planus; OR

(12) Severe parapsoriasis; OR

(13) Severe refractory atopic dermatitis/eczema; OR

(14) Severe refractory pruritus; OR

(15) Severe urticaria pigmentosa (cutaneous mastocytosis); OR

(16) Severely disabling psoriasis when ANY of the criteria is met in item (a) or item (b):

(a) Involves 5% or more of the member's body surface area (BSA) and/or involves the member's hands, feet, scalp, face, and/or neck; OR

(b) Psoriasis area and severity index (PASI) score is greater than 10; OR

(17) Vitiligo when ANY of the criteria in item (a) or item (b) is met:

(a) Involves 10% or more of the member's body surface area (BSA); OR

(b) Involves the scalp, face, and/or neck; OR

2. **Phototherapy UVA and/or UVB:**

Office or clinic-based phototherapy treatments with UVA and/or UVB are considered medically necessary when ALL criteria in items a through d are met:

a. Member is 10 years of age or older on the date of service (unless phototherapy is used for the treatment of neonatal jaundice); AND

b. Conventional therapy clinically appropriate for the member's condition (as determined by the treating provider) has been tried for at least eight (8) consecutive, calendar weeks and the conventional therapy has failed, no acceptable first-line therapy is available for the member's condition, and/or the member cannot tolerate the side effects of the conventional therapy (with conventional therapy including but not limited to topical

corticosteroids, systemic steroids, antihistamines, and/or immunomodulatory drugs such as methotrexate); AND

c. The member has ANY of the conditions listed in items (1) through (12):

(1) Severe refractory atopic dermatitis/eczema; OR

(2) Eosinophilic folliculitis and other pruritic eruptions of HIV infection; OR

(3) Lichen planus; OR

(4) Mycosis fungoides, early stage (i.e., stage IA, IB, or IIA) for phototherapy with UVB treatment only; OR

(5) Parapsoriasis; OR

(6) Photodermatoses; OR

(7) Pityriasis lichenoides; OR

(8) Pityriasis rosea; OR

(9) Prurigo nodularis; OR

(10) Moderate to severe refractory pruritus; OR

(11) Moderate to severe localized psoriasis for which UVA and/or UVB are indicated, the member's condition is unresponsive to conservative treatment, and ANY criteria is met in item (a) or item (b):

(a) Involves 5% or more of the member's body surface area (BSA) and/or involves the member's hands, feet, scalp, face, and/or neck; OR

(b) Psoriasis area and severity index (PASI) score is greater than 10; OR

(12) Vitiligo when ANY criteria in item (a) or item (b) is met:

(a) Involves 10% or more of the member's body surface area (BSA); OR

(b) Involves the scalp, face, and/or neck; OR

3. **Excimer Laser Therapy/Targeted UVB:**

Office or clinic-based UVB excimer laser treatments are considered medically necessary when BOTH criteria in items a through c are met:

a. Member is 10 years of age or older on the date of service; AND

b. Failed an 8-week course or has a contraindication to conventional therapy; AND

c. The member has ANY of the conditions listed in item (1) or item (2):

(1) Psoriasis when BOTH criteria are met in items (a) and (b):

(a) Moderate to severe localized psoriasis involving less than 10% of the member's body surface area for which narrowband UVB phototherapy is indicated; AND

(b) Treatment for psoriasis is limited to no more than 15 treatments within a 6 consecutive, calendar month period; OR

(2) Vitiligo when BOTH criteria are met in items (a) and (b):

(a) Member has ANY of conditions listed in items (1) through (3):

(1) Vitiligo involves less than 5% of the member's body surface area; OR

(2) The area being treated for vitiligo cannot be adequately reached during light box therapy (e.g., treatment of the face, fingers, neck, scalp, toes); OR

(3) The member requires treatment for vitiligo but has a contraindication for total body phototherapy (as specified in the Limitations section of this policy); AND

(b) Treatment of vitiligo with laser therapy is limited to no more than 12 consecutive, calendar weeks with a review required for up to 12 additional treatments (and all applicable criteria must be met for both the initial 12 consecutive, calendar weeks of treatment and 12 additional treatments beyond the initial authorization).

4. **Phototherapy (with UVA and/or UVB) or Excimer Laser Therapy (Targeted Phototherapy)**:

ANY of the conditions in items a through d require Plan Medical Director review for individual consideration:

a. Pediatric Member Under the Age of 10:

Plan Medical Director review is required for office or clinic-based phototherapy or excimer laser therapy for a Plan member under the age of 10 on the date of service (UNLESS the phototherapy is used for the treatment of neonatal jaundice in the outpatient setting; phototherapy does NOT require Plan prior authorization when provided in an outpatient setting to treat neonatal jaundice). Applicable clinical information must be submitted to the Plan by the treating provider and include the member's medical history, treatment to date, verification of the clinical effectiveness of phototherapy with UVA and/or UVB for the member's age and condition (including photographic documentation, if requested), and an individualized treatment plan (including expected duration treatment for this episode of care); OR

b. Phototherapy Treatment Frequency:

Plan Medical Director review is required for office or clinic-based phototherapy with UVA and/or UVB for a Plan member when treatment will be provided more frequently than three (3) times per week and/or extending beyond three (3) consecutive, calendar months of treatment for the same episode of care (i.e., a new onset of symptoms or exacerbation of symptoms from the member's baseline condition). Applicable clinical information must be submitted to the Plan by the treating provider and include the member's medical history, treatment to date, verification of the clinical effectiveness of phototherapy with UVA and/or UVB (including photographic documentation, if requested), and an individualized treatment plan (including expected duration of phototherapy with UVA and/or UVB treatment for this episode of care); OR

c. UVB Excimer Laser Treatment Frequency for Psoriasis:

Plan Medical Director review is required for office or clinic-based UVB excimer laser treatments for a Plan member with psoriasis when treatment will be provided beyond 15 treatments and/or treatments extending beyond a 6 consecutive, calendar month period for the same episode of care (i.e., a new onset of symptoms or exacerbation of symptoms from the member's baseline condition). Applicable clinical information must be submitted to the Plan by the treating provider and include the member's medical history, treatment to date for psoriasis, verification of the clinical effectiveness of UVB excimer laser treatments (including photographic documentation, if requested), and an individualized treatment plan (including expected duration of UVB excimer laser treatments for this episode of care); OR

d. UVB Excimer Laser Treatment Frequency for Vitiligo:

Plan Medical Director review is required for office or clinic-based UVB excimer laser treatment for a Plan member with vitiligo when treatment when Plan criteria are not met

(for the initial authorization up to 12 consecutive, calendar weeks or the additional 12 treatments) or for treatment of vitiligo beyond the initial treatment up to 12 consecutive, calendar weeks and 12 additional treatments for the same episode of care (i.e., a new onset of symptoms or exacerbation of symptoms from the member's baseline condition). Applicable clinical information must be submitted to the Plan by the treating provider and include the member's medical history, treatment to date for vitiligo, verification of the clinical effectiveness of UVB excimer laser treatment (including photographic documentation, if requested), and an individualized treatment plan (including expected duration of UVB excimer laser treatments for this episode of care).

Limitations and Exclusions

1. Contraindications for Phototherapy or Laser Therapy/Targeted Phototherapy:

   a. Absolute contraindications include ANY of the conditions listed in items (1) through (6):

      (1) Basal cell nevus syndrome; OR

      (2) Lupus erythematosus; OR

      (3) Personal history or presence of melanoma or presence of nonmelanoma skin cancer (including basal cell cancer and squamous cell cancer); OR

      (4) Porphyria; OR

      (5) Pregnancy; OR

      (6) Xeroderma pigmentosum.

   b. Relative Contraindications:

      Plan Medical Director review is required for a member with a relative contraindication to phototherapy or laser therapy/targeted phototherapy. Applicable clinical information must be submitted to the Plan Medical Director by the treating provider and include the member's medical history, duration of symptoms, results of physical examination, treatment to date (including documentation that other therapeutic options for the member's condition have been utilized with negative or ineffective outcomes), and the member's individualized treatment plan. Relative contraindications include a member with ANY of the conditions/contraindications listed in items (1) through (12):

      (1) Albinism; OR

      (2) Aphakia; OR

(3) Cataracts; OR

(4) Family history of melanoma; OR

(5) First-line treatment of mild psoriasis or treatment of generalized psoriasis or psoriatic arthritis; OR

(6) Personal history of arsenic intake (e.g., Fowler solution); OR

(7) Personal history of immunological therapy, contact with photosensitive substances, and/or a treatment with photosensitizing medications; OR

(8) Personal history of ionizing radiation therapy; OR

(9) Personal history of nonmelanoma skin cancer (including basal cell cancer and/or squamous cell cancer) and all other therapeutic options have been exhausted); OR

(10) Photosensitivity disorder; OR

(11) Phototherapy treatment of the genital area; OR

(12) Skin type I or type II who tend to burn easily.

2. Contraindications for PUVA:

   a. Absolute contraindications include ANY of the known conditions/contraindications listed in items (1) through (10):

      (1) Age 9 years of age or younger on the date of service; OR

      (2) Albinism; OR

      (3) Basal cell nevus syndrome; OR

      (4) Lupus erythematosus; OR

      (5) Personal history or presence of melanoma; OR

      (6) Photosensitivity disorder; OR

      (7) Porphyria; OR

(8) Pregnancy or breastfeeding (since psoralen is a pregnancy class C medication); OR

(9) Presence of nonmelanoma skin cancer (including basal cell cancer and squamous cell cancer); OR

(10) Xeroderma pigmentosum.

b. Relative Contraindications:

Plan Medical Director review is required for a member with a relative contraindication to PUVA. Applicable clinical information must be submitted to the Plan Medical Director by the treating provider and include the member's medical history, duration of symptoms, results of physical examination, treatment to date (including documentation that other therapeutic options for the member's condition have been utilized with negative or ineffective outcomes), and the member's individualized treatment plan. Relative contraindications include a member with ANY of the listed in items (1) through (11):

(1) Albinism; OR

(2) Aphakia; OR

(3) Cataracts; OR

(4) Past negative experience and/or response to light therapy; OR

(5) Personal history of arsenic intake (e.g., Fowler solution); OR

(6) Personal history of nonmelanoma skin cancer(s); OR

(7) Personal history of treatment with cyclosporine or methotrexate; OR

(8) Skin prone to burning easily and a first-degree relative with a history of melanoma; OR

(9) Skin types I and II (who tend to burn easily); OR

(10) Severe liver disease (that could lead to toxic levels of psoralens); OR

(11) Severe myocardial disease or other condition likely to make treatment (or standing if required in the treatment unit for a prolonged period) hazardous or difficult.

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 WellSense Medicare Advantage HOM 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, 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 WellSense 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 uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all-inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in this Applicable Coding section. Review the Plan's reimbursement policies for Plan billing guidelines. Coverage for services is subject to benefit eligibility under the member's benefit plan in effect at the time of the service. Member benefit documents are available at the following websites: www.bmchp.org for BMC HealthNet Plan members, www.SeniorsGetMore.org for Senior Care Options members, www.wellsense.org for WellSense New Hampshire Medicaid members, and www.WellSense.org/Medicare for WellSense Medicare Advantage HMO members.

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CPT Codes	Description: Codes covered when medically necessary for phototherapy, photochemotherapy, or laser treatment, as specified below.
96900	Actinotherapy (ultraviolet light) Plan note: Code used for phototherapy
96910	Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B
96912	Photochemotherapy; psoralens and ultraviolet A (PUVA)
96913	Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings)
96920	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm
96921	Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm
96922	Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm

CPT Codes	Description: Code covered for medically necessary phototherapy used to treat neonatal jaundice, as specified below.
96900	Actinotherapy (ultraviolet light) Plan note: Code used for phototherapy. This procedure code must be billed with one (1) of the primary diagnosis codes listed below for the prior authorization requirement to be waived for phototherapy used to treat neonatal jaundice.
ICD-10 Codes	**Description: No prior authorization is required for any of the following waived, primary diagnosis codes for medically necessary phototherapy used to treat neonatal jaundice, as specified below. (The waived, primary diagnosis code must be documented on the claim form with the covered procedure code for phototherapy).**
P58.0	Neonatal jaundice due to bruising
P58.1	Neonatal jaundice due to bleeding
P58.2	Neonatal jaundice due to infection
P58.3	Neonatal jaundice due to polycythemia
P58.41	Neonatal jaundice due to drugs or toxins transmitted from mother
P58.42	Neonatal jaundice due to drugs or toxins given to newborn
P58.5	Neonatal jaundice due to swallowed maternal blood
P58.8	Neonatal jaundice due to other specified excessive hemolysis
P58.9	Neonatal jaundice due to excessive hemolysis, unspecified
P59.0	Neonatal jaundice associated with pre term delivery
P59.1	Inspissated bile syndrome
P59.20	Neonatal jaundice from unspecified hepatocellular damage
P58.29	Neonatal jaundice from other hepatocellular damage
P59.3	Neonatal jaundice from breast milk inhibitor

P59.8	Neonatal jaundice from other specified causes
P59.9	Neonatal jaundice, Unspecified

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Policy History

Original Approval Date	Original Effective Date* and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 06/25/03	06/25/03 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 the BMC HealthNet Plan Commercial Product: 01/01/12
*Effective Date for the WellSense New Hampshire Medicaid Product: 01/01/13
*Effective Date for the Senior Care Options Product: 01/01/16
*Effective Date for the WellSense Medicare Advantage HMO Product: 01/01/22

Policy title was *Photochemotherapy or Phototherapy for Dermatological Conditions in the Outpatient Setting* until 01/31/21. As of 02/01/21, the policy title has been changed to *Photochemotherapy, Phototherapy, or Excimer Laser Therapy for Dermatological Conditions in the Outpatient Setting.*

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
12/06/05	Updated clinical coverage criteria.	Version 2	12/06/05: Q&CMC
02/06/07	Updated references and template.	Version 3	02/06/07: Q&CMC
02/19/08	Revised clinical criteria effective July 1, 2008.	07/01/08 Version 4	02/19/08: MPCTAC 02/26/08: Utilization Management Committee (UMC)

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name WellSense New Hampshire Health Plan.

Policy Revisions History			
			03/12/08: Quality Improvement Committee (QIC)
12/01/08	No changes.	Version 5	01/27/09: MPCTAC 01/27/09: UMC 02/25/09: QIC
12/01/09	No changes.	Version 6	12/23/09: MPCTAC 02/24/10: QIC
12/01/10	Updated clinical criteria and added limitations for phototherapy and photochemotherapy updated coding and references.	Version 7	12/28/10: MPCTAC 01/26/11: QIC
12/01/11	Updated references, added definition for atopic dermatitis.	Version 8	12/12/11: MPCTAC 12/20/11: QIC
07/01/12	Off cycle review for WellSense Health Plan, reformatted Clinical Guideline Statement updated coding, added reference to Northwood Policies for related DME.	Version 9	08/03/12: MPCTAC 09/13/12: QIC
01/01/13	Revised title and Summary section, referenced *Medically Necessary* policy, reformatted Description of Item or Service section, updated references. Deleted HCPCS codes E0691, E0692, E0693, and E0694 from applicable code list. Updated language in Applicable Coding introductory paragraph and referenced Northwood, Inc., added Limitations section. Changed name of policy category from "Clinical Coverage Guidelines" to "Medical Policy.	Version 10	01/16/13: MPCTAC 02/21/13: QIC
08/14/13 and 08/15/13	Off cycle review for WellSense Health Plan and merged policy format. Incorporate policy revisions dated 01/01/13 (as specified above) for the WellSense Health Plan product; these policy revisions were approved by MPCTAC on 01/16/13 and QIC on 02/21/13 for applicable Plan products.	Version 11	08/14/13: MPCTAC (electronic vote) 08/15/13: QIC
02/01/14	Review for effective date 06/01/14. Revised criteria in the Medical Policy Statement section and Limitations section. Updated Description of Item	06/01/14 Version 12	02/19/14: MPCTAC 02/26/14: QIC

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Policy Revisions History			
	or Service, Definitions, Clinical Background Information, and References sections.		
01/01/15	Review for effective date 03/01/15. Updated code definitions in the Applicable Coding section. Revised References section.	03/01/15 Version 13	01/21/15: MPCTAC 02/11/15: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and corresponding notes. Revised the language in the Applicable Coding section.	01/01/16 Version 14	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
11/25/15	Review for effective date 03/01/16. Revised criteria in the Medical Policy Statement and Limitations sections. Updated references.	03/01/16 Version 15	11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
11/01/16	Review for effective date 03/01/17. Revised criteria in the Medical Policy Statement and Limitations sections. Added ICD-10 primary diagnosis codes for neonatal jaundice with a waived prior authorization requirement for phototherapy. Added Plan notes to the Applicable Coding section. Administrative changes made to the Summary, Definitions, Clinical Background Information, References, and References to Applicable Laws and Regulations sections.	03/01/17 Version 16	11/16/16: MPCTAC 12/14/16: QIC
11/01/17	Review for effective date 02/01/18. Revised criteria in the Medical Policy Statement and Limitations sections. Administrative changes made to the References and Other Applicable Policies sections.	02/01/18 Version 17	11/15/17: MPCTAC
11/01/18	Review for effective date 02/01/19. Administrative changes made to the Limitations, Definitions, References, and Other Applicable Policies sections. Criteria revised in the Medical Policy Statement section.	02/01/19 Version 18	11/21/18: MPCTAC
11/01/19	Review for effective date 02/01/20. Administrative changes made to the	02/01/20 Version 19	11/20/19: MPCTAC

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Policy Revisions History			
	References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections. Criteria revised in the Medical Policy and Limitations sections.		
11/01/20	Review for effective date 02/01/21. Revised the policy title. Administrative changes made to the Policy Statement, Description of Item or Service, Limitations, Definitions, and References sections. Criteria revised in the Medical Policy Statement section.	02/01/21 Version 20	11/18/20: MPCTAC
11/01/21	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 Limitation and Exclusions section. Added WellSense Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary and References updated.	01/01/22 Version 21	11/17/21: MPCTAC
11/01/21	Review for effective date 02/01/22. Criteria removed in the Clinical Criteria and Limitations and Exclusions sections.	02/01/22 Version 22	11/17/21: MPCTAC

Next Review Date

11/01/22

Authorizing Entity

MPCTAC

Disclaimer Information: [+]

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.

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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.

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