# Evolent Health Medical Clinical Policies 2021

Maryland Physicians Care professional staff refer to the member's plan of benefits for coverage decisions, and if necessary, the clinical policies and other recognized criteria. Evolent Health's clinical policies are based on evidence in the peer-reviewed published medical literature, technology assessments and structured evidence reviews, evidence-based consensus statements, expert opinions of healthcare providers, and evidence-based guidelines from nationally recognized professional healthcare organizations and public health agencies.

| Policy Number | Policy Link | Policy Name | Policy Description |
|---|---|---|---|
| MP-002 | MP-002 Continuous Glucose Monitoring | Continuous Glucose Monitoring Systems | To address CGM systems and describe the criteria used to determine coverage decisions |
| MP-006 | MP-006 Continuous Home Pulse Oximetr | Continuous Home Pulse Oximetry | Outlines criteria for when Continuous pulse oximetry is performed in the home |
| MP-008 | MP-008 Home Apnea Monitoring V | Home Apnea Monitoring | Outlines criteria for when home apnea monitors are medically necessary |
| MP-010 | MP-010 Routine Foot Care Ver Aug 1 | Routine Foot Care | Outlines criteria for when routine foot care is medically necessary |
| MP-015 | MP-015 Gradient Compression Garme | Gradient Compression Garments/Stockings | Outlines criteria for when compression stockings and/or garments are medically necessary |
| MP-016 | MP-016 Temporomandibular | Temporomandibular Joint Disorders | Outlines criteria for TMJ Disorders |
| MP-019 | MP-019 Chelation Therapy Ver May 19. | Chelation Therapy | Outlines for criteria for when the Administration of FDA-Approved Chelating agents are medically necessary |
| MP-023 | MP-023 Sleep Apnea Treatment, PA | Sleep Apnea Treatment, PAP Devices | Outlines criteria for when PAP Devices for the treatment of sleep |

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| Policy Number | Policy Link | Policy Name | Policy Description |
|---|---|---|---|
| | | | apnea are medically necessary |
| MP-024 | MP-024 Continuous Passive Motion Devi | Continuous Passive Motion Devices | Outlines criteria for when CPM devises are medically necessary in the early post-op period following total knee replacements |
| MP-025 | MP-025 Vagus Nerve Stimulators Fe | Vagus Nerve Stimulators | Outlines criteria for when VNS is medically necessary |
| MP-027 | MP-027 Topographic Genoty | Topographic Genotyping | Outlines the criteria for when TG is medically necessary |
| MP-032 | MP-032 HPV Testing Ver Feb 20.c | HPV Testing | Outlines the criteria for when HPV testing is medically necessary |
| MP-036 | MP-036 Iontophoresis Ver M | Iontophoresis for Musculoskeletal Conditions | Outlines the criteria for when Iontophoresis for musculoskeletal conditions for the treatment of pain and edema is medically necessary |
| MP-038 | MP-038 Septoplasty Rhinoplasty Feb 19.( | Septoplasty Rhinoplasty | Outlines the criteria for when septoplasty-rhinoplasty is medically necessary |
| MP-040 | MP-040 Speech Generating Devices | Speech Generating Devices | Outlines the criteria for when SGDs and accessories are medically necessary |
| MP-041 | MP-041 Light Therapy in the Hom | Light Therapy in the Home, Ultraviolet B, Skin Conditions | Outlines for the criteria for when light therapy in the home, UVB for skin conditions is medically necessary |
| MP-042 | MP-042 Genetic Testing- Inherited C | Genetic Testing-Inherited Colorectal Cancers | Outlines the criteria for when genetic testing for inherited colorectal |

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| Policy Number | Policy Link | Policy Name | Policy Description |
|---|---|---|---|
| | | | cancers is medically necessary |
| MP-043 | MP-043 Nerve Conduction Velocity | Nerve Conduction Velocity Studies | Outlines the criteria for when NCS and NCV studies are medically necessary |
| MP-046 | MP-046 Breast Reconstruction Proc | Breast Reconstruction Procedures and External Breast Prosthesis | Outlines the criteria for when breast reconstruction and external breast prosthesis is medically necessary |
| MP-047 | MP-047 Cough Assist Devices Ver A | Cough Assist Devices | Outlines the criteria for when cough assist devices are medically necessary |
| MP-049 | MP-049 Visual Evoked Response Te | Visually Evoked Response Test | Outlines the criteria for when VER testing is medically necessary |
| MP-052 | MP-052 Bladder Cancer Biomarker Te | Bladder Cancer Biomarker Test | Outlines the criteria for when bladder cancer biomarker testing is medically necessary |
| MP-055 | MP-055 Computed Tomographic Colon | Computed Tomographic Colonography | Outlines the criteria for when CT Colonography is medically necessary |
| MP-056 | MP-056 Management of Unl | Management of Unlisted Non-Specific HCPCS CPT Codes | Outlines the criteria for the management of unlisted/non-specific HCPCS/CPTD codes |
| MP-057 | MP-057 CAD Mammography Ver / | CAD Mammography | Outlines the criteria for when CAD Mammography is medically necessary |
| MP-059 | MP-059 Heart Disease, Lifestyle Mc | Heart Disease, Lifestyle Modification Program | Outlines the criteria for when the heart disease lifestyle modification program is medically necessary |

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| Policy Number | Policy Link | Policy Name | Policy Description |
|---|---|---|---|
| MP-060 | MP-060 Stereotactic Radiosurgery & Bod | Stereotactic Radiosurgery & Body Radiation Therapy | Outlines the criteria for when SRS and SBRT is medically necessary |
| MP-061 | MP-061 Hospital Beds and Accessorie | Hospital Beds and Accessories | Outlines the criteria for when hospital beds and accessories are medically necessary |
| MP-063 | MP-063 Oral Appliances for Obst | Oral Appliances for Obstructive Sleep Apnea | Outlines the criteria for when oral appliances for obstructive sleep apnea is medically necessary |
| MP-066 | MP-066 Varicose Veins Nov 19.docx | Varicose Veins | Outlines the criteria for when the treatment of varicose veins is medically necessary |
| MP-068 | MP-068 Home PT INR Monitoring Feb | Home PT INR Monitoring | Outlines the criteria for when home PT/INR monitoring is medically necessary |
| MP-069 | MP-069 Home Sleep Study Feb 20.docx | Home Sleep Study | Outlines the criteria for when home sleep study is medically necessary |
| MP-072 | MP-072 Eye-Anterior Segmer | Eye-Anterior Segment Optical Coherence Tomography | Outlines the criteria for when AS-OCT is medically necessary |
| MP-074 | MP-074 Blepharoplasty, Blep | Blepharoplasty, Blepharoptosis, Brow Ptosis Repair | Outlines the criteria for when blepharoplasty and blepharoptosis/Brow Ptosis Repairs are medically necessary |
| MP-076 | MP-076 Prophylactic Bilatera | Prophylactic Bilateral Salpingo-Oophorectomy | Outlines the criteria for when PBSO is medically necessary |
| MP-078 | MP-078 Magnetoencephalo | Magnetoencephalography | Outlines the criteria for when MEG is medically necessary |

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| Policy Number | Policy Link | Policy Name | Policy Description |
|---|---|---|---|
| MP-079 | MP-079 Cosmetic versus Reconstructiv | Cosmetic versus Reconstructive Services | Outlines the criteria for when reconstructive services are medically necessary |
| MP-083 | MP-083 Skin Substitutes Ver May | Skin Substitutes – Human Skin Equivalents | Outlines the criteria for when Skin Substitutes – HSE is medically necessary |
| MP-084 | MP-084 Hyperbaric Oxygen Therapy Feb | Hyperbaric Oxygen Therapy | Outlines the criteria for when HBOT is medically necessary |
| MP-087 | MP-087 Intraoperative Neruc | Intraoperative Neurophysiological Testing | Outlines the criteria for when intraoperative neurophysiological testing is medically necessary |
| MP-088 | MP-088 Colorectal Cancer, Mutation Te | Colorectal Cancer, Mutation Testing | Outlines the criteria for when mutation testing for treatment of colorectal cancer is medically necessary |
| MP-089 | MP-089 Endometrial Ablatio | Endometrial Ablation | Outlines the criteria for when endometrial ablation is medically necessary |
| MP-090 | MP-090 Nerve Block, Paravertebral, | Nerve Block, Paravertebral, Facet Joint, and SI Injections | Outlines the criteria for when nerve block, paravertebral, facet joint and SI injections are medically necessary |
| MP-091 | MP-091 IVUS Coronary Vessels Ve | IVUS Coronary Vessels | Outlines the criteria for when IVUS for coronary vessels is medically necessary |
| MP-094 | MP-094 TENS Ver Jan 19.docx | Transcutaneous Electrical Nerve Stimulators | Outlines the criteria for when TENS is medically necessary |
| MP-097 | MP-097 Xiaflex (Collagenase Clostri | Xiaflex (Collagenase Clostridium Histolyticum) | Outlines the criteria for when xiaflex collagenase clostridium |

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|---|---|---|---|
| | | | histolyticum is medically necessary |
| MP-098 | MP-098 Chromosome Micro | Chromosome Microarray | Outlines the criteria for when chromosomal microarray testing is medically necessary |
| MP-101 | MP-101 Prophylactic Mastec | Prophylactic Mastectomy | Outlines the criteria for when prophylactic mastectomy is medically necessary |
| MP-103 | MP-103 Endovascular Repai | Endovascular Repair – Stent for AAA | Outlines the criteria for when endovascular repair/stent for abdominal aortic aneurysm is medically necessary |
| MP-104 | MP-104 Vision Therapy Ver Nov 19. | Vision Therapy | Outlines the criteria for when orthoptic vision therapy is medically necessary |
| MP-107 | MP-107 External Counterpulsation Th | External Counterpulsation Therapy | Outlines the criteria for when ECP is medically necessary |
| MP-108 | MP-108 Deep Brain & Dorsal Column (Sp | Deep Brain & Dorsal Column (Spinal Cord) Stimulators | Outlines the criteria for when deep brain and dorsal column (spinal cord) neurostimulators is medically necessary |
| MP-112 | MP-112 Laryngeal Inj for Vocal Cord Au | Laryngeal Injection for Vocal Cord Augmentation | Outlines the criteria for when office-based laryngeal injections for vocal cord augmentation is medically necessary |
| MP-114 | MP-114 High-Resolution An | High-Resolution Anoscopy | Outlines the criteria for when HRA is medically necessary |
| MP-115 | MP-115 Vysis ALK Break Apart FISH Tes | Vysis ALK Break Apart FISH Test | Outlines the criteria for when Genetic Testing, to guide the treatment |

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| Policy Number | Policy Link | Policy Name | Policy Description |
|---|---|---|---|
| | | | of lung cancer, is medically necessary |
| MP-116 | MP-116 Genetic Testing for Cystic Fil | Genetic Testing for Cystic Fibrosis | Outlines the criteria for when genetic testing for CF is medically necessary |
| MP-123 | MP-123 Incontinence, Biofee | Incontinence, Biofeedback | Outlines the criteria for when biofeedback for the treatment of incontinence is medically necessary |
| MP-124 | MP-124 Glaucoma, Invasive Procedures | Glaucoma, Invasive Procedures | Outlines the criteria for when invasive procedures for glaucoma is medically necessary |
| MP-126 | MP-126 Cell-Free Fetal DNA Test Ver A | Cell-Free Fetal DNA Test | Outlines the criteria for when Cell-free fetal DNA testing is medically necessary |
| MP-128 | MP-128 Thyroid Nodule Molecular Te | Thyroid Nodule Molecular Testing | Outlines the criteria for when molecular testing of thyroid FNA samples are medically necessary |
| MP-129 | MP-129 Posterior Tibial Nerve Stimulat | Posterior Tibial Nerve Stimulators | Outlines the criteria for when the use of PTNS for the treatment of urinary incontinence is medically necessary |
| MP-130 | MP-130 Home Oxygen Therapy Aug | Home Oxygen Therapy | Outlines the criteria for when home oxygen therapy is medically necessary |
| MP-132 | MP-132 Lower Limb Orthotics and Shoes | Lower Limb Orthotics and Shoes | Outlines the criteria for when lower limb orthotics and shoes are medically necessary |
| MP-138 | MP-138 Oral Maxillofacial Prosthe | Oral Maxillofacial Prosthesis | Outlines the criteria for when oral maxillofacial prostheses is medically necessary |

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| Policy Number | Policy Link | Policy Name | Policy Description |
|---|---|---|---|
| MP-140 | MP-140 CAD for MRI of Breast - Expe | CAD for MRI of Breast-Experimental | Outlines the criteria for when CAD for MRI of the breast is medically necessary |
| MP-151 | MP-151 Supervised Exercise Therapy for | Supervised Exercise Therapy for PAD | Outlines the criteria for SET for Peripheral Artery Disease is medically necessary |
| MP-211 | MP-211 Soliris Place of Service Feb 19.do | (Eculizumab) Soliris | Outlines the criteria for when Eculizumab (Soliris) is medically necessary |
| PA-003 | PA-003 Transplant-Heart Lung Ver Nov | Transplant – Heart Lung | Outlines the criteria for when heart-lung transplant is medically necessary |
| PA-004 | PA-004 Transplant-Small Bowel or Mult | Transplant – Small Bowel or Multivisceral | Outlines the criteria for when small bowel/liver and multivisceral transplants are medical necessary |
| PA-007 | PA-007 Transplant-Lung and Lobar Lun | Transplant – Lung and Lobar Lung | Outlines the criteria for when lung and lobar lung transplants are medically necessary |
| PA-009 | PA-009 Negative Pressure Wound Th | Negative Pressure Wound Therapy | Outlines the criteria for when negative pressure wound therapy in the home setting is medically necessary |
| PA-010 | PA-010 DME, Corrective Appl Oth | DME, Corrective Appliances and Other Devices; Repair/Replacement | Outlines the criteria for when DME is medically necessary |
| PA-011 | PA-011 NonInvasive Bone Growth Stimul | Noninvasive Bone Growth Stimulators | Outlines the criteria for when non-invasive BGS is medically necessary |
| PA-012 | PA-012 Microprocessor Con | Microprocessor Controlled Knee Prosthesis | Outlines the criteria for when a microprocessor-controlled knee prosthesis is medically necessary |

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| Policy Number | Policy Link | Policy Name | Policy Description |
|---|---|---|---|
| PA-016 | PA-016 Transplant-Pancreas Alone and | Transplant – Pancreas Alone and Pancreas/Kidney | Outlines the criteria for when pancreas and/or pancreas/kidney transplants are medically necessary |
| PA-018 | PA-018 Gene Expression Testing E | Gene Expression Testing Breast Cancer | Outlines the criteria for when gene expression testing for breast cancer is medically necessary |
| PA-022 | PA-022 Breast Reduction and Mast | Breast Reduction and Mastectomy Gynecomastia | Outlines the criteria for when breast reduction and mastectomy for gynecomastia is medically necessary |
| PA-028 | PA-028 Pressure Reducing Support S | Pressure Reducing Support Surfaces | Outlines the criteria for when pressure reducing support surfaces are medically necessary |
| PA-030 | PA-030 Transplant-Pediatric Heart Ver N | Transplant – Pediatric Heart | Outlines the criteria for when pediatric heart transplant is medically necessary |
| PA-033 | PA-033 Wireless Capsule Endoscopy | Wireless Capsule Endoscopy | Outlines the criteria for when WCE is medically necessary |
| PA-034 | PA-034 Continuous Glucose Monitors V | Continuous Glucose Monitors | Outlines the criteria for when continuous glucose monitors are medically necessary |
| PA-035 | PA-035 External Insulin Pumps Ver N | External Insulin Pumps | Outlines the criteria for when external insulin pumps are medically necessary |
| PA-040 | PA-040 Bariatric Surgery Ver Aug 19. | Bariatric Surgery | Outlines the criteria for when bariatric surgery is medically necessary |
| PA-042 | PA-042 Functional Electricual Stimulato | Functional Electrical Stimulators | Outlines the criteria for when NMES for treatment of muscle atrophy is medically necessary |

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| Policy Number | Policy Link | Policy Name | Policy Description |
|---|---|---|---|
| PA-046 | PA-046 Extracranial Carotid Angioplasty | Extracranial Carotid Angioplasty w/ Stenting | Outlines the criteria for when Extracranial CAS is medically necessary |
| PA-049 | PA-049 Dental Anesthesia Ver Feb | Dental Anesthesia | Outlines the criteria for when dental anesthesia is medically necessary |
| PA-051 | PA-051 Ventricular Assist Devices Ver Au | Ventricular Assist Devices | Outlines the criteria for when VADs is medically necessary |
| PA-053 | PA-053 Total Ankle Replacement Ver No | Total Ankle Replacement | Outlines the criteria for when TAR for the treatment of advanced end stage arthritis of the ankle is medically necessary |
| PA-055 | PA-055 Mol Suscept Testing Breast Ovari | Molecular Susceptibility Testing for Breast Cancer and/or Ovarian Cancer (BRCA and BART Testing) | Outlines the criteria for when BRCA and BART Testing is medically necessary |
| PA-056 | PA-056 Parenteral Nutrition Ver May 19 | Parenteral Nutrition | Outlines the criteria for when Parenteral Nutrition/TPN is medically necessary |
| PA-066 | PA-066 High Freq Chest Wall Oscillatic | High Frequency Chest Wall Oscillation Devices | Outlines the criteria for when HFCWA is medically necessary |
| PA-070 | PA-070 Power Mobility Devices Feb | Power Mobility Devices | Outlines the criteria for when PMDs is medically necessary |
| PA-071 | PA-071 Wheelchair Options and Access | Wheelchair Options and Accessories | Outlines the criteria for when wheelchair options and accessories are medically necessary |
| PA-074 | PA-074 Wearable Cardiac Defribillator | Wearable Cardiac Defibrillator | Outlines the criteria for when WCDs are medically necessary |
| PA-075 | PA-075 Lymphedema Pumps | Lymphedema Pumps and Appliances | Outlines the criteria for when lymphedema pumps and appliances are medically necessary |

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| Policy Number | Policy Link | Policy Name | Policy Description |
|---|---|---|---|
| PA-078 | PA-078 Clinical Trials Ver Nov 19.do | Clinical Trials | Outlines the criteria for when clinical trials are medically necessary |
| PA-084 | PA-084 Myoelectric Upper Limb Prosthes | Myoelectric Upper Limb Prosthesis | Outlines the criteria for when myoelectric upper limb prosthesis is medically necessary |
| PA-086 | PA-086 Vertebral Augmentation Ver M | Vertebral Augmentation | Outlines the criteria for when percutaneous kyphoplasty or vertebroplasty is performed on a thoracic or lumbar fracture is medically necessary |
| PA-087 | PA-087 Specialized Manual Wheelchairs | Specialized Manual Wheelchairs | Outlines the criteria for when specialized manual wheelchairs are medically necessary |
| PA-088 | PA-088 Transcatheter Aortic | Transcatheter Aortic Valve Implantation | Outlines the criteria for when TAVI, TAVR and TPV therapy is medically necessary |
| PA-095 | PA-095 Pancreatectomy w A | Pancreatectomy with Autologous Islet Cell Transplantation | Outlines the criteria for when pancreatectomy with autologous islet cell transplantation is medically necessary |
| PA-096 | PA-096 Esophagogastroduc | Esophagogastroduodenoscopy | Outlines the criteria for when EGD is medically necessary |
| PA-097 | PA-097 Molecular-Genetic T | Molecular-Genetic Testing | Outlines the criteria for when molecular/genetic tests are medically necessary |
| PA-100 | PA-100 Cardiac Defribillator, Subcut | Cardiac Defibrillator, Subcutaneous Implantable | Outlines the criteria for when S-ICDs is medically necessary |
| PA-101 | PA-101 Transient Elastography Ver Ma | Transient Elastography | Outlines the criteria for when TE (eg. FibroScan) is medically necessary |

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|---|---|---|---|
| PA-135 | PA-135 Artificial Disc Replacement Ve | Artificial Disc Replacement | Outlines the criteria for when artificial intervertebral disc replacement of the cervical and lumbar spine for the treatment of DDD is medically necessary |
| PA-136 | PA-136 Spinal Orthosis ver May 19. | Spinal Orthosis | Outlines the criteria for when spinal orthoses is medically necessary |
| PA-204 | PA-204 Genetic Test Whole Genome-Exo | Genetic Test Whole Genome-Exome Sequencing | Outlines the criteria for when genome-exome sequencing genetic testing is medically necessary |
| PA-211 | PA-211 Transanal Endoscopic Microsu | Transanal Endoscopic Microsurgery (TEM) | Outlines for the criteria for when TEM is medically necessary |
| PA-212 | PA-212 Avise CTD Non Coverage June | Avise CTD Non-Coverage | Outlines the criteria for when Avise CTD testing for RA, SLE, Graves Disease or Hashimoto Disease is medically necessary |
| PA-213 | PA-213 Platelet Rich Plasma (PRP) Non Cc | Platelet Rich Plasma (PRP) Non-Coverage | Outlines the criteria for when Platelet Rich Plasma for the treatment of osteoarthritis, TMJ, chronic wounds, hamstring injury, ankle sprain or any other application to be experimental and investigational is medically necessary |
| PA-215 | PA-215 Gastric Electrical Stimulatior | Gastric Electrical Stimulation | Outlines the criteria for when gastric electrical stimulation is medically necessary |

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|---|---|---|---|
| PA-217 | PA-217 Corneal Cross Linking June 2 | Corneal Cross-Linking | Outlines the criteria when corneal cross-linking is medically necessary |