










Evolut 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. Evolut 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_I	Home Apnea Monitoring	Outlines criteria for when home apnea monitors are medically necessary
MP-010	 MP-010 Routine Foot Care_Aug 21.d	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_May 21.doc	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












Evolut Health Medical Clinical Policies 2021










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 devices are medically necessary in the early post-op period following total knee replacements
MP-025	 MP-025 Vagus Nerve Stimulators_M	Vagus Nerve Stimulators	Outlines criteria for when VNS is medically necessary
MP-032	 MP-032 HPV Testing_Feb 21.docx	HPV Testing	Outlines the criteria for when HPV testing is medically necessary
MP-036	 MP-036 Iontophoresis_May	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_May 21	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 Home	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 cancers is medically necessary



Evolut Health Medical Clinical Policies 2021

Policy Number	Policy Link	Policy Name	Policy Description
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_Aug 2	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_M	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-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

Evolut Health Medical Clinical Policies 2021

Policy Number	Policy Link	Policy Name	Policy Description
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_Aug 21.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 21.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_Feb	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
MP-079	 MP-079 Cosmetic versus Reconstructiv	Cosmetic versus Reconstructive Services	Outlines the criteria for when reconstructive



Evolut Health Medical Clinical Policies 2021


Policy Number	Policy Link	Policy Name	Policy Description
			services are medically necessary
MP-083	 MP-083 Skin Substitutes_May 21	Skin Substitutes – Human Skin Equivalents	Outlines the criteria for when Skin Substitutes – HSE is medically necessary
MP-084	 MP-084 Hyperbaric Oxygen Therapy_Fel	Hyperbaric Oxygen Therapy	Outlines the criteria for when HBOT is medically necessary
MP-087	 MP-087 Intraoperative Neuro	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_At	IVUS Coronary Vessels	Outlines the criteria for when IVUS for coronary vessels is medically necessary
MP-094	 MP-094 TENS_May 21	Transcutaneous Electrical Nerve Stimulators	Outlines the criteria for when TENS is medically necessary
MP-097	 MP-097 Xiaflex (Collagenase Clostridium Histolyticum)	Xiaflex (Collagenase Clostridium Histolyticum)	Outlines the criteria for when xiaflex collagenase clostridium



Evolut Health Medical Clinical Policies 2021

Policy Number	Policy Link	Policy Name	Policy Description
			histolyticum 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 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_Aug 21.doc	Vision Therapy	Outlines the criteria for when orthoptic vision therapy is medically necessary
MP-107	 MP-107 External Counterpulsation TI	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
MP-112	 MP-112 Laryngeal Inj for Vocal Cord At	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 Te	Vysis ALK Break Apart FISH Test	Outlines the criteria for when Genetic Testing, to guide the treatment of lung cancer, is medically necessary











Evolut Health Medical Clinical Policies 2021

Policy Number	Policy Link	Policy Name	Policy Description
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_May	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 T	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 Stimula	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_Au	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 Prosth	Oral Maxillofacial Prosthesis	Outlines the criteria for when oral maxillofacial prostheses is medically necessary

Evolut Health Medical Clinical Policies 2021


Policy Number	Policy Link	Policy Name	Policy Description
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_Aug 21	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 Ther	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 Appli Oth	DME, Corrective Appliances and Other Devices; Repair/Replacement	Outlines the criteria for when DME is medically necessary
PA-011	 PA-011 Non-Invasive Bone C	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

Evolut Health Medical Clinical Policies 2021

Policy Number	Policy Link	Policy Name	Policy Description
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_Aug	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_F	Continuous Glucose Monitors	Outlines the criteria for when continuous glucose monitors are medically necessary
PA-035	 PA-035 External Insulin Pumps PA.03	External Insulin Pumps	Outlines the criteria for when external insulin pumps are medically necessary
PA-040	 PA-040 Bariatric Surgery_May 21.doc	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








Evolut Health Medical Clinical Policies 2021









Policy Number	Policy Link	Policy Name	Policy Description
PA-049	 PA-049 Dental Anesthesia_Feb 21	Dental Anesthesia	Outlines the criteria for when dental anesthesia is medically necessary
PA-051	 PA-051 Ventricular Assist Devices_June	Ventricular Assist Devices	Outlines the criteria for when VADs is medically necessary
PA-053	 PA-053 Total Ankle Replacement_Aug 2	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_May 21	Parenteral Nutrition	Outlines the criteria for when Parenteral Nutrition/TPN is medically necessary
PA-066	 PA-066 High Freq Chest Wall Oscillat	High Frequency Chest Wall Oscillation Devices	Outlines the criteria for when HFCWA is medically necessary
PA-070	 PA-070 Power Mobility Devices_Ma	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-073 (Added at the December 2021 QMUM Meeting)	 PA-073 Wheelchair Seating Options_No	Wheelchair Seating Options	Outlines when Wheelchair Seating Options are medically necessary
PA-074	 PA-074 Wearable Cardiac Defibrillator	Wearable Cardiac Defibrillator	Outlines the criteria for when WCDs are medically necessary



Evolut Health Medical Clinical Policies 2021





Policy Number	Policy Link	Policy Name	Policy Description
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_Aug 21	Clinical Trials	Outlines the criteria for when clinical trials are medically necessary
PA-084	 PA-084 Myoelectric Upper Limb Prosthe:	Myoelectric Upper Limb Prosthesis	Outlines the criteria for when myoelectric upper limb prosthesis is medically necessary
PA-086	 PA-086 Vertebral Augmentation_Feb :	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

Evolut Health Medical Clinical Policies 2021

Policy Number	Policy Link	Policy Name	Policy Description
PA-098	 PA-098 Chromosome Microa	Chromosome Microarray	Outlines the criteria for when chromosomal microarray testing is 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 Noninvasive Tests for Hepatic Fib	Noninvasive Tests for Hepatic Fibrosis	Outlines the criteria for when noninvasive tests for hepatic fibrosis are medically necessary
PA-135	 PA-135 Artificial Disc Replacement_Fe	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_Feb 21	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 Advise CTD Non Coverage_May	Advise CTD Non-Coverage	Outlines the criteria for when Advise CTD testing for RA, SLE, Graves Disease or Hashimoto Disease is medically necessary



Evolut Health Medical Clinical Policies 2021

Policy Number	Policy Link	Policy Name	Policy Description
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 Stimulation	Gastric Electrical Stimulation	Outlines the criteria for when gastric electrical stimulation is medically necessary
PA-217	 PA-217 Corneal Cross Linking_Nov 2	Corneal Cross Linking	Outlines the criteria when corneal cross-linking is medically necessary
PA-239 (added at the April 2021 Meeting)	 PA-239 Fecal Calprotectin Testing	Fecal Calprotectin Testing	Outlines the criteria to determine the diagnoses of IBS/IBD