UnitedHealthcare

UnitedHealthcare Commercial Medical & Drug Policies and Coverage Determination Guidelines

The Medical Policies, Medical Benefit Drug Policies, Coverage Determination Guidelines, Quality of Care Guidelines, Utilization Review Guidelines and corresponding update bulletins for UnitedHealthcare Commercial plans are listed below. Click the "+" sign to view more information.

Feedback

Medical Policy Update Bulletins

Current Policies & Guidelines

17-Alpha-Hydroxyprogesterone Caproate (Makena™ and 17P) – Commercial Medical Benefit Drug Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses intramuscular injection of 17-alpha-hydroxyprogesterone caproate, commonly called 17P or Makena™. Applicable Procedure Codes: J1726, J1729, J2675.

Ablative Treatment for Spinal Pain – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 05.01.2017 – This policy addresses thermal radiofrequency ablation and other ablation procedures for spine pain. Applicable Procedure Codes: 64633, 64634, 64635, 64636, 64999, 77003.

Abnormal Uterine Bleeding and Uterine Fibroids – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses the use of levonorgestrel-releasing intrauterine devices (LNG-IUD), uterine artery embolization (UAE), magnetic resonance-guided focused ultrasound ablation (MRgFUS), laparoscopic ultrasound-guided radiofrequency ablation, and transcervical ultrasound-guided radiofrequency ablation. Applicable Procedure Codes: 0071T, 0072T, 0404T, 37243, 58578, 58674, 58999, J7296, J7297, J7298, J7301, J7306, S4981.

Actemra® (Tocilizumab) Injection for Intravenous Infusion – Commercial Medical Benefit Drug Policy

Last Modified 03.01.2018

Effective Date: 03.01.2018 – This policy addresses the use of Actemra® (tocilizumab) injection for intravenous infusion for the treatment of polyarticular juvenile idiopathic arthritis, rheumatoid arthritis, systemic juvenile idiopathic arthritis, and cytokine release syndrome. Applicable Procedure Code: J3262.

Alpha1-Proteinase Inhibitors – Commercial Medical Benefit Drug Policy

Last Modified 02.01.2018

Effective Date: 02.01.2018 – This policy addresses alpha1-proteinase inhibitors (Aralast NP™, Glassia™, Prolastin®-C, and Zemaira®) for chronic augmentation and maintenance therapy of emphysema due to congenital deficiency of alpha1-proteinase inhibitor (A1-PI)/alpha1-antitrypsin (AAT) deficiency. Applicable Procedures Codes: J0256, J0257.

Ambulance Services – Commercial Coverage Determination Guideline

Last Modified 11.01.2017

Effective Date: 11.01.2017 – This policy addresses emergency ambulance (ground, water, or air), air ambulance, and non-emergency ambulance (ground or air) between facilities. Applicable Procedure Codes: A0225, A0380, A0382, A0384, A0390, A0392, A0394, A0396, A0398, A0420, A0422, A0424, A0425, A0426, A0427, A0428, A0429, A0430, A0431, A0432, A0433, A0434, A0435, A0436, A0998, A0999, S0207, S0208, S9960, S9961, T2007.

Anemia Drugs: Darbepoetin Alfa, Epoetin Alfa, and Methoxy Polyethylene Glycol-Epoetin Beta – Commercial Medical Benefit Drug Policy

Last Modified 10.01.2017

Effective Date: 10.01.2017 – This policy addresses the use of erythropoiesis stimulating agents (ESAs), including Aranesp® (darbepoetin alfa), Epogen® (epoetin alfa), Mircera® (methoxy polyethylene glycol-epoetin beta [MPG-epoetin beta]), and Procrit® (epoetin alfa). Applicable Procedure Codes: J0881, J0882, J0885, J0887, J0888, Q4081.

Apheresis – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses apheresis/therapeutic apheresis. Applicable Procedure Codes: 0342T, 36511, 36512, 36513, 36514, 36516, 36522, S2120.

Athletic Pubalgia Surgery – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 06.01.2017 – This policy addresses surgical repair for treating athletic pubalgia. Applicable Procedure Codes: 49659, 49999.

Attended Polysomnography for Evaluation of Sleep Disorders – Commercial Medical Policy

Last Modified 12.01.2017

Effective Date: 12.01.2017 – This policy addresses home sleep apnea testing (HSAT) using a portable monitor, attended full-channel nocturnal polysomnography, actigraphy, multiple sleep latency testing (MSLT), maintenance of wakefulness testing (MWT), abbreviated daytime sleep study, split-night sleep study, and attended repeat testing. Applicable Procedure Codes: 95782, 95783, 95800, 95801, 95803, 95805, 95806, 95807, 95808, 95810, 95811, G0398, G0399, G0400.

Autologous Chondrocyte Transplantation in the Knee – Commercial Medical Policy

Last Modified 10.01.2017

Effective Date: 10.01.2017 – This policy addresses autologous chondrocyte transplantation (ACT). Applicable Procedure Codes: 27412, J7330, S2112.

Balloon Sinus Ostial Dilation – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses balloon sinus ostial dilation. Applicable Procedure Codes: 31295, 31296, 31297.

Bariatric Surgery – Commercial Medical Policy

Last Modified 03.01.2018

Effective Date: 02.01.2018 – This policy addresses bariatric surgical procedures, including robotic-assisted gastric bypass surgery, surgical adjustment or alteration of a prior bariatric procedure, and gastrointestinal liners. Applicable Procedure Codes: 0312T, 0313T, 0314T, 0315T, 0316T, 0317T, 43644, 43645, 43647, 43648, 43659, 43770, 43771, 43772, 43773, 43774, 43775, 43842, 43843, 43845, 43846, 43847, 43848, 43860, 43865, 43881, 43882, 43886, 43887, 43888, 43999, 64590, 64595, 95980, 95981, 95982.

Benlysta® (Belimumab) – Commercial Medical Benefit Drug Policy

Last Modified 08.01.2017

Effective Date: 07.01.2017 – This policy addresses the use of Benlysta® (belimumab) for the treatment of systemic lupus erythematosus (SLE). Applicable Procedure Code: J0490.

Blepharoplasty, Blepharoptosis and Brow Ptosis Repair– Commercial Coverage Determination Guideline

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses upper eyelid blepharoplasty, upper eyelid blepharoptosis repair, brow ptosis, eyelid surgery with an anophthalmic socket, lower eyelid blepharoplasty, ectropion or punctal eversion, entropion, lid retraction surgery, canthoplasty/canthopexy, and repair of floppy eyelid syndrome (FES). Applicable Procedure Codes: 15820, 15821, 15822, 15823, 21280, 21282, 67900, 67901, 67902, 67903, 67904, 67906, 67908, 67909, 67911, 67914, 67915, 67916, 67917, 67921, 67922, 67923, 67924, 67950, 67961, 67966.

Bone or Soft Tissue Healing and Fusion Enhancement Products – Commercial Medical Policy

Last Modified 03.01.2018

Effective Date: 03.01.2018 – This policy addresses autographs, allografts, amniotic tissue membrane products, bone morphogenetic proteins (BMP), ceramic-based products, cell-based products, platelet-rich plasma, and OptiMesh®. Applicable Procedure Codes: 0232T, 20930, 20931, 22558, 22585, 22899, Q4100, Q4131, Q4149.

Botulinum Toxins A and B – Commercial Medical Benefit Drug Policy

Last Modified 02.01.2018

Effective Date: 01.01.2018 – This policy addresses the use of botulinum toxin types A and B, including Dysport® (abobotulinumtoxinA), Xeomin® (incobotulinumtoxinA), Botox® (onabotulinumtoxinA), and Myobloc® (rimabotulinumtoxinB). Applicable Procedure Codes: J0585, J0586, J0587, J0588.

Breast Imaging for Screening and Diagnosing Cancer– Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses Breast Imaging as an adjunct to mammography, breast magnetic resonance imaging (MRI), magnetic resonance elastography of the breast, breast specific gamma imaging (Scintimammography), electrical impedance scanning (EIS), computer-aided detection for MRI of the breast, breast ultrasound, computer-aided detection for ultrasound, computer-aided tactile breast imaging, and automated breast ultrasound. Applicable Procedure Codes: 0159T, 0346T, 0422T, 76377, 76498, 76499, 76641, 76642, 77058, 77059, 77065, 77066, 77067, S8080.

Breast Reconstruction Post Mastectomy– Commercial Coverage Determination Guideline

Last Modified 12.01.2017

Effective Date: 12.01.2017 – This policy addresses breast reconstruction post-mastectomy. Applicable Procedure Codes: 11920, 11921, 11922, 11970, 11971, 15271, 15272, 15777, 19301, 19302, 19303, 19304, 19305, 19306, 19307, 19316, 19318, 19324, 19325, 19330, 19340, 19342, 19350, 19355, 19357, 19361, 19364, 19366, 19367, 19368, 19369, 19380, 19396, 19499, L8600, S2066, S2067, S2068.

Breast Reduction Surgery – Commercial Coverage Determination Guideline

Last Modified 02.05.2018

Effective Date: 12.01.2017 – This policy addresses breast reduction surgries. Applicable Procedure Code: 19318.

Breast Repair/Reconstruction Not Following Mastectomy – Commercial Coverage Determination Guideline

Last Modified 02.01.2018

Effective Date: 12.01.2017 – This policy addresses breast repair/reconstruction not following mastectomy. Applicable Procedure Codes: 19328, 19330, 19355, 19370, 19371, 19380.

Brineura™ (Cerliponase Alfa) – Commercial Medical Benefit Drug Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses the use of Brineura™ (cerliponase alfa) in pediatric patients with Late Infantile Neuronal Ceroid Lipofuscinosis (LINCL). Applicable Procedure Code: C9014, J3590.

Bronchial Thermoplasty– Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 07.01.2017 – This policy addresses bronchial thermoplasty. Applicable Procedure Codes: 31660, 31661.

Buprenorphine (Probuphine® & Sublocade™) – Commercial Medical Benefit Drug Policy

Last Modified 03.01.2018

Effective Date: 03.01.2018 – This policy addresses the use of use of buprenorphine (Probuphine® and Sublocade™) for the treatment of opioid dependence/opioid use disorder. Applicable Procedure Codes: 11981, 11982, G0516, G0517, G0518, J0570, J3490.

Cardiovascular Disease Risk Tests– Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses arterial compliance testing using waveform analysis, carotid intima-media thickness (CIMT) measurement, advanced lipoprotein analysis, tests that measure the lipoprotein-associated phospholipase A2 (Lp-PLA2) enzyme and other human A2 phospholipases, tests that measure long-chain omega-3 fatty acids, and endothelial function assessment. Applicable Procedure Codes: 0111T, 0126T, 0337T, 0423T, 82172, 83695, 83698, 83701, 83704, 93050, 93799, 93895.

Carrier Testing for Genetic Diseases – Commercial Medical Policy

Last Modified 11.01.2017

Effective Date: 11.01.2017 – This policy addresses the Ashkenazi Jewish carrier screening and expanded carrier screening panel testing. Applicable Procedure Codes: 81228, 81229, 81412.

Chelation Therapy for Non-Overload Conditions– Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 04.01.2017 – This policy addresses chelation therapy. Applicable Procedure Codes: J3490, M0300, S9355.

Chemosensitivity and Chemoresistance Assays in Cancer– Commercial Medical Policy

Last Modified 11.01.2017

Effective Date: 09.01.2017 – This policy addresses chemosensitivity and chemoresistance assays in cancer. Applicable Procedure Codes: 81535, 81536, 86849, 89240.

Chemotherapy Observation or Inpatient Hospitalization– Commercial Utilization Review Guideline

Last Modified 08.01.2017

Effective Date: 04.01.2017 – This policy addresses chemotherapy observation or overnight stay.

Chromosome Microarray Testing– Commercial Medical Policy

Last Modified 11.01.2017

Effective Date: 10.01.2017 – This policy addresses genome-wide comparative genomic hybridization microarray testing or single nucleotide polymorphism (SNP) chromosomal microarray analysis. Applicable Procedure Codes: 0004M, 81228, 81229, S3870.

Clinical Trials – Commercial Coverage Determination Guideline

Last Modified 02.01.2018

Effective Date: 12.01.2017 – This policy addresses clinical trials. Applicable Procedure Codes: G0276, G0293, G0294, G9057, S9988, S9990, S9991, S9992, S9994, S9996.

Clotting Factors and Coagulant Blood Products – Commercial Medical Benefit Drug Policy

Last Modified 02.01.2018

Effective Date: 01.01.2018 – This policy addresses clotting factors and coagulant blood products. Applicable Procedure Codes: J7175, J7178, J7179, J7180, J7181, J7182, J7183, J7185, J7186, J7187, J7188, J7189, J7190, J7192, J7193, J7194, J7195, J7198, J7199, J7200, J7201, J7202, J7205, J7207, J7209, J7210, J7211.

Cochlear Implants– Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses cochlear implants. Applicable Procedure Codes: 69930, L8614, L8615, L8616, L8617, L8618, L8619, L8621, L8622, L8623, L8624, L8627, L8628, L8629.

Cognitive Rehabilitation – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses cognitive rehabilitation and coma stimulation. Applicable Procedure Codes: 97127, G0515, S9056.

Collagen Crosslinks and Biochemical Markers of Bone Turnover – Commercial Medical Policy

Last Modified 03.01.2018

Effective Date: 03.01.2018 – This policy addresses serum or urine collagen crosslinks or biochemical markers to assess risk of fracture, predict bone loss or assess response to antiresorptive therapy. Applicable Procedure Code: 82523.

Computed Tomographic Colonography– Commercial Medical Policy

Last Modified 09.01.2017

Effective Date: 09.01.2017 – This policy addresses computed tomographic colonography. Applicable Procedure Codes: 74261, 74262, 74263.

Computerized Dynamic Posturography– Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 05.01.2017 – This policy addresses computerized dynamic posturography (CDP) testing. Applicable Procedure Code: 92548.

Continuous Glucose Monitoring and Insulin Delivery for Managing Diabetes – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses insulin delivery, continuous glucose monitoring, and remote glucose monitoring. Applicable Procedure Codes: 0446T, 0447T, 0448T, 95249, 95250, 95251, A9274, A9276, A9277, A9278, K0553, K0554, E0784, E1399, S1030, S1031, S1034, S1035, S1036, S1037.

Core Decompression for Avascular Necrosis– Commercial Medical Policy

Last Modified 09.01.2017

Effective Date: 09.01.2017 – This policy addresses core decompression avascular necrosis . Applicable Procedure Codes: 23929, 27299, 27599, 27899, S2325.

Corneal Hysteresis and Intraocular Pressure Measurement– Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 06.01.2017 – This policy addresses Measurement of corneal hysteresis and ocular blood flow and monitoring of intraocular pressure. Applicable Procedure Codes: 0198T, 0329T, 66999, 67299, 92145.

Cosmetic and Reconstructive Procedures – Commercial Coverage Determination Guideline

Last Modified 02.01.2018

Effective Date: 01.01.2018 – This policy addresses cosmetic and reconstructive procedures.

Cytological Examination of Breast Fluids for Cancer Screening– Commercial Medical Policy

Last Modified 11.01.2017

Effective Date: 08.01.2017 – This policy addresses breast ductal lavage, breast ductal fluid aspiration and cytology, and fiberoptic ductoscopy with or without ductal lavage. Applicable Procedure Code: 19499.

Deep Brain and Cortical Stimulation – Commercial Medical Policy

Last Modified 02.01.2018

Effective Date: 02.01.2018 – This policy addresses deep braing and responsive sortical Stimulation. Applicable Procedure Codes: 61850, 61860, 61863, 61864, 61867, 61868, 61885, 61886, 64999, 95978, 95979, L8679, L8680, L8682, L8685, L8686, L8687, L8688.

Denosumab (Prolia® & Xgeva®) – Commercial Medical Benefit Drug Policy

Last Modified 03.01.2018

Effective Date: 03.01.2018 – This policy addresses the use of denosumab (Prolia® & Xgeva®). Applicable Procedure Code: J0897.

Discogenic Pain Treatment– Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 08.01.2017 – This policy addresses thermal intradiscal procedures (TIPs) and percutaneous discectomy and decompression procedures for treating discogenic pain. Applicable Procedure Codes: 22526, 22527, 62287, 62380, S2348.

Durable Medical Equipment, Orthotics, Ostomy Supplies, Medical Supplies and Repairs/Replacements – Commercial Coverage Determination Guideline

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses durable medical equipment (DME), orthotics, ostomy supplies, medical supplies and repairs/replacements.

Elbow Replacement Surgery (Arthroplasty) – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 04.01.2017 – This policy addresses elbow arthroplasty. Applicable Procedure Codes: 24360, 24361, 24362, 24363, 24370, 24371.

Electric Tumor Treatment Field Therapy – Commercial Medical Policy

Last Modified 11.01.2017

Effective Date: 11.01.2017 – This policy addresses the use of devices to generate electric tumor treatment fields (TTF). Applicable Procedure Codes: 77299, E0766.

Electrical and Ultrasound Bone Growth Stimulators – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses electrical, electromagnetic, and ultrasonic bone growth stimulators. Applicable Procedure Codes: 20975, 20979, E0747, E0748, E0749, E0760.

Electrical Bioimpedance for Cardiac Output Measurement – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 08.01.2017 – This policy addresses electrical bioimpedance for cardiac output measurement. Applicable Procedure Code: 93701.

Electrical Stimulation and Electromagnetic Therapy for Wounds – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses electrical stimulation and electromagnetic therapy for wounds. Applicable Procedure Codes: E0769, G0281, G0282, G0295, G0329.

Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation – Commercial Medical Policy

Last Modified 03.01.2018

Effective Date: 03.01.2018 – This policy addresses functional electrical stimulation (FES), neuromuscular electrical stimulation (NMES), interferential therapy (IFT), pulsed electrical stimulation (PES), peripheral subcutaneous field stimulation (PSFS) or peripheral nerve field stimulation (PNFS), microcurrent electrical nerve stimulation (MENS), percutaneous electrical nerve stimulation (PENS) or percutaneous neuromodulation therapy (PNT), and dorsal root ganglion (DRG) stimulation. Applicable Procedure Codes: 63650, 63655, 63685, E0744, E0745, E0762, E0764, E0770, E1399, L8679, L8680, L8682, L8685, L8686, L8687, L8688, S8130, S8131.

Embolization of the Ovarian and Iliac Veins for Pelvic Congestion Syndrome – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 04.01.2017 – This policy addresses embolization of the ovarian or internal iliac veins. Applicable Procedure Code: 37241.

Emergency Health Care Services and Urgent Care Center Services – Commercial Coverage Determination Guideline

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses emergency health care services, physician-ordered emergency department visits, screening and stabilization of an emergency medical conditions, and post-stabilization care services. Applicable Procedure Codes: 99217, 99218, 99219, 99220, 99224, 99225, 99226, 99234, 99235, 99236, 99281, 99282, 99283, 99284, 99285, 99288, G0378, G0379, G0380, G0381, G0382, G0383, G0384, G0390, S9083, S9088.

Entyvio® (Vedolizumab) – Commercial Medical Benefit Drug Policy

Last Modified 08.01.2017

Effective Date: 07.01.2017 – This policy addresses the use of Entyvio® (vedolizumab) for the treatment of Crohn's disease and ulcerative colitis. Applicable Procedure Code: J3380.

Enzyme Replacement Therapy – Commercial Medical Benefit Drug Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses enzyme replacement therapy, including the use of Adagen (pegademase bovine), Aldurazyme (laronidase), Elaprase (idursulfase), Fabrazyme (agalsidase beta), Kanuma (sebelipase alfa), Lumizyme (alglucosidase alfa), Mepsevii (vestronidase alfa-vjbk), Naglazyme (galsulfase), and Vimizim (elosulfase alfa). Applicable Procedure Codes: J0180, J0221, J1322, J1458, J1743, J1931, J2504, J2840, J3590.

Epidural Steroid and Facet Injections for Spinal Pain – Commercial Medical Policy

Last Modified 02.01.2018

Effective Date: 02.01.2018 – This policy addresses epidural steroid and facet injections for spinal pain. Applicable Procedure Codes: 0213T, 0214T, 0215T, 0216T, 0217T, 0218T, 0230T, 0231T, 62322, 62323, 64483, 64484, 64490, 64491, 64492, 64493, 64494, 64495.

Epiduroscopy, Epidural Lysis of Adhesions and Functional Anesthetic Discography – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses epiduroscopy (including spinal myeloscopy), percutaneous and endoscopic epidural lysis of adhesions, and functional anesthetic discography

(FAD) for the diagnosis or treament of any type of neck or back pain or spinal disorder. Applicable Procedure Codes: 62263, 62264, 64999.

Exondys 51™ (Eteplirsen) – Commercial Medical Benefit Drug Policy

Last Modified 01.02.2018

Effective Date: 01.01.2018 – This policy addresses the use of Exondys 51™ (eteplirsen) for the treatment of Duchenne muscular dystrophy (DMD). Applicable Procedure Code: J1428.

Extracorporeal Shock Wave Therapy (ESWT) – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses extracorporeal shock wave therapy (ESWT). Applicable Procedure Codes: 0101T, 0102T, 28890.

Fecal Calprotectin Testing – Commercial Medical Policy

Last Modified 02.01.2018

Effective Date: 02.01.2018 – This policy addresses fecal measurement of calprotectin. Applicable Procedure Code: 83993.

Femoroacetabular Impingement Syndrome – Commercial Medical Policy

Last Modified 12.01.2017

Effective Date: 12.01.2017 – This policy addresses surgical treatment for femoroacetabular impingement (FAI) syndrome. Applicable Procedure Codes: 27299, 29914, 29915, 29916, 29999.

Fetal Aneuploidy Testing Using Cell-Free Fetal Nucleic Acids in Maternal Blood – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses DNA-based noninvasive prenatal tests of fetal aneuploidy. Applicable Procedure Codes: 0009M, 81420, 81422, 81507.

Functional Endoscopic Sinus Surgery (FESS) – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses functional endoscopic sinus surgery (FESS). Applicable Procedure Codes: 31240, 31254, 31255, 31256, 31267, 31276, 31287, 31288.

Gait Analysis – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 05.01.2017 – This policy addresses gait analysis. Applicable Procedure Codes: 96000, 96001, 96002, 96003, 96004.

Gastrointestinal Motility Disorders, Diagnosis and Treatment – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 06.01.2017 – This policy addresses gastric electrical stimulation therapy, manometry and rectal sensation, tone, and compliance test, defecography, electrogastrography, and electroenterography. Applicable Procedure Codes: 43647, 43648, 43881, 43882, 64590, 64595, 76496, 76498, 91117, 91120, 91122, 91132, 91133, 95980, 95981, 95982.

Gender Dysphoria Treatment – Commercial Medical Policy

Last Modified 10.01.2017

Effective Date: 10.01.2017 – This policy addresses gender dysphoria treatment, including gender reassignment surgery and certain ancillary procedures.

Gene Expression Tests for Cardiac Indications – Commercial Medical Policy

Last Modified 11.01.2017

Effective Date: 11.01.2017 – This policy addresses the use of gene expression tests for coronary artery disease. Applicable Procedure Code: 81493.

Genetic Testing for Hereditary Cancer – Commercial Medical Policy

Last Modified 02.06.2018

Effective Date: 01.01.2018 – This policy addresses BRCA1, BRCA2, and multi-gene hereditary cancer panel testing. Applicable Procedure Codes: 81162, 81211, 81212, 81213, 81214, 81215, 81216, 81217, 81432, 81433.

Glaucoma Surgical Treatments – Commercial Medical Policy

Last Modified 03.01.2018

Effective Date: 03.01.2018 – This policy addresses glaucoma drainage devices, canaloplasty, and viscocanalostomy. Applicable Procedure Codes: 0191T, 0253T, 0376T, 0449T, 0450T, 0474T, 66174, 66175, 66179, 66180, 66183, 66184, L8612.

Gonadotropin Releasing Hormone Analogs – Commercial Medical Benefit Drug Policy

Last Modified 11.01.2017

Effective Date: 11.01.2017 – This policy addresses gonadotropin releasing hormone analog (GnRH analog) drug products, including Firmagon (degarelix), Lupron Depot (leuprolide acetate), Lupron Depot-Ped (leuprolide acetate), Supprelin LA (histrelin acetate), Trelstar (triptorelin pamoate), Triptodur (triptorelin), Vantas (histrelin acetate), and Zoladex (goserelin acetate). Applicable Procedure Codes: J1950, J3315, J3490, J9155, J9202, J9217, J9225, J9226.

Gynecomastia Treatment – Commercial Coverage Determination Guideline

Last Modified 12.01.2017

Effective Date: 12.01.2017 – This policy addresses mastectomy or suction lipectomy. Applicable Procedure Code: 19300.

Habilitative Services for Essential Health Groups – Commercial Coverage Determination Guideline

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses outpatient and inpatient habilitative services, including physical therapy, occupational therapy, manipulative treatment, speech therapy, post-cochlear implant aural therapy, and cognitive therapy for Essential Health groups.

Hearing Aids and Devices Including Wearable, Bone-Anchored and Semi-Implantable – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses wearable hearing aids (including non-implantable bone conduction hearing aids utilizing a headband), semi-implantable electromagnetic hearing aids (SEHA), fully or partially implantable bone anchored hearing aids, totally implanted middle ear hearing systems, intraoral bone conduction hearing aids, and laser or light based hearing aids.

Hepatitis Screening – Commercial Medical Policy

Last Modified 10.01.2017

Effective Date: 10.01.2017 – This policy addresses hepatitis screening. Applicable Procedure Codes: 86704, 86705, 86706, 86707, 86708, 86709, 86803, 86804, 87340, 87341, 87350, 87902, 87912, G0472, G0499.

Hereditary Angioedema (HAE), Treatment and Prophylaxis – Commercial Medical Benefit Drug Policy

Last Modified 11.01.2017

Effective Date: 11.01.2017 – This policy addresses the use of C1 esterace inhibitors (human), C1 esterace inhibitors (recombinant), and plasma kallikrein inhibitors (human) for the treatment and prophlaxis of hereditary angioedema (HAE), including the following drug products: Berinert® (for intravenous injection), Cinryze® (for intravenous injection), Ruconest® (for intravenous injection), and Kalbitor® (ecallantide, for subcutaneous injection). Applicable Procedure Codes: J0596, J0597, J0598, J1290.

High Frequency Chest Wall Compression Devices– Commercial Medical Policy

Last Modified 09.01.2017

Effective Date: 09.01.2017 – This policy addresses high-frequency chest wall compression (HFCWC). Applicable Procedure Codes: 94669, A7025, A7026, E0483.

Hip Resurfacing and Replacement Surgery (Arthroplasty) – Commercial Medical Policy

Last Modified 12.01.2017

Effective Date: 12.01.2017 – This policy addresses hip resurfacing and replacement surgery (arthroplasty). Applicable Procedure Codes: 27120, 27122, 27125, 27130, 27132, 27134, 27137, 27138, 27299, S2118.

Home Health Care – Commercial Coverage Determination Guideline

Last Modified 12.01.2017

Effective Date: 12.01.2017 – This policy addresses home health care services.

Home Hemodialysis – Commercial Medical Policy

Last Modified 02.01.2018

Effective Date: 02.01.2018 – This policy addresses home hemodialysis (HHD). Applicable Procedure Codes: 90963, 90964, 90965, 90966, 90967, 90968, 90969, 90970, 90989, 90993, 99512, S9335.

Home Traction Therapy – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 07.01.2017 – This policy addresses home traction therapy. Applicable Procedure Codes: E0830, E0840, E0849, E0850, E0855, E0856, E0860, E0941.

Hospital Readmissions – Commercial Quality of Care Guideline

Last Modified 10.23.2017

Effective Date: 10.01.2017 – This policy addresses hospital readmissions.

Hysterectomy for Benign Conditions – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 04.01.2017 – This policy addresses hysterectomy. Applicable Procedure Codes: 58150, 58152, 58180, 58541, 58542, 58543, 58544, 58570, 58571, 58572, 58573, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58290, 58291, 58292, 58293, 58294, 58550, 58552, 58553, 58554.

Ilaris® (Canakinumab) – Commercial Medical Benefit Drug Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses the use of Ilaris® (canakinumab) for the treatment of cryopyrin-associated periodic syndromes (CAPS), tumor necrosis factor (TNF) receptor-associated periodic syndrome (TRAPS), hyperimmunoglobulin D (Hyper-IgD) syndrome (HIDS)/mevalonate kinase deficiency (MKD), familial mediterranean fever (FMF), and systemic juvenile idiopathic arthritis (SJIA). Applicable Procedure Code: J0638.

Immune Globulin (IVIG and SCIG) – Commercial Medical Benefit Drug Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses the use of intravenous (IV) and subcutaneous (SC) immune globulin (IG) products, including Bivigam™, Carimune® NF, Cuvitru™, Flebogamma® DIF, Gammagard® Liquid, Gammagard® S/D, Gammaked™, Gammaplex®, Octagam®, Privigen®, Gamunex®-C, Hizentra®, and HyQvia®. Applicable Procedure Codes: 90283, 90284, J1459, J1555, J1556, J1557, J1559, J1561, J1566, J1568, J1569, J1572, J1575, J1599.

Immune Globulin Site of Care Review Guidelines for Medical Necessity of Hospital Outpatient Facility Infusion – Commercial Utilization Review Guideline

Last Modified 11.01.2017

Effective Date: 11.01.2017 – This policy addresses hospital outpatient facility infusion service for immune globulin (IVIG and SCIG) therapy.

Implantable Beta-Emitting Microspheres for Treatment of Malignant Tumors – Commercial Medical Policy

Last Modified 02.01.2018

Effective Date: 02.01.2018 – This policy addresses Yttrium-90 (90Y) microsphere radioembolization for the treatment of unresectable metastatic liver tumors from primary colorectal cancer (CRC), unresectable metastatic liver tumors from neuroendocrine tumors, and unresectable primary hepatocellular carcinoma (HCC). Applicable Procedure Codes: 37243, 79445, S2095.

Implanted Electrical Stimulator for Spinal Cord – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 08.01.2017 – This policy addresses implanted electrical stimulator for spinal cord. Applicable Procedure Codes: 63650, 63655, 63685, C1767, C1778, C1816, C1820, C1822, C1883, C1897, L8679, L8680, L8682, L8683, L8685, L8686, L8687, L8688, L8695.

Infertility Diagnosis and Treatment – Commercial Medical Policy

Last Modified 02.01.2018

Effective Date: 02.01.2018 – This policy addresses diagnostic and therapeutic procedures for infertility and cryopreservation.

Infertility Services – Commercial Coverage Determination Guideline

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses diagnostic and therapeutic services for infertility.

Infliximab (Remicade®, Inflectra™, Renflexis™) – Commercial Medical Benefit Drug Policy

Last Modified 10.01.2017

Effective Date: 10.01.2017 – This policy addresses the use of infliximab products as tumor necrosis factor (TNF) blockers, including Remicade® (infliximab), Inflectra™ (infliximab-dyyb), and Renflexis™ (infliximab-abda). Applicable Procedure Codes: J1745, Q5102.

Inpatient Pediatric Feeding Programs – Commercial Utilization Review Guideline

Last Modified 08.01.2017

Effective Date: 03.01.2017 – This policy addresses inpatient pediatric feeding programs.

Intensity-Modulated Radiation Therapy – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses the use of intensity-modulated radiation therapy (IMRT). Applicable Procedure Codes: 77301, 77338, 77385, 77386, 77387, 77520, 77522, 77523, 77525, G6015, G6016, G6017.

Intraoperative Hyperthermic Intraperitoneal Chemotherapy (HIPEC) – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 07.01.2017 – This policy addresses intraoperative hyperthermic intraperitoneal chemotherapy (HIPEC). Applicable Procedure Code: 96549.

Intrauterine Fetal Surgery – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 05.01.2017 – This policy addresses intrauterine fetal surgery. Applicable Procedure Codes: 59070, 59072, 59074, 59076, 59897, S2400, S2401, S2402, S2403, S2404, S2405, S2409, S2411.

Intravenous Enzyme Replacement Therapy (ERT) for Gaucher Disease – Commercial Medical Benefit Drug Policy

Last Modified 02.01.2018

Effective Date: 09.01.2017 – This policy addresses the use of intravenous enzyme replacement drug products for the treatment of Gaucher disease, including Cerezyme® (imiglucerase), Elelyso® (taliglucerase), and VPRIV® (velaglucerase). Applicable Procedure Codes: J1786, J3060 J3385.

Laser Interstitial Thermal Therapy – Commercial Medical Policy

Last Modified 10.01.2017

Effective Date: 10.01.2017 – This policy addresses laser interstitial thermal therapy. Applicable Procedure Codes: 19499, 32999, 55899, 64999.

Lemtrada (Alemtuzumab) – Commercial Medical Benefit Drug Policy

Last Modified 08.01.2017

Effective Date: 06.01.2017 – This policy addresses the use of Lemtrada (alemtuzumab) for treatment of relapsing-remitting multiple sclerosis. Applicable Procedure Code: J0202.

Light and Laser Therapy for Cutaneous Lesions and Pilonidal Disease – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 07.01.2017 – This policy addresses light and laser therapy, including light phototherapy, photodynamic therapy, intense pulsed light, pulsed dye laser, and laser hair removal. Applicable Procedure Codes: 17106, 17107, 17108, 17380.

Lithotripsy for Salivary Stones– Commercial Medical Policy

Last Modified 09.01.2017

Effective Date: 09.01.2017 – This policy addresses extracorporeal shock wave lithotripsy (ESWL) and endoscopic intracorporeal laser lithotripsy for treating salivary stones. Applicable Procedure Codes: 42699.

Luxturna™ (Voretigene Neparvovec-Rzyl) – Commercial Medical Benefit Drug Policy

Last Modified 01.19.2018

Effective Date: 01.19.2018 – This policy addresses the use of Luxturna™ (voretigene neparvovec-rzyl) for the treatment of inherited retinal dystrophies (IRD) caused by mutations in the retinal pigment epithelium-specific protein 65kDa (RPE65) gene. Applicable Procedure Codes: C9399, J3490, J3590.

Macular Degeneration Treatment Procedures – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 07.01.2017 – This policy addresses Implantable Miniature Telescope (IMT), conjunctival incision with posterior extrascleral placement of a pharmacologic agent, epiretinal radiation therapy, and laser photocoagulation. Applicable Procedure Codes: 0190T, 0308T, 67299, 92499.

Magnetic Resonance Spectroscopy (MRS) – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 08.01.2017 – This policy addresses magnetic resonance spectroscopy (MRS). Applicable Procedure Code: 76390.

Manipulation Under Anesthesia – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 03.01.2017 – This policy addresses manipulation under anesthesia (MUA). Applicable Procedure Codes: 21073, 22505, 25259, 27275, 27860, 23700, 24300, 26340, 27198, 27570, D7830.

Manipulative Therapy – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 05.01.2017 – This policy addresses manipulative therapy and craniosacral therapy. Applicable Procedure Codes: 98925, 98926, 98927, 98928, 98929, 98940, 98941, 98942, 98943, S8990.

Maximum Dosage – Commercial Medical Benefit Drug Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses the maximum dosage per administration for medications administered by a medical professional, including bevacizumab (Avastin®), eculizumab (Soliris®), infliximab (Remicade®), infliximab-abda (Renflexis™), infliximab-dyyb (Inflectra™), omalizumab (Xolair®), pegfilgrastim (Neulasta®), rituximab (Rituxan®), trastuzumab

(Herceptin®), ustekinumab (Stelara®), vedolizumab (Entyvio®), and zoledronic acid (zoledronic acid, Reclast®, and Zometa®). Applicable Procedure Codes: J1300, J1745, J2357, J2505, J3357, J3358, J3380, J3489, J9035, J9310, J9355, Q5102.

Mechanical Stretching Devices – Commercial Medical Policy

Last Modified 02.01.2018

Effective Date: 02.01.2018 – This policy addresses the use of low-load prolonged-duration stretch devices, static progressive (SP) stretch splint devices, and patient actuated serial stretch (PASS) devices. Applicable Procedure Codes: E1399, E1800, E1801, E1802, E1805, E1806, E1810, E1811, E1812, E1815, E1816, E1818, E1825, E1830, E1831, E1840, E1841.

Meniscus Implant and Allograft – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 07.01.2017 – This policy addresses meniscus allograft transplantation with human cadaver tissue and collagen meniscus implants. Applicable Procedure Codes: 29868, G0428.

Mifeprex® (Mifepristone) – Commercial Medical Benefit Drug Policy

Last Modified 08.01.2017

Effective Date: 07.01.2017 – This policy addresses the use of Mifeprex® (mifepristone) in combination with misoprostol for termination of pregnancy. Applicable Procedure Codes: S0190, S0191.

Minimally Invasive Procedures for Gastroesophageal Reflux Disease (GERD) – Commercial Medical Policy

Last Modified 11.01.2017

Effective Date: 11.01.2017 – This policy addresses endoscopic therapies and the LINX™ Reflux Management System for treating gastroesophageal reflux disease (GERD). Applicable Procedure Codes: 43210, 43257, 43284, 43289, 43499, 43999.

Molecular Oncology Testing for Cancer Diagnosis, Prognosis, and Treatment Decisions – Commercial Medical Policy

Last Modified 02.01.2018

Effective Date: 02.01.2018 – This policy addresses gene expression testing and profiling for oncology indications, topographic genotyping, and multi-gene cancer panels (molecular profiling). Applicable Procedure Codes: 0005U, 0011M, 0019U, 0021U, 81228, 81229, 81445, 81450, 81455, 81504, 81519, 81525, 81540, 81541, 81551, 81599.

Motorized Spinal Traction – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 07.01.2017 – This policy addresses motorized spinal traction devices. Applicable Procedure Code: S9090.

Nerve Graft to Restore Erectile Function During Radical Prostatectomy– Commercial Medical Policy

Last Modified 09.01.2017

Effective Date: 09.01-2017 – This policy addresses sural or other nerve grafts to restore erectile function during radical prostatectomy. Applicable Procedure Codes: 55899, 64999.

Neurophysiologic Testing and Monitoring – Commercial Medical Policy

Last Modified 11.01.2017

Effective Date: 11.01.2017 – This policy addresses electromyography (EMG), nerve conduction studies, physiologic recording of tremor, quantitative sensory testing, seizure monitoring systems, and visual evoked potentials for glaucoma. Applicable Procedure Codes: 0106T, 0107T, 0108T, 0109T, 0110T, 0464T, 95860, 95861, 95863, 95864, 95865, 95866, 95867, 95868, 95869, 95870, 95872, 95873, 95874, 95885, 95886, 95887, 95905, 95907, 95908, 95909, 95910, 95911, 95912, 95913, 95937, 95999, 96002, 96003, 96004, A9279, A9280, G0255, S3900.0.

Neuropsychological Testing Under the Medical Benefit– Commercial Medical Policy

Last Modified 09.01.2017

Effective Date: 09.01.2017 – This policy addresses neuropsychological testing and computerized cognitive testing under the medical benefit. Applicable Procedure Codes: 96116, 96118, 96119,

96120.

Obstructive Sleep Apnea Treatment – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 08.01.2017 – This policy addresses nonsurgical and surgical treatment of obstructive sleep apnea (OSA). Applicable Procedure Codes: 0466T, 0467T, 0468T, 21193, 21194, 21195, 21196, 21198, 21199, 21206, 21685, 41512, 41530, 41599, 42145, 42299, 64553, 64568, 64569, 64570, E0485, E0486, L8679, L8680, L8686, S2080.

Occipital Neuralgia and Headache Treatment – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses occipital neuralgia and headache treatments, including injection of local anesthetics and/or steroids used as occipital nerve blocks, surgery, occipital neurectomy or surgical nerve decompression, radiofrequency ablation (thermal or pulsed) or denervation, and neurostimulation or electrical stimulation. Applicable Procedure Codes: 62281, 63185, 63190, 64405, 64553, 64555, 64568, 64570, 64575, 64590, 64633, 64634, 64722, 64744, 64771, 64999, 95972, E0720, L8679, L8680, L8683, L8685.

Ocrevus™ (Ocrelizumab) – Commercial Medical Benefit Drug Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses the use of Ocrevus™ (ocrelizumab) for the treatment of multiple sclerosis. Applicable Procedure Code: J2350.

Off-Label/Unproven Specialty Drug Treatment – Commercial Medical Benefit Drug Policy

Last Modified 08.01.2017

Effective Date: 08.01.2017 – This policy addresses off-label and unproven indications of FDA-approved injectable specialty drugs.

Office Based Program – Commercial Utilization Review Guideline

Last Modified 02.01.2018

Effective Date: 10.01.2017 – This policy addresses certain elective procedures which should be performed in an Office setting. Applicable Procedure Codes: 10120, 10140, 11400, 11401, 11402, 11403, 11404, 11406, 11420, 11421, 11422, 11423, 11424, 11426, 11442, 11606, 19000, 27096, 31579, 36473, 36475, 36478, 45300, 45330, 46922, 55250, 57460, 62270, 62320, 62321, 62322, 62323, 64479, 64483, 64490, 64493, 64520, 64633, 64635.

Omnibus Codes – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses multiple services/procedures.

Oncology Medication Clinical Coverage – Commercial Medical Benefit Drug Policy

Last Modified 11.01.2017

Effective Date: 11.01.2017 – This policy addresses parameters for coverage of injectable oncology medications and select ancillary and supportive care medications for oncology conditions covered under the medical benefit. Applicable Procedure Codes: J0640, J0641, J1950, J2353, J2354, J9000-J9999.

Ophthalmologic Policy: Vascular Endothelial Growth Factor (VEGF) Inhibitors – Commercial Medical Benefit Drug Policy

Last Modified 03.12.2018

Effective Date: 01.01.2018 – This policy addresses the use of vascular endothelial growth factor (VEGF) inhibitors, including Eylea™ (aflibercept), Avastin® (bevacizumab), Macugen® (pegaptanib), and Lucentis® (ranibizumab). Applicable Procedure Codes: J0178, J2503, J2778, J9035.

Orencia® (Abatacept) Injection for Intravenous Infusion – Commercial Medical Benefit Drug Policy

Last Modified 03.01.2018

Effective Date: 03.01.2018 – This policy addresses the use of Orencia® (abatacept) injection for intravenous infusion for the treatment of polyarticular juvenile idiopathic arthritis, rheumatoid

arthritis, and psoriatic arthritis. Applicable Procedure Code: J0129.

Orthognathic (Jaw) Surgery – Commercial Coverage Determination Guideline

Last Modified 12.01.2017

Effective Date: 12.01.2017 – This policy addresses orthognathic (jaw) surgery.

Osteochondral Grafting– Commercial Medical Policy

Last Modified 09.01.2017

Effective Date: 09.01.2017 – This policy addresses osteochondral autograft transplantation, osteochondral allograft transplantation, and minced articular cartilage repair (allograft or autograft). Applicable Procedure Codes: 27415, 27416, 29866, 29867, 28446.

Outpatient Cardiac Telemetry – Commercial Medical Policy

Last Modified 03.01.2018

Effective Date: 03.01.2018 – This policy addresses outpatient cardiac telemetry. Applicable Procedure Codes: 93228, 93229.

Panniculectomy and Body Contouring Procedures – Commercial Coverage Determination Guideline

Last Modified 02.01.2018

Effective Date: 11.01.2017 – This policy addresses panniculectomy, abdominoplasty, lipectomy, and suction-assisted lipectomy of the trunk. Applicable Procedure Codes: 15830, 15832, 15833, 15834, 15835, 15836, 15837, 15838, 15839, 15847, 15876, 15877, 15878, 15879.

Pectus Deformity Repair – Commercial Coverage Determination Guideline

Last Modified 11.01.2017

Effective Date: 11.01.2017 – This policy addresses surgical repair of pectus excavatum and pectus carinatum. Applicable Procedure Codes: 21740, 21742, 21743.

Percutaneous Vertebroplasty and Kyphoplasty – Commercial Medical Policy

Last Modified 10.01.2017

Effective Date: 10.01.2017 – This policy addresses percutaneous vertebroplasty and kyphoplasty for treating spinal pain. Applicable Procedure Codes: 22510, 22511, 22512, 22513, 22514, 22515.

Pharmacogenetic Testing – Commercial Medical Policy

Last Modified 11.01.2017

Effective Date: 11.01.2017 – This policy addresses the use of pharmacogenetic testing panels for genetic polymorphisms. Applicable Procedure Code: 81479.

Plagiocephaly and Craniosynostosis Treatment– Commercial Medical Policy

Last Modified 09.01.2017

Effective Date: 09.01.2017 – This policy addresses cranial orthotic devices and surgical treatment to repair craniosynostosis. Applicable Procedure Codes: 21175, 61550, 61552, 61556, 61557, 61558, 61559, D5924, L0112, L0113, S1040.

Platelet Derived Growth Factors for Treatment of Wounds – Commercial Medical Policy

Last Modified 03.01.2018

Effective Date: 03.01.2018 – This policy addresses recombinant-human platelet derived growth factors and autologous platelet rich plasma. Applicable Procedure Codes: 0232T, G0460, S0157, S9055.

Pneumatic Compression Devices – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 04.01.2017 – This policy addresses pneumatic compression devices. Applicable Procedure Codes: A4600, E0650, E0651, E0655, E0660, E0665, E0666, E0667, E0668, E0669, E0670, E0671, E0672, E0673, E0675, E0676.

Preterm Labor Management – Commercial Medical Policy

Last Modified 11.01.2017

Effective Date: 11.01.2017 – This policy addresses tocolytic therapy, subcutaneous terbutaline pump maintenance therapy, magnesium sulfate, and home uterine activity monitoring (HUAM). Applicable Procedure Codes: J3105, J3475, S9001, S9349.

Preventive Care Services – Commercial Coverage Determination Guideline

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses preventive care services.

Private Duty Nursing Services (PDN) – Commercial Coverage Determination Guideline

Last Modified 08.01.2017

Effective Date: 08.01.2017 – This policy addresses prolotherapy for musculoskeletal indications. Applicable Procedure Codes: 0232T, M0076.

Prolotherapy for Musculoskeletal Indications – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses prolotherapy for musculoskeletal indications. Applicable Procedure Codes: 0232T, 0481T, M0076.

Propranolol Treatment for Infantile Hemangiomas: Inpatient Protocol – Commercial Utilization Review Guideline

Last Modified 08.01.2017

Effective Date: 03.01.2017 – This policy addresses the use of oral propranolol for the treatment of infantile hemangiomas (IH).

Prosthetic Devices, Wigs, Specialized, Microprocessor or Myoelectric Limbs – Commercial Coverage Determination Guideline

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses prosthetic devices, wigs, and specialized/microprocessor/ myoelectric limbs, and includes applicable procedure codes for breast prosthesis, eye/nose/facial prosthesis, ear prosthesis, lower and upper limb prosthetics, additions to upper extremity, prosthetic socks, repairs and replacements, wigs, and voice amplifier.

Proton Beam Radiation Therapy – Commercial Medical Policy

Last Modified 03.01.2018

Effective Date: 03.01.2018 – This policy addresses proton beam radiation therapy. Applicable Procedure Codes: 77301, 77338, 77385, 77386, 77387, 77520, 77522, 77523, 77525, G6015, G6016, G6017.

Radicava™ (Edaravone) – Commercial Medical Benefit Drug Policy

Last Modified 09.01.2017

Effective Date: 09.01.2017 – This policy addresses the use of Radicava™ (edaravone) for the treatment of amyotrophic lateral sclerosis (ALS). Applicable Procedure Code: J3490.

Rehabilitation Services (Outpatient) – Commercial Coverage Determination Guideline

Last Modified 01.01.2018

EEffective Date: 01.01.2018 – This policy addresses outpatient rehabilitation services, including physical therapy, occupational therapy, manipulative treatment, speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, post-cochlear implant aural therapy, and cognitive rehabilitation therapy.

Repository Corticotropin Injection (H.P. Acthar Gel®) – Commercial Medical Benefit Drug Policy

Last Modified 09.01.2017

Effective Date: 09.01.2017 – This policy addresses the use of repository corticotropin injection (H.P. Acthar Gel®) for the treatment of infantile spasm, opsoclonus-myoclonus syndrome, and acute exacerbation of multiple sclerosis (MS). Applicable Procedure Code: J0800.

Respiratory Interleukins (Cinqair®, Fasenra®, and Nucala®) – Commercial Medical Benefit Drug Policy

Last Modified 03.01.2018

Effective Date: 03.01.2018 – This policy addresses the use of interleukin-5 (IL-5) antagonists, including Cinqair® (reslizumab), Fasenra® (benralizumab), and Nucala® (mepolizumab). Applicable Procedure Codes: J2182, J2786.

Review at Launch for New to Market Medications – Commercial Medical Benefit Drug Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses review of certain new to market medications that are healthcare provider administered. Applicable Procedure Codes: C9399, J3490, J3590.

Rhinoplasty and Other Nasal Surgeries – Commercial Coverage Determination Guideline

Last Modified 11.01.2017

Effective Date: 11.01.2017 – This policy addresses rhinoplasty, repair of nasal vestibular stenosis or alar collapse, septal dermatoplasty, lysis intranasal synechia, and rhinophyma. Applicable Procedure Codes: 30120, 30400, 30410, 30420, 30430, 30435, 30450, 30460, 30462, 30465, 30560, 30620.

Rituxan® (Rituximab) – Commercial Medical Benefit Drug Policy

Last Modified 08.01.2017

Effective Date: 07.01.2017 – This policy addresses the use of Rituxan® (rituximab) for the treatment of immune thrombocytopenic purpura (ITP), autoimmune mucocutaneous blistering diseases, Wegener’s granulomatosis or microscopic polyangiitis, post-transplant B-lymphoproliferative disorder, and neuromyelitis optica. Applicable Procedure Code: J9310.

Sensory Integration Therapy and Auditory Integration Training – Commercial Medical Policy

Last Modified 10.01.2017

Effective Date: 10.01.2017 – This policy addresses sensory integration therapy and auditory integration training. Applicable Procedure Code: 97533.

Shoulder Replacement Surgery (Arthroplasty) – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 04.01.2017 – This policy addresses shoulder arthroplasty and hemiarthroplasty. Applicable Procedure Codes: 23470, 23472, 23473, 23474, 23616.

Simponi Aria® (Golimumab) Injection for Intravenous Infusion – Commercial Medical Benefit Drug Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses Simponi Aria® (golimumab) injection for intravenous infusion for the treatment of ankylosing spondylitis, psoriatic arthritis, and rheumatoid arthritis. Applicable Procedure Code: J1602.

Site of Service for Certain Outpatient Surgical Procedures – Commercial Utilization Review Guideline

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses sites of service for certain outpatient surgical procedures.

Skilled Care and Custodial Care Services – Commercial Coverage Determination Guideline

Last Modified 09.19.2017

Effective Date: 09.01.2017 – This policy addresses skilled care and custodial care services. Applicable Procedure Codes: 99509, S5100, S5101, S5102, S5105, S5120, S5121, S5125, S5126, S5130, S5131, S5135, S5136, S5140, S5141, S5150, S5151, S5170, S5175, S9125, T1005, T1019, T1020.

Sodium Hyaluronate – Commercial Medical Policy

Last Modified 03.01.2018

Effective Date: 03.01.2018 – This policy addresses intra-articular injections of sodium hyaluronate, sodium hyaluronate preparations, and hyaluronic acid gel preparations. Applicable Procedure Codes: 20605, 20606, 20610, 20611, J3490, J7320, J7321, J7322, J7323, J7324, J7325, J7326, J7327, J7328.

Soliris® (Eculizumab) – Commercial Medical Benefit Drug Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses the use of Soliris® (eculizumab) for the treatment of atypical hemolytic uremic syndrome (aHUS), paroxysmal nocturnal hemoglobinuria (PNH), and myasthenia gravis. Applicable Procedure Code: J1300.

Somatostatin Analogs – Commercial Medical Benefit Drug Policy

Last Modified 02.01.2018

Effective Date: 02.01.2018 – This policy addresses the use of somatostatin analogs, including Sandostatin® (octreotide acetate), Sandostatin® LAR (octreotide acetate LAR), Signifor® (pasireotide diaspartate), Signifor® LAR (pasireotide), and Somatuline® Depot (lanreotide). Applicable Procedure Codes: J1930, J2353, J2354, J2502.

Specialty Medication Administration – Site of Care Review Guidelines – Commercial Utilization Review Guideline

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses outpatient hospital facility-based intravenous medication infusion, including Actemra® (tocilizumab), Entyvio® (vedolizumab), Exondys 51™ (eteplirsen), Ilaris® (canakinumab), Inflectra™ (infliximab-dyyb), Ocrevus™ (ocrelizumab), Orencia® (abatacept), Radicava™ (edaravone), Remicade® (infliximab), Renflexis™ (infliximab-abda), Simponi® Aria™ (golimumab), and Soliris® (eculizumab).

Speech Language Pathology Services – Commercial Coverage Determination Guideline

Last Modified 03.01.2018

Effective Date: 02.01.2018 – This policy addresses acquired apraxia of speech rehabilitation, dysarthria rehabilitation, voice disorders rehabilitation, developmental speech disorders rehabilitation, and developmental language disorders rehabilitation. Applicable Procedure Codes: 70371, 92507, 92508, 92521, 92522, 92523, 92524, 92526, 96105, S9152, V5362, V5363.

Spinal Ultrasonography – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses spinal and paraspinal ultrasonography. Applicable Procedure Codes: 76536, 76800, 76856, 76857, 76881, 76882.

Spinraza™ (Nusinersen) – Commercial Medical Benefit Drug Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses the use of Spinraza™ (nusinersen) for the treatment of spinal muscular atrophy (SMA). Applicable Procedure Code: J2326.

Stelara® (Ustekinumab) – Commercial Medical Benefit Drug Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses the use of Stelara® (ustekinumab) for the treatment of Crohn's disease, plaque psoriasis, and psoriatic arthritis. Applicable Procedure Codes: J3357, J3358.

Surgical and Ablative Procedures for Venous Insufficiency and Varicose Veins – Commercial Medical Policy

Last Modified 03.01.2018

Effective Date: 03.01.2018 – This policy addresses varicose vein ablative and stripping procedures and ligation procedures. Applicable Procedure Codes: 36465, 36466, 36473, 36474, 36475, 36476, 36478, 36479, 36482, 36483, 37700, 37718, 37722, 37780, 37799.

Surgical Treatment for Spine Pain – Commercial Medical Policy

Last Modified 02.01.2018

Effective Date: 02.01.2018 – This policy addresses spinal fusion using extreme lateral interbody fusion (XLIF®) or direct lateral interbody fusion (DLIF).

Synagis® (Palivizumab) – Commercial Medical Benefit Drug Policy

Last Modified 10.01.2017

Effective Date: 10.01.2017 – This policy addresses the use of Synagis® (palivizumab) to prevent serious respiratory syncytial virus disease (RSV) in high risk infants and young children. Applicable Procedure Code: 90378.

Temporomandibular Joint Disorders – Commercial Medical Policy

Last Modified 03.01.2018

Effective Date: 02.01.2018 – This policy addresses treatment of temporomandibular joint (TMJ) disorders. Applicable Procedure Codes: 20605, 20606, 21010, 21050, 21060, 21085, 21089, 21110, 21240, 21242, 21243, 29800, 29804, 90901, 97039, 97139, E0746, E1399, E1700, E1701, E1702.

Thermal Capsulorrhaphy/Thermal Shrinkage Therapy – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 03.01.2017 – This policy addresses thermal shrinkage therapy of joint capsules, ligaments, and tendons. Applicable Procedure Codes: 23929, 29999, S2300.

Thermography – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 04.01.2017 – This policy addresses Thermography, including digital infrared thermal imaging, temperature gradient studies, and magnetic resonance (MR) thermography. Applicable Procedure Codes: 76498, 93740.

Total Artificial Disc Replacement for the Spine – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 05.01.2017 – This policy addresses cervical and lumbar artificial total disc replacement. Applicable Procedure Codes: 0095T, 0098T, 0163T, 0164T, 0165T, 0375T, 22856, 22857, 22858, 22861, 22862, 22864, 22865.

Total Artificial Heart – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses the SynCardia™ temporary Total Artificial Heart. Applicable Procedure Codes: 33927, 33928, 33929.

Total Knee Replacement Surgery (Arthroplasty) – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 04.01.2017 – This policy addresses total knee replacement surgery (arthroplasty). Applicable Procedure Codes: 27445, 27446, 27447, 27486, 27487.

Transcatheter Heart Valve Procedures – Commercial Medical Policy

Last Modified 02.01.2018

Effective Date: 02.01.2018 – This policy addresses transcatheter aortic and pulmonary heart valve replacement, transcatheter mitral valve replacement, percutaneous transcatheter mitral valve annuloplasty and leaflet repair, transcatheter heart valve replacement within a failed bioprosthesis (valve-in-valve procedure), and transcatheter cerebral protection devices. Applicable Procedure Codes: 0345T, 0483T, 0484T, 33361, 33362, 33363, 33364, 33365, 33366, 33367, 33368, 33369, 33418, 33419, 33477, 93799.

Transcranial Magnetic Stimulation – Commercial Medical Policy

Last Modified 03.01.2018

Effective Date: 03.01.2018 – This policy addresses transcranial magnetic stimulation and navigated transcranial magnetic stimulation (nTMS). Applicable Procedure Codes: 64999, 90867, 90868, 90869.

Transpupillary Thermotherapy – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 06.01.2017 – This policy addresses transpupillary thermotherapy. Applicable Procedure Codes: 67299, 92499.

Umbilical Cord Blood Harvesting and Storage for Future Use – Commercial Medical Policy

Last Modified 08.01.2017

Effective Date: 07.01.2017 – This policy addresses collection and storage of umbilical cord blood for possible later use. Applicable Procedure Codes: 38205, 38206, 38207, 88240, S2140.

Unicondylar Spacer Devices for Treatment of Pain or Disability– Commercial Medical Policy

Last Modified 09.01.2017

Effective Date: 09.01.2017 – This policy addresses Unicondylar spacer devices for treating knee joint pain or disability from any cause. Applicable Procedure Code: 27599.

Vaccines – Commercial Medical Benefit Drug Policy

Last Modified 08.01.2017

Effective Date: 06.01.2017 – This policy addresses vaccines/immunizations.

Vagus Nerve Stimulation – Commercial Medical Policy

Last Modified 01.01.2018

Effective Date: 01.01.2018 – This policy addresses implantable vagus nerve stimulators and transcutaneous (nonimplantable) vagus nerve stimulation. Applicable Procedure Codes: 61885, 64553, 64568, 64570, E0770, E1399, L8679, L8680, L8682, L8683, L8685, L8686, L8687, L8688.

Virtual Upper Gastrointestinal Endoscopy – Commercial Medical Policy

Last Modified 10.01.2017

Effective Date: 10.01.2017 – This policy addresses virtual upper gastrointestinal endoscopy. Applicable Procedure Codes: 76497, 76498.

Visual Information Processing Evaluation and Orthoptic and Vision Therapy – Commercial Medical Policy

Last Modified 10.01.2017

Effective Date: 10.01.2017 – This policy addresses occlusion therapy, orthoptic or vision therapy the use of visual information processing evaluations to diagnose reading or learning disabilities, visual perceptual therapy, and vision restoration therapy. Applicable Procedure Codes: 92065, 92499.

Warming Therapy and Ultrasound Therapy for Wounds – Commercial Medical Policy

Last Modified 10.01.2017

Effective Date: 10.01.2017 – This policy addresses warming therapy, noncontact normothermic wound therapy, and low frequency ultrasound for treating wounds. Applicable Procedure Codes: 97610, A4639, A6000, E0221, E0231, E0232.

White Blood Cell Colony Stimulating Factors – Commercial Medical Benefit Drug Policy

Last Modified 09.01.2017

Effective Date: 09.01.2017 – This policy addresses the use of white blood cell colony stimulating factors (CSFs), including the drug products Granix, Leukine, Neulasta, Neupogen, and Zarxio, for bone marrow/stem cell transplant, acute myeloid leukemia (AML) induction or consolidation therapy, and the treatment of neutropenia. Applicable Procedure Codes: J1442, J1447, J2505, J2820, Q5101.

Whole Exome and Whole Genome Sequencing – Commercial Medical Policy

Last Modified 03.01.2018

Effective Date: 03.01.2018 – This policy addresses whole exome and whole genome sequencing. Applicable Procedure Codes: 81415, 81416, 81417.

Xolair® (Omalizumab) – Commercial Medical Benefit Drug Policy

Last Modified 12.01.2017

Effective Date: 12.01.2017 – This policy addresses the use of Xolair® (omalizumab) for subcutaneous use for the treatment of moderate to severe persistent asthma and chronic urticaria. Applicable Procedure Code: J2357.

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