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-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 Temporomandibula	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, P/	Sleep Apnea Treatment, PAP Devices	Outlines criteria for when PAP Devices for the treatment of sleep apnea are medically necessary

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Policy Number	Policy Link	Policy Name	Policy Description
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

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Policy Number	Policy Link	Policy Name	Policy Description
MP-042	MP-042 Genetic Testing- Inherited C	Genetic Testing-Inherited Colorectal Cancers	Outlines the criteria for when genetic testing for inherited colorectal 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 Au	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

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Policy Number	Policy Link	Policy Name	Policy Description
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
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

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Policy Number	Policy Link	Policy Name	Policy Description
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
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

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Policy Number	Policy Link	Policy Name	Policy Description
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 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 Mastect	Prophylactic Mastectomy	Outlines the criteria for when prophylactic mastectomy is medically necessary
MP-103	MP-103 Endovascular Repair	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 (S	Deep Brain & Dorsal Column (Spinal Cord) Stimulators	Outlines the criteria for when deep brain and dorsal column (spinal cord) neurostimulators is medically necessary

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Policy Number	Policy Link	Policy Name	Policy Description
MP-112	MP-112 Laryngeal Inj for Vocal Cord A	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 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

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Policy Number	Policy Link	Policy Name	Policy Description
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
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
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

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Policy Number	Policy Link	Policy Name	Policy Description
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
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

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Policy Number	Policy Link	Policy Name	Policy Description
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
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

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Policy Number	Policy Link	Policy Name	Policy Description
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
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

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Policy Number	Policy Link	Policy Name	Policy Description
			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
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

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Policy Number	Policy Link	Policy Name	Policy Description
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
PA-217	PA-217 Corneal Cross Linking June 2	Corneal Cross Linking	Outlines the criteria when corneal cross-linking is medically necessary

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Policy Number	Policy Link	Policy Name	Policy Description
PA-239 (added at the April 2021 Meeting)	Fecal Calprotectin Testing PA.239.MPC.	Fecal Calprotectin Testing	Outlines the criteria to determine the diagnoses of IBS/IBD

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