Medical Coverage Policy Retirement Notice

Updated 5/1/2024

The following medical coverage policies have been "retired." Where so indicated, review for medical necessity for these services/procedures/devices will now take place using alternative medical coverage policies, InterQual, eviCore, or OncoHealth.

Change Healthcare's InterQual uses rigorously developed, and nationally recognized, dataset for decision support to promote appropriate and medically necessary care. For more information, click on this link: https://www.changehealthcare.com/solutions/interqual

EviCore Healthcare is a national organization "...committed to advancing healthcare management through intelligent care. For more information, click on this link: https://www.evicore.com/resources/pages/providers.aspx#ReferenceGuidelines

OncoHealth is the leading oncology specialist dedicated to helping health plans, employers, oncologists, and patients navigate the physical, mental, and financial complexities of cancer. OncoHealth's cancer care utilization management uses NCDs / LCDs, NCCN, and peer-reviewed literature to support medical necessity determinations. https://oncohealth.us/

Policy	Effective Date	Comment
297 – Authorization Qualifying Diagnoses	1/1/2024	Retired, no longer needed
297 – Authorization Qualifying Diagnoses	1/1/2024	Unretired, required for review of certain codes on PA
051 – Bone Graft Allografts as Standalone Spinal Stabilization Devices	2/1/2024	Retired, content included in Policy 236
243 – Medical Necessity Definition	2/1/2024	Retired, content included in Policy 213
292 – Medicare Non-Texas LCD Coverage	2/1/2024	Retired, content included in Policy 213
023 – Varicose Veins	3/1/2024	Retired, use InterQual Medicare and Commercial Product criteria
031 – Epidural Adhesiolysis or RACZ	3/1/2024	Retired, content included in Policy 236, use eviCore for review criteria
032 – Extracorporeal Shock Wave Treatment (ESWT) for Plantar Fasciitis and Muscular Skeletal Conditions	3/1/2024	Retired, content included in Policy 236
056 – Interspinous Process Decompression System	3/1/2024	Retired, content included in Policy 236, use eviCore for review criteria
075 – Prolotherapy	3/1/2024	Retired, content included in Policy 236
295 – Respiratory Assist Device	3/1/2024	Retired, use InterQual Medicare and Commercial Product criteria

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350 – Medicaid Over the Limit Supplies	4/1/2024	Retired, content added to Policy 028 Durable Medical Equipment which will be renamed to Durable Medical Equipment and Over the Limit Supplies
251 – Neuromuscular Stimulation	5/1/2024	Retired, Use InterQual criteria.
083 – Panniculectomy – Removal of Redundant Tissue	7/1/2024	Retired, Use Medical Policy 263

Policy	Effective Date	Comment
226 - Electrical Tumor Treatment Field	01/01/2023	Retired – use InterQual®,
023 - Varicose Veins of the Lower Extremities	03/01/2023	Un-retired
262 - COVID-19 and Telemedicine	06/1/2023	Retired
207 – Bronchial Thermoplasty	11/1/2023	Retired, content included in Policy 236

Policy	Effective Date	Comment
283 - Asthma biologics	01/01/2022	Retired – no longer needed
284 - Biosimilar medications	01/01/2022	Retired – no longer needed
285 - Erythropoesis-Stimulating Agents	01/01/2022	Retired – no longer needed
286 - Immunological Modifier Meds	01/01/2022	Retired – no longer needed
287 - Long-Acting Reversible Contraceptives	01/01/2022	Retired – no longer needed
288 - Hemophilia A Meds	01/01/2022	Retired – no longer needed
070 - Pulmonary Rehabilitation Outpatient	01/01/2022	Retired – no longer needed
081 - Trigger Point Injections	07/01/2022	Un-retired
246 - Sipuleucel-T (Provenge)	07/01/2022	Retired. Use Medical Policy 219

Policy	Effective Date	Comment
003 - Occupational Therapy	01/01/2021	Replaced with policy 272
004 - Physical Therapy	01/01/2021	Replaced with policy 272
081 - Trigger Point Injections	01/01/2021	Retired (un-retired 7/1/22)
112 - Speech Therapy	01/01/2021	Replaced with policy 272
251 - Neuromuscular Stimulation	02/01/2021	Un-retired
274 - Risdiplam (Evrysdi)	05/01/2021	Retired. Use Optum criteria

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027 - Diathermy	06/01/2021	Retired
140 - Breast Reconstruction Surgery and Prophylactic Mastectomy	07/01/2021	Use InterQual® for review criteria
208 - Private Duty Nursing	08/01/2021	Use InterQual® for review criteria
011 - Botulinum Toxin Inj for Chemodenervation	10/01/2021	Retired
264 - Medicaid Noninvasive Prenatal Testing	10/01/2021	Use TMPPM for criteria
265 - Medicaid Bariatric Surgery	10/01/2021	Use TMPPM for criteria
66 - Medicaid Power Scooters	10/01/2021	Use TMPPM for criteria
267 - Medicaid Anesthesia for Dental Procedures	10/01/2021	Use TMPPM for criteria
268 - Medicaid Prescribed Pediatric Extended Care Center	10/01/2021	Use TMPPM for criteria
269 - Medicaid Wheelchairs - Manual	10/01/2021	Use TMPPM for criteria
270 - Medicaid Bone Growth Stimulators	10/01/2021	Use TMPPM for criteria
271 - Medicaid Wheelchairs - Powered	10/01/2021	Use TMPPM for criteria
273 - Group Therapy Services	10/01/2021	Criteria included in policy 272
276 Medicaid Burosumab-twza (Crysvita)	11/01/2021	Use TMPPM for criteria
277 Medicaid Teprotumumab-trbw (Tepezza)	11/01/2021	Use TMPPM for criteria
048 - Incontinence Alarms	12/01/2021	Retired
244 - Peer-to-Peer Opportunity	12/01/2021	Retired (un-retired 1/1/22)
248 - Assistant Surgeon Policy	12/01/2021	Retired (un-retired 1/1/22)

Policy	Effective Date	Comment
240 - Transcranial Magnetic Stimulation for Depression	01/01/2020	Retired
041 - HF Chest Wall Oscillator Vest	03/01/2020	Use InterQual® for review criteria
040 - Gynecomastia Surgery	06/01/2020	Use InterQual® for review criteria
212 - Xofigo	06/01/2020	Use Medical Policy 219
245 - Talimogene Laherparepvec (Imlygic)	06/01/2020	Use Medical Policy 219
140 - Breast Reconstruction Surgery and Prophylactic Mastectomy	07/01/2020	Use InterQual® for review criteria
203 - Proton Beam Therapy	07/01/2020	Use Oncology Analytics® for review criteria
041 - HF Chest Wall Oscillator Vest	08/01/2020	Use InterQual® for review criteria
062 - Off-label Use of FDA Approved Drugs	08/01/2020	Retired. Use Medical Policy 215
017 - Cochlear Implants	09/01/2020	Retired
128 - Phototherapy	09/01/2020	Retired
255 - Caplacizumab (Cablivi)	09/01/2020	Retired. Use Medical Policy 215

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101 - Regional Sympathetic Blocks	10/01/2020	Use eviCore® for review criteria
221 - EECP	10/01/2020	Retired
251 - Neuromuscular Stimulation	10/01/2020	Retired (un-retired 2/1/22)
058 - Regional Cerebral Blood Flow via Implanted Cerebral Thermal Perf	12/01/2020	Retired
237 - Eteplirsen (Exondys51)	12/01/2020	Replaced with new policy 280
241 - Adoptive Immunotherapy	12/01/2020	Replaced with policies 278 and 279
259 - Golodirsen (Vyondys 53)	12/01/2020	Replaced with new policy 280

Policy	Effective Date	Comment
202 - Virtual Colonoscopy	03/01/2019	Use eviCore® for review criteria
231 - Heart Transplant Rejection Monitoring AlloMap	07/01/2019	Use InterQual® for review criteria
232 - Intensive Behavioral Therapy for ASD (ABA)	07/01/2019	Use InterQual® for review criteria
066 - Neuromuscular Re-Education	09/01/2019	Retired
223 - Breast Digital Tomosynthesis	11/01/2019	Retired

Policy	Effective Date	Comment
009 - Bone Growth Stimulator	03/01/2018	Use InterQual® for review criteria
103 - Selective Internal Radiation Therapy	03/01/2018	Retired
225 - Neuropsychological Testing	04/01/2018	Use InterQual® for review criteria
010 - Bone-Anchored Hearing Aids	06/01/2018	Use InterQual® for review criteria
012 - Compression garments/devices	06/01/2018	Use InterQual® for review criteria
023 - Varicose Veins of the Lower Extremities	06/01/2018	Use InterQual® for review criteria
136 - Wireless Capsule Endoscopy	06/01/2018	Use InterQual® for review criteria
220 - Telemedicine	06/01/2018	Retired
015 - Automated Non-Invasive Nerve Conduction Testing	07/01/2018	Retired
205 - Double Balloon Enteroscopy	07/01/2018	Retired
222 - Left Atrial Appendage Closure	07/01/2018	Use InterQual® for review criteria
133 - Cardioverter Defibrillator - Wearable	08/01/2018	Use InterQual® for review criteria
007 - Autologous Chondrocyte Implantation	10/01/2018	Use eviCore® for review criteria
046 - Intrathecal drug Delivery System	10/01/2018	Use eviCore® for review criteria
059 - Joint Resurfacing	10/01/2018	Use eviCore® for review criteria
061 - Artificial Disc Replacement	10/01/2018	Use eviCore® for review criteria
076 - Radio Frequency Facet Joint Denervation	10/01/2018	Use eviCore® for review criteria

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078 - Spinal Cord Stimulators	10/01/2018	Use eviCore® for review criteria
104 - Orthognathic Surgery for Maxillary Mandibular Facial Deformities	11/01/2018	Use InterQual® for review criteria

Policy	Effective Date	Comment
014 - Apolipoprotein E Genotype or Phenotype	2017	Retired
043 - INR Home Testing	2017	Retired
036 - Gastric Pacing/Stimulation	2017	Use InterQual® for review criteria
053 - Bariatric Surgery	2017	Use InterQual® for review criteria
055 - Insulin pumps	2017	Retired
130 - Vagus Nerve Stimulation	2017	Use InterQual® for review criteria