Evolent Health Medical Clinical Policies 2022

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 Name	Policy Description
MP-006	Continuous Home Pulse Oximetry	Outlines criteria for when Continuous pulse oximetry is performed in the home
MP-008	Home Apnea Monitoring	Outlines criteria for when home apnea monitors are medically necessary
MP-010	Routine Foot Care	Outlines criteria for when routine foot care is medically necessary
MP-016	Temporomandibular Joint Disorders	Outlines criteria for TMJ Disorders
MP-019	Chelation Therapy	Outlines for criteria for when the Administration of FDA-Approved Chelating agents are medically necessary
MP-023	Sleep Apnea Treatment, PAP Devices	Outlines criteria for when PAP Devices for the treatment of sleep apnea are medically necessary
MP-024	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	Vagus Nerve Stimulators	Outlines criteria for when VNS is medically necessary
MP-032	HPV Testing	Outlines the criteria for when HPV testing is medically necessary
MP-036	Iontophoresis for Musculoskeletal Conditions	Outlines the criteria for when Iontophoresis for musculoskeletal conditions for the treatment of pain and edema is medically necessary

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Policy Number	Policy Name	Policy Description
MP-038	Septoplasty Rhinoplasty	Outlines the criteria for when septoplasty-rhinoplasty is medically necessary
MP-040	Speech Generating Devices	Outlines the criteria for when SGDs and accessories are medically necessary
MP-041	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	Genetic Testing-Inherited Colorectal Cancers	Outlines the criteria for when genetic testing for inherited colorectal cancers is medically necessary
MP-043	Nerve Conduction Velocity Studies	Outlines the criteria for when NCS and NCV studies are medically necessary
MP-046	Breast Reconstruction Procedures and External Breast Prosthesis	Outlines the criteria for when breast reconstruction and external breast prosthesis is medically necessary
MP-047	Cough Assist Devices	Outlines the criteria for when cough assist devices are medically necessary
MP-049	Visually Evoked Response Test	Outlines the criteria for when VER testing is medically necessary
MP-052	Bladder Cancer Biomarker Test	Outlines the criteria for when bladder cancer biomarker testing is medically necessary
MP-056	Management of Unlisted Non-Specific HCPCS CPT Codes	Outlines the criteria for the management of unlisted/non-specific HCPCS/CPTD codes
MP-059	Heart Disease, Lifestyle Modification Program	Outlines the criteria for when the heart disease lifestyle modification program is medically necessary
MP-060	Stereotactic Radiosurgery & Body Radiation Therapy	Outlines the criteria for when SRS and SBRT is medically necessary

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Policy Number	Policy Name	Policy Description
MP-061	Hospital Beds and Accessories	Outlines the criteria for when hospital beds and accessories are medically necessary
MP-063	Oral Appliances for Obstructive Sleep Apnea	Outlines the criteria for when oral appliances for obstructive sleep apnea is medically necessary
MP-066	Varicose Veins	Outlines the criteria for when the treatment of varicose veins is medically necessary
MP-068	Home PT INR Monitoring	Outlines the criteria for when home PT/INR monitoring is medically necessary
MP-069	Home Sleep Study	Outlines the criteria for when home sleep study is medically necessary
MP-072	Eye-Anterior Segment Optical Coherence Tomography	Outlines the criteria for when AS-OCT is medically necessary
MP-074	Blepharoplasty, Blepharoptosis, Brow Ptosis Repair	Outlines the criteria for when blepharoplasty and blepharoptosis/Brow Ptosis Repairs are medically necessary
MP-076	Prophylactic Bilateral Salpingo-Oophorectomy	Outlines the criteria for when PBSO is medically necessary
MP-078	Magnetoencephalography	Outlines the criteria for when MEG is medically necessary
MP-079	Cosmetic versus Reconstructive Services	Outlines the criteria for when reconstructive services are medically necessary
MP-083	Skin Substitutes – Human Skin Equivalents	Outlines the criteria for when Skin Substitutes – HSE is medically necessary
MP-084	Hyperbaric Oxygen Therapy	Outlines the criteria for when HBOT is medically necessary
MP-087	Intraoperative Neurophysiological Testing	Outlines the criteria for when intraoperative neurophysiological testing is medically necessary
MP-088	Colorectal Cancer, Mutation Testing	Outlines the criteria for when mutation testing for treatment

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		of colorectal cancer is medically necessary
MP-089	Endometrial Ablation	Outlines the criteria for when endometrial ablation is medically necessary
MP-090	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	IVUS Coronary Vessels	Outlines the criteria for when IVUS for coronary vessels is medically necessary
MP-094	Transcutaneous Electrical Nerve Stimulators	Outlines the criteria for when TENS is medically necessary
MP-097	Xiaflex (Collagenase Clostridium Histolyticum)	Outlines the criteria for when xiaflex collagenase clostridium histolyticum is medically necessary
MP-101	Prophylactic Mastectomy	Outlines the criteria for when prophylactic mastectomy is medically necessary
MP-103	Endovascular Repair – Stent for AAA	Outlines the criteria for when endovascular repair/stent for abdominal aortic aneurysm is medically necessary
MP-104	Vision Therapy	Outlines the criteria for when orthoptic vision therapy is medically necessary
MP-107	External Counterpulsation Therapy	Outlines the criteria for when ECP is medically necessary
MP-108	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	Laryngeal Injection for Vocal Cord Augmentation	Outlines the criteria for when office-based laryngeal injections for vocal cord augmentation is medically necessary
MP-114	High-Resolution Anoscopy	Outlines the criteria for when HRA is medically necessary

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Policy Number	Policy Name	Policy Description
MP-115	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	Genetic Testing for Cystic Fibrosis	Outlines the criteria for when genetic testing for CF is medically necessary
MP-123	Incontinence, Biofeedback	Outlines the criteria for when biofeedback for the treatment of incontinence is medically necessary
MP-124	Glaucoma, Invasive Procedures	Outlines the criteria for when invasive procedures for glaucoma is medically necessary
MP-126	Cell-Free Fetal DNA Test	Outlines the criteria for when Cell-free fetal DNA testing is medically necessary
MP-128	Thyroid Nodule Molecular Testing	Outlines the criteria for when molecular testing of thyroid FNA samples are medically necessary
MP-129	Posterior Tibial Nerve Stimulators	Outlines the criteria for when the use of PTNS for the treatment of urinary incontinence is medically necessary
MP-130	Home Oxygen Therapy	Outlines the criteria for when home oxygen therapy is medically necessary
MP-132	Lower Limb Orthotics and Shoes	Outlines the criteria for when lower limb orthotics and shoes are medically necessary
MP-138	Oral Maxillofacial Prosthesis	Outlines the criteria for when oral maxillofacial prostheses is medically necessary
MP-151	Supervised Exercise Therapy for PAD	Outlines the criteria for SET for Peripheral Artery Disease is medically necessary
PA-003	Transplant – Heart Lung	Outlines the criteria for when heart-lung transplant is medically necessary

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Policy Number	Policy Name	Policy Description
PA-004	Transplant – Small Bowel or Multivisceral	Outlines the criteria for when small bowel/liver and multivisceral transplants are medical necessary
PA-007	Transplant – Lung and Lobar Lung	Outlines the criteria for when lung and lobar lung transplants are medically necessary
PA-009	Negative Pressure Wound Therapy	Outlines the criteria for when negative pressure wound therapy in the home setting is medically necessary
PA-010	DME, Corrective Appliances and Other Devices; Repair/Replacement	Outlines the criteria for when DME is medically necessary
PA-011	Noninvasive Bone Growth Stimulators	Outlines the criteria for when non-invasive BGS is medically necessary
PA-012	Microprocessor Controlled Knee Prosthesis	Outlines the criteria for when a microprocessor- controlled knee prosthesis is medically necessary
PA-016	Transplant – Pancreas Alone and Pancreas/Kidney	Outlines the criteria for when pancreas and/or pancreas/kidney transplants are medically necessary
PA-018	Gene Expression Testing Breast Cancer	Outlines the criteria for when gene expression testing for breast cancer is medically necessary
PA-022	Breast Reduction and Mastectomy Gynecomastia	Outlines the criteria for when breast reduction and mastectomy for gynecomastia is medically necessary
PA-028	Pressure Reducing Support Surfaces	Outlines the criteria for when pressure reducing support surfaces are medically necessary
PA-030	Transplant – Pediatric Heart	Outlines the criteria for when pediatric heart transplant is medically necessary
PA-033	Wireless Capsule Endoscopy	Outlines the criteria for when WCE is medically necessary

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Policy Number	Policy Name	Policy Description
PA-034	Continuous Glucose Monitors	Outlines the criteria for when continuous glucose monitors are medically necessary
PA-035	External Insulin Pumps	Outlines the criteria for when external insulin pumps are medically necessary
PA-040	Bariatric Surgery	Outlines the criteria for when bariatric surgery is medically necessary
PA-042	Functional Electrical Stimulators	Outlines the criteria for when NMES for treatment of muscle atrophy is medically necessary
PA-046	Extracranial Carotid Angioplasty w/ Stenting	Outlines the criteria for when Extracranial CAS is medically necessary
PA-051	Ventricular Assist Devices	Outlines the criteria for when VADs is medically necessary
PA-053	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	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	Parenteral Nutrition	Outlines the criteria for when Parenteral Nutrition/TPN is medically necessary
PA-066	High Frequency Chest Wall Oscillation Devices	Outlines the criteria for when HFCWA is medically necessary
PA-070	Power Mobility Devices	Outlines the criteria for when PMDs is medically necessary
PA-071	Wheelchair Options and Accessories	Outlines the criteria for when wheelchair options and accessories are medically necessary
PA-073	Wheelchair Seating Options	Outlines when Wheelchair Seating Options are medically necessary
PA-074	Wearable Cardiac Defibrillator	Outlines the criteria for when WCDs are medically necessary

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Policy Number	Policy Name	Policy Description
PA-078	Clinical Trials	Outlines the criteria for when clinical trials are medically necessary
PA-084	Myoelectric Upper Limb Prosthesis	Outlines the criteria for when myoelectric upper limb prosthesis is medically necessary
PA-086	Vertebral Augmentation	Outlines the criteria for when percutaneous kyphoplasty or vertebroplasty is performed on a thoracic or lumbar fracture is medically necessary
PA-087	Specialized Manual Wheelchairs	Outlines the criteria for when specialized manual wheelchairs are medically necessary
PA-088	Transcatheter Aortic Valve Implantation	Outlines the criteria for when TAVI, TAVR and TPV therapy is medically necessary
PA-095	Pancreatectomy with Autologous Islet Cell Transplantation	Outlines the criteria for when pancreatectomy with autologous islet cell transplantation is medically necessary
PA-096	Esophagogastroduodenoscopy	Outlines the criteria for when EGD is medically necessary
PA-097	Molecular-Genetic Testing	Outlines the criteria for when molecular/genetic tests are medically necessary
PA-098	Chromosome Microarray	Outlines the criteria for when chromosomal microarray testing is medically necessary
PA-100	Cardiac Defibrillator, Subcutaneous Implantable	Outlines the criteria for when S-ICDs is medically necessary
PA-101	Noninvasive Tests for Hepatic Fibrosis	Outlines the criteria for when noninvasive tests for hepatic fibrosis are medically necessary
PA-135	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 Name	Policy Description
PA-136	Spinal Orthosis	Outlines the criteria for when spinal orthoses is medically necessary
PA-204	Genetic Test Whole Genome-Exome Sequencing	Outlines the criteria for when genome-exome sequencing genetic testing is medically necessary
PA-212	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	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	Gastric Electrical Stimulation	Outlines the criteria for when gastric electrical stimulation is medically necessary
PA-239	Fecal Calprotectin Testing	Outlines the criteria to determine the diagnoses of IBS/IBD