Medical Policy Updates Effective April 01, 2026

MVP Health Care Medical Policy

Benign Prostatic Hyperplasia (BPH) Treatments

Type of Policy:	Surgical
Prior Approval Date:	09/08/2025
Approval Date:	12/01/2025
Effective Date:	04/01/2026
Related Polices:	Prostate Cancer Interventions

Codes Requiring Prior Authorization

Prior authorization may vary by plan which means the codes listed below may be specific to one product or all products. Please refer to the product grid found at the end of this policy for detailed authorization requirements for specific plans.

CPT Codes:

52441 - Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; single implant

52442- Cystourethroscopy, with insertion of permanent adjustable transprostatic implant; each additional permanent adjustable transprostatic implant (List separately in addition to code for primary procedure)

52443 -Cystourethroscopy with initial transurethral anterior prostate commissurotomy with a nondrug-coated balloon catheter followed by therapeutic drug delivery into the prostate by a drug-coated balloon catheter, including transrectal ultrasound and fluoroscopy

52597 - Transurethral robotic-assisted waterjet resection of prostate, including intraoperative planning, ultrasound guidance, control of postoperative bleeding, complete, including vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation

53854 - Transurethral destruction of prostate tissue; by radiofrequency generated water vapor thermotherapy

HCPCS Codes:

C9739- Cystourethroscopy, with insertion of transprostatic implant; one to three implants

C9740 - Cystourethroscopy, with insertion of transprostatic implant; four or more implants

Requiring Retrospective Review

CPT Codes:

C9769 - Cystourethroscopy, with insertion of temporary prostatic implant/stent with fixation/anchor and incisional struts

51721 – Insertion of transurethral ablation transducer for delivery of thermal ultrasound for prostate tissue ablation, including suprapubic tube placement during the same session and placement of an endorectal cooling device, when performed

52284 - Cystourethroscopy, with mechanical urethral dilation and urethral therapeutic drug delivery by drug-coated balloon catheter for urethral stricture or stenosis, male, including fluoroscopy, when performed

55881- Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation

55882- Ablation of prostate tissue, transurethral, using thermal ultrasound, including magnetic resonance imaging guidance for, and monitoring of, tissue ablation; with insertion of transurethral ultrasound transducer for delivery of thermal ultrasound, including suprapubic tube placement and placement of an endorectal cooling device, when performed

Experimental/Investigational

CPT Codes:

C9769 - Cystourethroscopy, with insertion of temporary prostatic implant/stent with fixation/anchor and incisional struts

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including suprapubic tube placement and placement of an endorectal cooling device, when performed

Common Diagnosis Codes

ICD-10- CM Diagnosis Codes: N40.1

Common Procedure Codes

52450, 52601, 52630, 52648, 52649, 53850, 54520, 55801, 55821, 55831, C2596

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Overview

Benign prostatic hyperplasia (BPH) is caused by the abnormal growth of benign (non-cancerous) prostate cells which enlarges the prostate gland. The gland may push against the bladder and urethra, causing lower urinary tract symptoms that include urinary outflow obstruction such as increased frequency of urination, hesitancy, nocturia (urinating at night), urgency and weak urinary stream. This policy will cover several surgical treatments designed to relieve obstruction.

Initial treatment for BPH is usually drug therapy (e.g. alpha blocker, PDE5 Inhibitor, finasteride/dutasteride) designed to relieve obstruction. There are several surgical treatments for BPH that involve burning, cutting or removal of prostatic tissue.[9] The most commonly performed minimally invasive treatments for BPH include transurethral resection of the prostate (TURP), vaporization, laser ablation, laser enucleation, open laparoscopic prostatectomy, transurethral microwave therapy (TUMT), transurethral needle ablation of the prostate (TUNA) and Urolift.

The Prostatic Urethral Lift procedure (eg. UroLift® System) is a minimally invasive approach to treating symptoms of urinary outflow obstruction secondary to benign prostatic hypertrophy (BPH). The Prostatic Urethral Lift (PUL) procedure lifts or holds the enlarged prostate tissue out of the way so it no longer blocks the urethra.

The PUL procedure consists of small permanent trans-prostatic implants, made with common implantable materials, (i.e., nitinol, stainless steel, and PET suture), placed cystoscopically to compress the prostate tissue, therefore increasing the urethral lumen and reducing obstruction to urine flow. In general, 4 or 5 implants are delivered into the prostatic urethra to maintain urethral patency.

Water Vapor Thermal Therapy (e.g., Rezum System) which uses convective radiofrequency (RF) water vapor energy to treat men with moderate-to-severe lower urinary tract symptoms.

Aquablation® (AquaBeam® by Procept BioRobotics) uses image guided waterjet ablation that is heat free and requires general anesthesia.

Transurethral Ultrasound Ablation (TULSA; TULSA-Pro) uses ultrasound to produce a high temperature to ablate the prostate via a catheter through the urethra. The TULSA-Pro also combines the use of Magnetic Resonance Imaging (MRI) to direct the robot driven ultrasound.

Transurethral balloon dilation (e.g., Optilume) is a medical procedure where a small balloon is put into the body through the urethra. The balloon is filled with air or liquid that helps push back the tissue and stretch the urethra if it has become too narrow.

Indications/Criteria

MVP considers the following approaches to the treatment of benign prostatic hypertrophy (BPH) medically necessary for customers with benign prostatic hypertrophy:

- Transurethral resection of the prostate (TURP (52601, 52630))
- Laser prostatectomy (52648)
- Laser based procedures including contact laser ablation of the prostate (CLAP (52648))
- Holmium laser ablation, enucleation, resection (HoLAP, HoLEP, HoLRP (52649))
- Open laparoscopic prostatectomy (55801, 55821, 55831)
- Photoselective vaporization of the prostate (PVP (52648))
- Transurethral electrovaporization (TUVP, TVP, TUEP, TUVRP (52648))
- Transurethral microwave thermotherapy (TUMT (53850))
- Transurethral incision of the prostate (TUIP (54520))

Prostatic urethral lift (e.g., UroLift) (CPT code 52441) is considered medically necessary for the treatment of symptomatic benign prostatic hyperplasia (BPH) when ALL of the following criteria are met:

- age 45 or above
- estimated prostate volume < 100 cc
- failure, contraindication, or intolerance to a trial of conventional medication therapy for BPH. (e.g., alpha blocker, PDE5 Inhibitor, finasteride/dutasteride)

The UroLift® System should not be used if the patient has:

- Prostate volume of >100 cc
- A urinary tract infection

- Urethra conditions that may prevent insertion of delivery system into the bladder
- Urinary incontinence
- Current gross hernaturia
- A known allergy to nickel

Water vapor thermal therapy (Rezum™ System) (CPT code 53854) is considered medically necessary for the treatment of symptomatic benign prostatic hyperplasia (BPH) when ALL of the following criteria are met:

- Age 50 or above
- Symptomatic despite maximal medical management including ALL of the following:
    - International Prostate Symptom Score (IPSS) greater than or equal to 12
    - Maximum urinary flow rate (Qmax) or less than or equal to 15 ml/s (voided volume greater than 125cc)
    - Failure, contraindication, or intolerance to at least three months of conventional medical therapy for BPH. (e.g., alpha blocker, PDE5 Inhibitor, finasteride/dutasteride)
- Prostate volume of 30-80 ml

Transurethral waterjet ablation (Aquablation®) using the AquaBeam® System is considered medically necessary for the treatment of symptomatic benign prostatic hyperplasia (BPH) when ALL of the following criteria are met:

- Age 45 or above
- Symptomatic despite maximal medical management including ALL of the following:
    - International Prostate Symptom Score (IPSS) greater than or equal to 12
    - Maximum urinary flow rate (Qmax) or less than or equal to 15 ml/s (voided volume greater than 125cc)
    - Failure, contraindication, or intolerance to at least three months of conventional medical therapy for BPH. (e.g., alpha blocker, PDE5 Inhibitor, finasteride/dutasteride)
- Prostate volume of 30-150cc

Transurethral waterjet ablation or water vapor thermal therapy are not medically necessary if there is any of the following:

- Known or suspected prostate cancer or prostate specific antigen (PSA) greater than 10ng/mL unless there is a negative prostate biopsy within the last 6 months

- Active urinary tract infection
- History of bacterial prostatitis in the past three (3) months
- Prior prostate surgery
- Neurogenic bladder
- Active urethral stricture

Exclusions

Transurethral ultrasound ablation (TULSA; TULSA-Pro) procedure proposed for the treatment of benign prostate hypertrophy is considered investigational because there is a low-quality body of evidence regarding the safety and effectiveness of the procedure compared with other treatments.

Transurethral balloon dilation procedure using drug coated balloons (e.g., the Optilume) proposed for the treatment of benign prostate hypertrophy and/or urethral stricture is considered investigational because there is a low-quality body of evidence regarding the safety and effectiveness of the procedure compared with other treatments.

Medicare Variation

Treatment for lower urinary tract symptoms using fluid jet system (Aquablation®) will be covered for Medicare customer ONCE when the following criteria is met:

1. Indications including **ALL** of the following:
    a. Prostate volume of 30-150 cc by transrectal ultrasound (TRUS)
    b. Persistent moderate to severe symptoms despite maximal medical management including **ALL** of the following:
        i. International Prostate Symptom Score (IPSS) ≥12
        ii. Maximum urinary flow rate (Qmax) of ≤15 mL/s (voided volume greater than 125 cc)
        iii. Failure, contraindication or intolerance to at least three months of conventional medical therapy for LUTS/BPH (e.g., alpha blocker, PDE5 Inhibitor, finasteride/dutasteride)

2. Only treatment using an FDA approved/cleared device will be considered reasonable and necessary.

Limitations

The following are considered not reasonable and necessary:

1. Body mass index ≥ 42kg/m2

2. Known or suspected prostate cancer (based on NCCN Prostate Cancer Early Detection guidelines) or a prostate specific antigen (PSA) >10 ng/mL unless the patient has had a negative prostate biopsy within the last 6 months.
3. Bladder cancer, neurogenic bladder, bladder calculus or clinically significant bladder diverticulum
4. Active urinary tract or systemic infection
5. Treatment for chronic prostatitis
6. Diagnosis of urethral stricture, meatal stenosis, or bladder neck contracture
7. Damaged external urinary sphincter
8. Known allergy to device materials
9. Inability to safely stop anticoagulants or antiplatelet agents preoperatively.

For full Medicare coverage details refer to the following LCD for Medicare Customers: National Government Services, Inc. Local Coverage Determination (LCD) Fluid Jet System Treatment for LUTS/BPH (L38367). Revision effective date: 11/01/2020.

References (Updated 2025)

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Customer Product	Medical Management Requirements*
New York Products	
HMO	Prior Auth
PPO in Plan	Prior Auth
PPO OOP	Prior Auth
POS in Plan	Prior Auth
POS OOP	Prior Auth
Essential Plan	Prior Auth
MVP Medicaid Managed Care	Prior Auth
MVP Child Health Plus	Prior Auth
MVP Harmonious Health Care Plan	Prior Auth
MVP Medicare Complete Wellness	Prior Auth
MVP Medicare Preferred Gold HMO POS	Prior Auth
MVP Medicare Secure Plus HMO POS	Prior Auth
MVP Medicare WellSelect PPO	Prior Auth
MVP DualAccess D-SNP HMO	Prior Auth
MVP DualAccess Complete D-SNP HMO	Prior Auth
USA Care PPO	Potential for Retrospective Review
Healthy NY	Prior Auth
MVP Premier	Prior Auth
MVP Premier Plus	Prior Auth
MVP Premier Plus HDHP	Prior Auth
MVP Secure	Prior Auth
MVP EPO	Prior Auth
MVP EPO HDHP	Prior Auth
MVP PPO	Prior Auth
MVP PPO HDHP	Prior Auth
ASO	See SPD
Vermont Products	
POS in Plan	Prior Auth
POS OOP	Prior Auth
MVP VT HMO	Prior Auth
MVP VT HDHP HMO	Prior Auth
MVP VT Plus HMO	Prior Auth
MVP VT Plus HDHP HMO	Prior Auth
ASO	See SPD
♦ Note: Prior authorization requirements for HDHP products are the same as the base product (e.g. HDHP HMO auth requirements are the same as listed for HMO).	

***Medical Management Requirements**

Prior Auth	Prior Authorization Required
Potential for Retrospective Review	No Prior Authorization Required. May be subject to Retrospective Review
Retro Review	Retrospective Review Required
Not Covered	Service is not a covered benefit.
See SPD	See Specific Plan Design

MVP Health Care Medical Policy

Revision History:

02/01/2022 – Coverage added for water vapor thermal therapy (e.g., Rezum system) based on Medicare criteria and American Urological Association. Removed Medicare variation for water vapor thermal therapy. Criteria was removed requiring three months of two different combinations of medication therapies. HIFU procedure (55880) was moved to the Investigational Procedures policy.

06/01/2023 –Added exclusion and Medicare variation for aquablation.

06/01/2025 – Annual review, TULSA (CPT Codes: 51721, 55881, 55882) added to exclusions, update to Medicare variation

08/01/2025 – Aquablation (AquaBeam) (0421T) added to prior authorization with coverage criteria added to policy.

02/01/2026 – Mechanical urethral dilation using Optilume® added to exclusions.

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CPT Codes:

~~0421T- Transurethral waterjet ablation of prostate, including control of post-operative bleeding, including ultrasound guidance, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included when performed)~~

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Experimental/Investigational

CPT Codes:

C9769 - Cystourethroscopy, with insertion of temporary prostatic implant/stent with fixation/anchor and incisional struts

~~C2596 - Probe, image guided, robotic, waterjet ablation~~

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The PUL procedure consists of small permanent trans-prostatic implants, made with common implantable materials, (i.e., nitinol, stainless steel, and PET suture), placed cystoscopically to compress the prostate tissue, therefore increasing the urethral lumen and reducing obstruction to urine flow. In general, 4 or 5 implants are delivered into the prostatic urethra to maintain urethral patency.

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Aquablation® (AquaBeam® by Procept BioRobotics) uses image guided waterjet ablation that is heat free and requires general anesthesia.

Transurethral Ultrasound Ablation (TULSA; TULSA-Pro) uses ultrasound to produce a high temperature to ablate the prostate via a catheter through the urethra. The TULSA-Pro also combines the use of Magnetic Resonance Imaging (MRI) to direct the robot driven ultrasound.

–Transurethral balloon dilation (e.g., Optilume) is a medical procedure where a small balloon is put into the body through the urethra. The balloon is filled with air or liquid that helps push back the tissue and stretch the urethra if it has become too narrow.

Indications/Criteria

MVP considers the following approaches to the treatment of benign prostatic hypertrophy (BPH) medically necessary for customers with benign prostatic hypertrophy:

- Transurethral resection of the prostate (TURP (52601, 52630))
- Laser prostatectomy (~~52647,~~ 52648)
- Laser based procedures including contact laser ablation of the prostate (CLAP (52648))
- Holmium laser ablation, enucleation, resection (HoLAP, HoLEP, HoLRP (52649))
- Open laparoscopic prostatectomy (55801, 55821, 55831)
- Photoselective vaporization of the prostate (PVP (52648))
- Transurethral electrovaporization (TUVP, TVP, TUEP, TUVRP (52648))
- Transurethral microwave thermotherapy (TUMT (53850))
- Transurethral incision of the prostate (TUIP (54520))

Prostatic urethral lift (e.g., UroLift) (CPT code 52441) is considered medically necessary for the treatment of symptomatic benign prostatic hyperplasia (BPH) when ALL of the following criteria are met:

- age 45 or above

- estimated prostate volume < 100 cc
- failure, contraindication, or intolerance to a trial of conventional medication therapy for BPH. (e.g., alpha blocker, PDE5 Inhibitor, finasteride/dutasteride)

The UroLift® System should not be used if the patient has:

- Prostate volume of >100 cc
- A urinary tract infection
- Urethra conditions that may prevent insertion of delivery system into the bladder
- Urinary incontinence
- Current gross hernaturia
- A known allergy to nickel

Water vapor thermal therapy (Rezum™ System) (CPT code 53854) is considered medically necessary for the treatment of symptomatic benign prostatic hyperplasia (BPH) when ALL of the following criteria are met:

- Age 50 or above
- Symptomatic despite maximal medical management including ALL of the following:
    - International Prostate Symptom Score (IPSS) greater than or equal to 12
    - Maximum urinary flow rate (Qmax) or less than or equal to 15 ml/s (voided volume greater than 125cc)
    - Failure, contraindication, or intolerance to at least three months of conventional medical therapy for BPH. (e.g., alpha blocker, PDE5 Inhibitor, finasteride/dutasteride)
- Prostate volume of 30-80 ml

Transurethral waterjet ablation (Aquablation®) ~~(CPT code 0421T)~~ using the AquaBeam® System is considered medically necessary for the treatment of symptomatic benign prostatic hyperplasia (BPH) when ALL of the following criteria are met:

- Age 45 or above
- Symptomatic despite maximal medical management including ALL of the following:
    - International Prostate Symptom Score (IPSS) greater than or equal to 12
    - Maximum urinary flow rate (Qmax) or less than or equal to 15 ml/s (voided volume greater than 125cc)

- Failure, contraindication, or intolerance to at least three months of conventional medical therapy for BPH. (e.g., alpha blocker, PDE5 Inhibitor, finasteride/dutasteride)

- Prostate volume of 30-150cc

Transurethral waterjet ablation or water vapor thermal therapy are not medically necessary if there is any of the following:

- Known or suspected prostate cancer or prostate specific antigen (PSA) greater than 10ng/mL unless there is a negative prostate biopsy within the last 6 months
- Active urinary tract infection
- History of bacterial prostatitis in the past three (3) months
- Prior prostate surgery
- Neurogenic bladder
- Active urethral stricture

Exclusions

Transurethral uUltrasound aAblation (TULSA; TULSA-Pro) pProcedure proposed for the treatment of benign prostate hypertrophy is considered investigational because there is a low-quality body of evidence regarding the safety and effectiveness of the procedure compared with other treatments.

Transurethral balloon dilation procedure using drug coated balloons (e.g., the Optilume) proposed for the treatment of benign prostate hypertrophy and/or urethral stricture is considered investigational because there is a low-quality body of evidence regarding the safety and effectiveness of the procedure compared with other treatments.

Medicare Variation

Treatment for lower urinary tract symptoms using fluid jet system (Aquablation®) will be covered for Medicare customer ONCE when the following criteria is met:

1. Indications including **ALL** of the following:
    a. Prostate volume of 30-150 cc by transrectal ultrasound (TRUS)
    b. Persistent moderate to severe symptoms despite maximal medical management including **ALL** of the following:
        i. International Prostate Symptom Score (IPSS) ≥12
        ii. Maximum urinary flow rate (Qmax) of ≤15 mL/s (voided volume greater than 125 cc)
        iii. Failure, contraindication or intolerance to at least three months of conventional medical therapy for LUTS/BPH (e.g., alpha blocker, PDE5 Inhibitor, finasteride/dutasteride)

2. Only treatment using an FDA approved/cleared device will be considered reasonable and necessary.

Limitations
The following are considered not reasonable and necessary:

1. Body mass index ≥ 42kg/m2
2. Known or suspected prostate cancer (based on NCCN Prostate Cancer Early Detection guidelines) or a prostate specific antigen (PSA) >10 ng/mL unless the patient has had a negative prostate biopsy within the last 6 months.
3. Bladder cancer, neurogenic bladder, bladder calculus or clinically significant bladder diverticulum
4. Active urinary tract or systemic infection
5. Treatment for chronic prostatitis
6. Diagnosis of urethral stricture, meatal stenosis, or bladder neck contracture
7. Damaged external urinary sphincter
8. Known allergy to device materials
9. Inability to safely stop anticoagulants or antiplatelet agents preoperatively.

For full Medicare coverage details refer to the following LCD for Medicare Customers: National Government Services, Inc. Local Coverage Determination (LCD) Fluid Jet System Treatment for LUTS/BPH (L38367). Revision effective date: 11/01/2020.

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Customer Product	Medical Management Requirements*
New York Products	
HMO	Prior Auth
PPO in Plan	Prior Auth
PPO OOP	Prior Auth
POS in Plan	Prior Auth
POS OOP	Prior Auth
Essential Plan	Prior Auth
MVP Medicaid Managed Care	Prior Auth
MVP Child Health Plus	Prior Auth
MVP Harmonious Health Care Plan	Prior Auth
MVP Medicare Complete Wellness	Prior Auth
MVP Medicare Preferred Gold HMO POS	Prior Auth
MVP Medicare Secure Plus HMO POS	Prior Auth
MVP Medicare WellSelect PPO	Prior Auth
MVP DualAccess D-SNP HMO	Prior Auth
MVP DualAccess Complete D-SNP HMO	Prior Auth
USA Care PPO	Potential for Retrospective Review
Healthy NY	Prior Auth
MVP Premier	Prior Auth
MVP Premier Plus	Prior Auth
MVP Premier Plus HDHP	Prior Auth
MVP Secure	Prior Auth
MVP EPO	Prior Auth
MVP EPO HDHP	Prior Auth
MVP PPO	Prior Auth
MVP PPO HDHP	Prior Auth
Student Health Plans	Prior Auth
ASO	See SPD
Vermont Products	
POS in Plan	Prior Auth
POS OOP	Prior Auth
MVP VT HMO	Prior Auth
MVP VT HDHP HMO	Prior Auth
MVP VT Plus HMO	Prior Auth
MVP VT Plus HDHP HMO	Prior Auth
ASO	See SPD
♦ Note: Prior authorization requirements for HDHP products are the same as the base product (e.g. HDHP HMO auth requirements are the same as listed for HMO).	

***Medical Management Requirements**

Prior Auth	Prior Authorization Required
Potential for Retrospective Review	No Prior Authorization Required. May be subject to Retrospective Review
Retro Review	Retrospective Review Required
Not Covered	Service is not a covered benefit.
See SPD	See Specific Plan Design

Revision History:

02/01/2022 – Coverage added for water vapor thermal therapy (e.g., Rezum system) based on Medicare criteria and American Urological Association. Removed Medicare variation for water vapor thermal

therapy. Criteria was removed requiring three months of two different combination of medication therapies. HIFU procedure (55880) was moved to the Investigational Procedures policy.

06/01/2023 –Added exclusion and Medicare variation for aquablation.

06/01/2025 – Annual review, TULSA (CPT Codes: 51721, 55881, 55882) added to exclusions, update to Medicare variation

08/01/2025 – Aquablation (AquaBeam) (0421T) added to prior authorization with coverage criteria added to policy.

02/01/2026 – Mechanical urethral dilation using Optilume® added to exclusions.

MVP Health Care Clinical Guidelines

Clinical Guidelines Development, Implementation, and Review Process

Type of Policy:	N/A
Prior Approval Date:	02/05/2024
Approval Date:	01/05/2026
Effective Date:	04/01/2026
Related Polices:	N/A

Overview

MVP clinical guidelines are developed and maintained to address the need for standards of care across the health plan for preventive care and clinical conditions that are relevant to MVP membership.

Policy

1. MVP Health Plan acknowledges that clinical practice guidelines have sound scientific basis that include clinical literature and expert consensus.
2. MVP adopts clinical guidelines from governmental sources and nationally recognized professional societies that provide evidence-based clinical support and background information. Guidelines are not meant to replace the role of clinical judgment of individual practitioners. Instead, they are to assist practitioners in the delivery of good medical care.
3. MVP encourages practitioner usage of clinical practice guidelines to reduce inter-practitioner variation in the diagnosis and treatment of specific conditions. Clinical practice guidelines also encourage following the established best practices for specific conditions, therefore, improving care.
4. Since certain behavioral disorders have a high prevalence, MVP seeks to endorse or develop clinical practice guidelines that support appropriate care of behavioral health services that address adult, children, and adolescent populations.

5. MVP maintains clinical practice guidelines that provide the clinical basis for the MVP disease management programs.
6. National sources for MVP clinical guidelines include, but are not limited to, organizations such as The United States Preventive Services Task Force (USPSTF), The National Institutes of Health (NIH) and its affiliates, peer reviewed medical literature, the American Diabetes Association, Centers for Medicare and Medicaid Services (CMS), the American Psychiatric Association (APA), American Academy of Pediatrics (AAP), The American College of Obstetricians and Gynecologists (ACOG), and the Centers for Disease Control and Prevention (CDC). In cases where there is no nationally recognized source, guidelines are derived from current scientific evidence with consultation by appropriate board-certified practitioners. Other sources include hospital delivery systems, plan providers, Individual Provider Associations (IPAs), Medical Management (MMC), and Quality Improvement Committee (QIC) members.
7. All existing clinical guidelines are reviewed at least annually by an MVP Medical Director, are reviewed by MVP internal departments and consulting physicians, and are presented to the Medical Management Committee and the Quality Improvement Committee. A comprehensive review, evaluation, and update will be done on each clinical guideline at least once every two years or more frequently when new evidence is available in the medical literature.
8. Proposed guidelines are compared to utilization management prior-authorization criteria, relevant benefit interpretations, protocols from the 24-hour nurse line, case/disease management programs, and customer education materials including those on the MVP web site to ensure that the documents are consistent and within the scope of MVP covered benefits.
9. To ensure that MVP guidelines are relevant to the local community, participating practitioners are involved in the guideline development and adoption process. Newly proposed guidelines are distributed for review and comment to participating physicians and Medical Directors. This includes guidelines developed at the local, regional collaborative or national level. The practitioners chosen to review the proposed guideline are selected from specialties that are relevant to the guideline being reviewed or developed. Practitioners are asked to comment on the guideline's relevance and suggest modifications that will enhance the guideline for the local community.
10. Similarly, established guidelines that were developed internally or as part of a regional collaborative that are due for re-evaluation are also distributed for review and comment to participating physicians, and Medical Directors. Physicians are asked to comment on the guideline's relevance.

Guidelines from nationally recognized sources such as the NIH, CDC, USPSTF, or AAP that are due for a two-year re-evaluation will be presented to the Medical Management Committee (MMC) and the Quality Improvement Committee (QIC).

11. Once adopted by the MVP Quality Improvement Committee, the new and updated guidelines are available to all providers including primary care physicians (PCPs), hospitals, and outpatient clinics, as applicable. Existing practitioners are alerted via the web site and by written notices from the plan via fax or newsletter. Copies of the guidelines are made available to all new providers either via a welcome letter distributed when the provider is accepted in-plan or via the MVP Provider Quality Improvement Manual (PQIM). All materials available via the web site are available in hard copy upon request. The guideline effective date is 30 days after the first day of the month following the QIC meeting when it was approved or reaffirmed.
12. Guidelines are also available to customers via the web site and preventive care guidelines are published annually in the customer newsletter.

Procedure

Standard Review of New Clinical Guidelines

The following steps outline the procedure for adoption of a *new* guideline:

1. Verify that the clinical condition is relevant to MVP customers. Sources to review include MVP's top twenty current inpatient and outpatient diagnosis encounter lists, retrospective claims analysis, geographic distribution of disease data from the Centers for Disease Control and Prevention and current peer reviewed medical literature.
2. Identify a potential source document and review to be sure that the document does not conflict with utilization management prior-authorization criteria, relevant benefit interpretations, case/disease management programs, protocols from the 24-hour nurse line and customer education materials including those on the MVP website.
3. Forward the document to the MVP Medical Director(s) for comment.

   The draft clinical guideline is sent for internal and external review. External opinions are sought from participating physicians. Internal opinions are sought from a variety of areas including opinions from the Medical Director(s), Quality Improvement, Pharmacy, and Utilization Management departments. Additional opinions may be sought from other departments such as Operations and Professional Relations.

   The updated clinical guidelines are presented to the Medical Management Committee for review and recommendation. The clinical guideline is presented to the Quality Improvement Committee for approval.

Standard Review of Existing Clinical Guidelines

The following steps outline the procedure for review, update, and approval for *existing* clinical guidelines.

1. Start the review process approximately three months prior to the deadline for presentation to the QIC.
2. Verify that the clinical condition is still relevant to MVP customers. Sources to review include MVP's top 20 current inpatient and outpatient diagnosis encounter lists, retrospective claims analysis, geographic distribution of disease data from the Centers for Disease Control and Prevention and current peer reviewed medical literature.
3. Review the original authorizing agency or source agency to verify that there have been no recent changes to the recommendation. Verify that there are no plans to announce an update within the near future, if applicable. Verify that the information is in the public domain and is not proprietary or copyrighted. If the information of interest is copyrighted, obtain and document permissions.
5. Review the guidelines against current utilization management prior authorization criteria, relevant benefit interpretations, protocols from the 24-hour nurse line, case/disease management programs, and customer education materials including those on the MVP web site.

   Clinical guidelines are presented to the Medical Management Committee (MMC), and the draft is sent for internal and external review. External opinions are sought from physicians who are in the relevant specialty. Internal opinions are sought from a variety of areas including opinions from the Medical Director(s), Quality Improvement, Pharmacy, and Utilization Management departments. Additional opinions may be sought from other departments such as Operations and Professional Relations.

   The updated clinical guidelines are presented to the Medical Management Committee for review and recommendation. The clinical guideline is presented to the Quality Improvement Committee for approval.

References:

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3. American Diabetes Association About ADA Home
4. American Psychiatric Association https://www.psychiatry.org
5. Centers for Disease Control and Prevention https://www.cdc.gov/

6. Monroe County Medical Society https://www.mcms.org/

Revision History:

04/01/2022 – Annual review with no changes.

04/01/2024 – Annual review; updated and added references.

04/01/2026 – Annual review; updated to modernize language and for clarity.

MVP Health Care Medical Policy

Compression Devices

Type of Policy:	DME
Prior Approval Date:	02/18/2025
Approval Date:	01/05/2026
Effective Date:	04/01/2026
Related Polices:	Lymphedema Compression Garments/Compression Stockings Durable Medical Equipment

Codes Requiring Prior Authorization

Prior authorization may vary by plan which means the codes listed below may be specific to one product or all products. Please refer to the product grid found at the end of this policy for detailed authorization requirements for specific plans.

For Durable Medical Equipment (DME) that requires Prior Authorization, refer to https://www.mvphealthcare.com/providers/reference-library/#utilization

CPT Code:	Description:
E0650	Pneumatic compressor, nonsegmental home model
E0651	Pneumatic compressor, segmental home model without calibrated gradient pressure
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure
E0655	Nonsegmental pneumatic appliance for use with pneumatic compressor, half arm
E0656	Segmental pneumatic appliance for use with pneumatic compressor, trunk
E0657	Segmental pneumatic appliance for use with pneumatic compressor, chest
E0658	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full arms and chest
E0659	Segmental pneumatic appliance for use with pneumatic compressor, integrated, head, neck and chest

E0660	Nonsegmental pneumatic appliance for use with pneumatic compressor, full leg
E0665	Nonsegmental pneumatic appliance for use with pneumatic compressor, full arm
E0666	Nonsegmental pneumatic appliance for use with pneumatic compressor, half leg
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg
E0670	Segmental pneumatic appliance for use with pneumatic compressor, integrated, two full legs and trunk
E0671	Segmental gradient pressure pneumatic appliance, full leg
E0672	Segmental gradient pressure pneumatic appliance, full arm
E0673	Segmental gradient pressure pneumatic appliance, half leg
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency
E0676	Intermittent limb compression device (includes all accessories), not otherwise specified
E0677	Non-pneumatic sequential compression garment, trunk
E0678	Nonpneumatic sequential compression garment, full leg
E0679	Nonpneumatic sequential compression garment, half leg
E0680	Nonpneumatic compression controller with sequential calibrated gradient pressure
E0681	Nonpneumatic compression controller without calibrated gradient pressure
E0682	Nonpneumatic sequential compression garment, full arm
E0683	Nonpneumatic, nonsequential, peristaltic wave compression pump

Codes Subject to Retrospective Review

N/A

Experimental/Investigational

E0659	Segmental pneumatic appliance for use with pneumatic compressor, integrated, head, neck and chest
E0677	Non-pneumatic sequential compression garment, trunk
E0678	Nonpneumatic sequential compression garment, full leg
E0679	Nonpneumatic sequential compression garment, half leg

E0680	Nonpneumatic compression controller with sequential calibrated gradient pressure
E0681	Nonpneumatic compression controller without calibrated gradient pressure
E0682	Nonpneumatic sequential compression garment, full arm
E0683	Nonpneumatic, nonsequential, peristaltic wave compression pump

Common Diagnosis Codes

C50.0 – C50.92 - Malignant neoplasm of breast

C79.81 - Secondary malignant neoplasm of breast

D05.00 – D05.92 - Carcinoma in situ of breast

I89.0 - Lymphedema, not elsewhere classified

I97.2 - Postmastectomy lymphedema syndrome

Q82.0 - Hereditary lymphedema

Common Procedure Codes

N/A

Please refer to the product grid for detailed authorization requirements for specific plans. Codes requiring prior-authorization for some products may require retrospective review for plans that do not require prior-authorization. Common diagnosis codes are included for informational purposes only and every attempt has been made to update and keep these codes accurate. These codes may not be all inclusive. CPT codes are subject to change as replacement codes are adopted by CMS. Any codes related to CMS updates will be adopted and applied to this policy.

Overview

Edema:

Edema is a non-specific term for the accumulation of fluid in tissue, most often in the extremities. There are numerous causes for edema, ranging from systemic disorders (e.g., congestive heart failure, etc.) to local conditions (post-surgery, congenital abnormalities, etc.). (Examples are not all-inclusive).

Lymphedema, as discussed below, is just one group of conditions that can be a cause of accumulation of fluid in the tissue. Lymphedema arises from disorders of the lymphatic system. It is essential to rule out other causes of edema in order to diagnose lymphedema. Edema from other causes is not classified as lymphedema.

Primary Lymphedema

Primary lymphedema is a disorder of the lymphatic system that occurs on its own. It is inherited and uncommon. Examples (not all-inclusive) are:

- congenital lymphedema due to lymphatic aplasia or hypoplasia;

- Milroy's disease, an autosomal dominant familial form of congenital lymphedema;
- lymphedema praecox; or
- lymphedema tarda.

Secondary Lymphedema

Secondary lymphedema is a disorder of lymphatic flow that is caused by some other disease or condition. It is more common than primary lymphedema. It is most commonly caused by surgery (especially lymph node dissection, such as for breast cancer), radiation therapy (especially axillary or inguinal), trauma, lymphatic obstruction by tumor, and, in developing countries, lymphatic filariasis. Secondary lymphedema may also result from compression of the lymphatic and venous channels resulting from leakage of fluid into interstitial tissues in patients with chronic venous insufficiency.

A pneumatic compression device (PCD) uses compression to assist with the elimination of retained excess fluid and swelling. The pump uses a sleeve-type device that mobilizes arm or leg edema through the use of cycled times and pressure.

There are three main types of pneumatic compression devices (PCD) that are described below:

- non-segmented (single chamber non-programmable pump) pneumatic compressor (E0650);
- segmented (multi-chamber non-programmable pump) pneumatic compressor without calibrated gradient pressure (no manual control of pressure) (E0651); and
- segmented (multi-chamber) pneumatic compressor with (manually) calibrated gradient pressure (E0652).

A non-segmented pneumatic compressor/single-chamber non-programmable pump (E0650) is a device that has a single outflow port on the compressor.

A segmented pneumatic compressor (E0651, E0652) is a device that has multiple outflow ports on the compressor that lead to distinct segments of the appliance that inflate sequentially. A segmented device without calibrated gradient pressure (E0651) is one in which either (a) the same pressure is present in each segment or (b) there is a pre-determined pressure gradient in successive segments but no ability to individually set or adjust pressures in each of several segments. In an E0651 device, the pressure is usually set by a single control on the distal segment. A segmented device with calibrated gradient pressure (E0652) is characterized by a manual control on at least three outflow ports that can deliver an individually determined pressure to each segmental unit.

Single-or multi-chamber programmable pumps are similar to the pumps described above except that it is possible to make manual adjustments in the pressure in the individual compartments and/or the length and frequency of the inflation cycles.

Compression appliances include compression bandages, compression garments, and non-elastic binders. Compression garments are made of elastic compression material used to provide static compression to promote venous and/or lymphatic circulation. The compression garment may be prefabricated or custom fabricated for adequate graduated compression. Non-elastic binders provide static compression of the extremity without the use of elastic, but use wraps, adjustable Velcro or buckle straps).

A Non-Pneumatic Compression pumps has been approved by the FDA in April 2021. The Koya Dayspring system uses a compression device that uses an alloy of nickel and titanium to create a shape memory that can be programmed with a controller and a mobile phone application to apply active gradient pressure.

Medical Record Documentation Requirements

The determination by the physician of the medical necessity of a pneumatic compression device must include symptoms and objective findings, including measurements which establish the severity of the condition.

The trial of conservative therapy must be thoroughly documented in the medical record before prescribing any type of pneumatic compression device (E0650-E0652).

At a minimum, re-assessments conducted for a trial must include detailed measurements, obtained in the same manner and with reference to the same anatomic landmarks, prior to and at the conclusion of the various trials and therapy, with bilateral comparisons where appropriate.

The trial of conservative therapy must be documented in the customer's medical record before prescribing any type of pneumatic compression device (E0650-E0652). This assessment may be performed by the prescribing physician or any other licensed/certified medical professional (LCMP) directly involved in the beneficiary's lymphedema treatment. The LCMP may not have any financial relationship with the supplier providing the device. If the assessment is performed by an LCMP, the prescribing physician must receive and review the report of the evaluation. In addition, the prescribing physician must sign and date the report, and state concurrence or disagreement with the assessment.

Indications/Criteria

Lymphedema:

Treatment of primary or secondary Lymphedema with a pneumatic compression device (E0650 or E0651) is covered when all the following criteria is met:

- Diagnosis of either primary or secondary lymphedema;
- Persistence of chronic and severe lymphedema as identified by the documented presence of at least one of the following clinical findings:

- Marked hyperkeratosis with hyperplasia and hyperpigmentation
- Papillomatosis cutis lymphostatica,
- Deformity of elephantiasis,
- Skin breakdown with persisting lymphorrhea,
- Detailed measurements over time confirming the persistence of the lymphedema with a history evidencing a likely etiology, and

A four-week trial of conservative therapy demonstrating failed response to treatment is required. The four-week trial of conservative therapy must include all of the following:

- Regular and compliant use of an appropriate compression bandage system or compression garment to provide adequate graduated compression.
  - (Adequate compression is defined as (1) sufficient pressure at the lowest pressure point to cause fluid movement and (2) sufficient pressure across the gradient [from highest to lowest pressure point] to move fluid from distal to proximal.) The compression used must not create a tourniquet effect at any point
  - The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression starting with a minimum of 30 mmHg distally
- Regular exercise
- Elevation of the limb

Only when no further improvement has occurred in the most recent four weeks and the above indications/criteria for lymphedema are met, may the lymphedema be considered unresponsive to conservative therapy, and coverage for a pneumatic compression device (E0650, E0651) considered.

At the end of the four-week trial, if there has been improvement, then reimbursement for a PCD is not justified. Where improvement has occurred, the trial of conservative therapy must be continued with subsequent reassessment at intervals at least a week apart.

Chronic Venous Insufficiency With Venous Stasis Ulcers

Treatment of chronic venous insufficiency with venous stasis ulcers with a pneumatic compression device (E0650 or E0651) is covered when all the following criteria is met:

- Edema in the affected lower extremity
- One or more venous stasis ulcer(s)
- A six-month trial of conservative therapy demonstrating failed response to treatment is required.

The six-month trial of conservative therapy must include all of the following:

- Compliant use of an appropriate compression bandage system or compression garment to provide adequate graduated compression
    - Adequate compression is defined as (1) sufficient pressure at the lowest pressure point to cause fluid movement and (2) sufficient pressure across the gradient [from highest to lowest pressure point] to move fluid from distal to proximal. The compression used must not create a tourniquet effect at any point.
    - The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression starting with a minimum of 30 mmHg distally.
- Medications as appropriate (e.g., diuretics and/or other treatment of congestive failure, etc.)
- Regular exercise
- Elevation of the limb
- Appropriate wound care for the ulcer (including sharp debridement where appropriate)

Only when no further improvement has occurred for a continuous period of six months and the above indications/criteria chronic venous insufficiency are still met for the use of a pneumatic compression device (E0650, E0651) to treat chronic venous insufficiency is covered.

At the end of the six-month trial, if there has been improvement, then coverage for pneumatic compression device is considered not medically necessary. Where improvement has occurred, the trial of conservative therapy must be continued with subsequent reassessments.

Lymphedema extending Onto The Chest, Trunk, and/or Abdomen

The only time that a segmented, calibrated gradient pneumatic compression device (HCPCS code E0652) would be covered is when the individual has unique characteristics that prevent them from receiving satisfactory pneumatic compression treatment using a non-segmented device in conjunction with a segmented appliance or a segmented compression device without manual control of pressure in each chamber.

Treatment of lymphedema extending onto the chest, trunk and/or abdomen with a pneumatic compression device (E0652) is covered when all the following criteria is met:

- Diagnosis of either primary or secondary lymphedema;
- the above indications/criteria for lymphedema for a pneumatic compression device (E0650 or E0651) are met;

- the lymphedema extends onto the chest, trunk and/or abdomen that extends past the limits of a standard compression sleeve, and the chest, trunk and/or abdominal lymphedema;
- A four-week trial of conservative therapy demonstrating failed response to treatment with and E0650 or E0651 is required. The four-week trial of conservative therapy must include all of the following:
    - At least four weeks of regular, daily, multiple-hour home usage of the E0650 or E0651 after careful, in-person fitting, training and supervision by a technician who is skilled in and who regularly and successfully uses the appliance provided;
    - Compliant use of an appropriate compression bandage system or compression garment to provide adequate graduated compression
    - Adequate compression is defined as (1) sufficient pressure at the lowest pressure point to cause fluid movement and (2) sufficient pressure across the gradient [from highest to lowest pressure point] to move fluid from distal to proximal. The compression used must not create a tourniquet effect at any point. The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression starting with a minimum of 30 mmHg distally;
    - Regular exercise;
    - Elevation where appropriate;
    - Manual lymphatic drainage (where available) and self-manual lymphatic drainage (MLD) for at least 30 minutes per day;
    - Evaluation of diet and implementation of any necessary change;
    - Medications as appropriate (e.g., diuretics and/or other treatment of congestive failure, etc.);
    - Correction (where possible) of anemia and/or hypoproteinemia.

Where improvement has occurred, the trial of conservative therapy must be continued with subsequent reassessment at intervals at least a week apart. When and only when no further improvement has occurred in the most recent four weeks and the above indications/criteria above for lymphedema extending onto the chest, trunk and/or abdomen are met, a pneumatic compression device (E0652) is covered.

At the end of the four-week trial, if there has been any improvement of the lymphedema extending onto the chest, trunk and/or abdomen, then the pneumatic compression device (E0652) is not covered.

For any pneumatic compression device, equipment purchase or equipment rental will be considered on an individual case-by-case basis. A trial of a three-month rental period is required prior to purchase. Continued coverage beyond the first three months requires

documented improvement and adherence with use as ordered by the healthcare professional, clinical documentation from the health care professional confirms clinical improvement (e.g., improvement in venous stasis ulcers, decrease in lymphedema). Equipment may be purchased with improvement in condition and adherence.

A non-segmented pneumatic compressor (E0650) is used with appliances/sleeves coded by E0655-E0666 or E0671-E0673. Segmented pneumatic compressors (E0651 or E0652) are used with appliances/sleeves coded by E0667-E0669. Sleeves E0656, E0657, and E0658 are only used with E0652.

When a foot or hand segment is used in conjunction with any leg or arm appliance respectively, there must be no separate billing for this segment. It is considered included in the code for the leg or arm appliance.

Exclusions

Not meeting criteria under Indications/Criteria in this policy.

Pneumatic compression device (E0562) is not covered for the treatment of lymphedema of the extremities alone even if the above lymphedema indications/criteria are met.

Pneumatic compression device (E0562) is not covered for the treatment of chronic venous insufficiency even if the above chronic venous insufficiency indications/criteria are met.

Pneumatic Compression Devices (E0650 or E0651) used to treat edema from causes other than lymphedema are not covered.

Pneumatic compression devices (E0675 and E0676) have not been proven to be effective in the treatment of other conditions (e.g., peripheral artery disease, arterial ischemic ulcers of the lower extremities, fracture and soft-tissue healing) and in the prevention of venous thromboembolism, including deep vein thrombosis and pulmonary embolism in the home setting.

Non-Pneumatic Compression Devices (Koya Dayspring system - HCPCS codes E0677, E0678, E0680, E0681, E0682) are not covered because there is insufficient evidence in the peer reviewed medical literature to support the safety and effectiveness of these devices.

Nonpneumatic, nonsequential, peristaltic wave compression pump (for example; Venowave VW5 (HCPCS Code E0683) are considered experimental and investigational for any indication because there currently is not enough published peer reviewed medical literature to support the safety and effectiveness of these devices.

Segmented pneumatic appliance for lymphedema treatment of the head, face and neck (e.g., Flexitouch)(HCPC Code: E0659) is experimental and investigational because there is insufficient evidence in the peer-reviewed medical literature to establish the efficacy, clinical value, or safety.

MVP Medicaid Managed Care Variation:

Pneumatic compression devices (lymphedema pumps) are covered for the treatment of generalized or refractory lymphedema, or refractory edema from chronic venous insufficiency, only when all less invasive treatments have been attempted and are unsuccessful.

Pneumatic Compression Devices (HCPCS Codes: E0650 and E0651):

Pneumatic Compression Devices (HCPCS Codes: E0650 and E0651) are covered for Medicaid Managed Care customers when the following coverage criteria are met:

I. Lymphedema

- The member has a diagnosis of lymphedema, and
- Persistence of chronic and severe lymphedema as documented by presence of at least one of the following:
    - Marked hyperkeratosis with hyperplasia and hyperpigmentation
    - Papillomatosis cutis lymphostatica
    - Deformity of limb or involved area - i.e., elephantiasis (measurements to support compared to contralateral limb)
    - Skin breakdown with persisting lymphorrhea
    - Detailed measurements over time confirming the persistence of lymphedema with a history evidencing a likely etiology, and

A documented 4-week trial of conservative therapy demonstrating failed response to the treatment is required. The trial must include ALL the following:

- Regular compliance with an appropriate compression bandage system or compression garment to provide adequate compression. (Adequate compression is defined as having sufficient pressure at lowest pressure point to cause fluid movement, and sufficient pressure across the gradient (from highest to lowest pressure point) to move fluid from distal to proximal.) The compression should not create a tourniquet effect at any point.
- The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression with a minimum of 30mmHg distally.
- Regular exercise program
- Elevation of limb
- Evidence of participation in a manual lymph drainage (MLD) program and results.

- Evidence of appropriate medication treatment for co-morbidities, i.e., congestive heart failure (CHF) and results.

- Symptoms and objective findings, including measurements which establish the severity of the condition
- Reason the device is required, including treatments which have been tried and failed

II. Chronic Venous Insufficiency (CVI)

Pneumatic compression devices (HCPCS codes E0650 or E0651) are covered for treatment of CVI of the lower extremities ONLY if the member has ALL the following:

- Edema in the affected lower extremity
- One or more venous stasis ulcer(s)
- Non-healing ulcers after a six-month trial of conservative therapy directed by the treating practitioner. The six-month trial includes:
  - The 4-week lymphedema trial criteria outlined above; AND
  - Appropriate wound care for the ulcer(s) (including sharp debridement where appropriate)

Segmented, calibrated gradient pneumatic compression devices (HCPCS code E0652):

A segmented, calibrated gradient pneumatic compression device (HCPCS code E0652) is only covered when the Medicaid Managed Care Customer has unique characteristics which prevent them from receiving adequate satisfactory pneumatic compression treatment using a non-segmented device along with a segmented appliance or compression device without manual control of the pressure in each chamber.

A segmented, calibrated gradient pneumatic compression device (HCPCS code E0652) is covered for the treatment of lymphedema extending onto the chest, trunk and/or abdomen when ALL the following are met:

- Diagnosis of lymphedema of an extremity
- Coverage criteria for E0650 and E0651 are met
- The member has lymphedema extending onto the chest, trunk and/or abdomen that extends past the limits of a standard compression sleeve, and the chest, trunk and/or abdominal lymphedema has failed to improve with a four-week trial. 4-week trial includes all the requirements for the 4-week trial outlined above under Lymphedema, AND:
  - Manual lymph drainage (MLD) (where available) and self MLD for at least 30 minutes/day
  - Evaluation of diet and implementation of necessary changes

- Medications as appropriate (i.e., diuretics and/or treatment of CHF, etc.)
- correction (where possible) of anemia and/or hyponatremia

Coverage criteria are according to the New York State Medicaid Program eMedNY DME Procedure Codes Guidelines and Coverage Guidelines manual.

Medicare

There is a CMS National Coverage Determination (NCD) for Pneumatic Compression Devices (280.6). For full coverage and limitation details refer to: Centers for Medicare & Medicaid Services (CMS). National Coverage Determination (NCD) for Pneumatic Compression Devices (280.6). Effective Date: 01/14/2002. Available: www.cms.gov/

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Customer Product	Medical Management Requirements*
New York Products	
HMO	Prior Auth
PPO In Plan	Prior Auth
PPO OOP	Prior Auth
POS In Plan	Prior Auth
POS OOP	Prior Auth
Essential Plan	Prior Auth
MVP Medicaid Managed Care	Prior Auth
MVP Child Health Plus	Prior Auth
MVP Harmonious Health Care Plan	Prior Auth
MVP Medicare Complete Wellness	Prior Auth
MVP Medicare Preferred Gold HMO POS	Prior Auth
MVP Medicare Secure Plus HMO POS	Prior Auth
MVP Medicare WellSelect PPO	Prior Auth
MVP DualAccess D-SNP HMO	Prior Auth
MVP DualAccess Complete D-SNP HMO	Prior Auth
USA Care	Potential for Retrospective Review
Healthy NY	Prior Auth
MVP Premier	Prior Auth
MVP Premier Plus	Prior Auth
MVP Premier Plus HDHP	Prior Auth
MVP Secure	Prior Auth
MVP EPO	Prior Auth
MVP EPO HDHP	Prior Auth
MVP PPO	Prior Auth
MVP PPO HDHP	Prior Auth
Student Health Plans	Prior Auth
ASO	See SPD
Vermont Products	
POS In Plan	Prior Auth
POS OOP	Prior Auth
MVP VT HMO	Prior Auth
MVP VT HDHP HMO	Prior Auth
MVP VT Plus HMO	Prior Auth
MVP VT Plus HDHP HMO	Prior Auth
MVP Secure	Prior Auth
ASO	See SPD
♦ Note: Prior authorization requirements for HDHP products are the same as the base product (e.g. HDHP HMO auth requirements are the same as listed for HMO).	

***Medical Management Requirements**

Prior Auth	Prior Authorization Required
Potential for Retrospective Review	No Prior Authorization Required. May be subject to Retrospective Review
Retro Review	Retrospective Review Required
Not Covered	Service is not a covered benefit.
See SPD	See Specific Plan Design

Revision History:

8/1/2021 – Annual Review. Updated to new format. No changes to indications or criteria.

8/1/2023 – Annual review, policy name changed to compression devices because policy includes both pneumatic and non-pneumatic compression devices. Koya dayspring added as an exclusion.

01/01/2024 – Updated HCPCS codes, deleted K1024, K1025, K1031, K1032, K1033. Replaced with new HCPCS codes E0678, E0679, E0680, E0681, E0682.

04/01/2024 – Medicaid Managed Care variation updated to reflect new coverage criteria for E0650 – E0652 pneumatic compression devices.

06/01/2025 – Added exclusion for E0683 - Nonpneumatic, nonsequential, peristaltic wave compression pump.

04/01/2026 – Added exclusion for E0659 segmental pneumatic appliance for head, neck and chest. Added E0658 to policy coverage criteria.

MVP Health Care Medical Policy

Compression Devices

Type of Policy:	DME
Prior Approval Date:	02/18/2025
Approval Date:	01/05/2026
Effective Date:	04/01/2026
Related Polices:	Lymphedema Compression Garments/Compression Stockings Durable Medical Equipment

Codes Requiring Prior Authorization

Prior authorization may vary by plan which means the codes listed below may be specific to one product or all products. Please refer to the product grid found at the end of this policy for detailed authorization requirements for specific plans.

For Durable Medical Equipment (DME) that requires Prior Authorization, refer to https://www.mvphealthcare.com/providers/reference-library/#utilization

CPT Code:	Description:
E0650	Pneumatic compressor, nonsegmental home model
E0651	Pneumatic compressor, segmental home model without calibrated gradient pressure
E0652	Pneumatic compressor, segmental home model with calibrated gradient pressure
E0655	Nonsegmental pneumatic appliance for use with pneumatic compressor, half arm
E0656	Segmental pneumatic appliance for use with pneumatic compressor, trunk
E0657	Segmental pneumatic appliance for use with pneumatic compressor, chest
E0658	Segmental pneumatic appliance for use with pneumatic compressor, integrated, 2 full arms and chest
E0659	Segmental pneumatic appliance for use with pneumatic compressor, integrated, head, neck and chest

E0660	Nonsegmental pneumatic appliance for use with pneumatic compressor, full leg
E0665	Nonsegmental pneumatic appliance for use with pneumatic compressor, full arm
E0666	Nonsegmental pneumatic appliance for use with pneumatic compressor, half leg
E0667	Segmental pneumatic appliance for use with pneumatic compressor, full leg
E0668	Segmental pneumatic appliance for use with pneumatic compressor, full arm
E0669	Segmental pneumatic appliance for use with pneumatic compressor, half leg
E0670	Segmental pneumatic appliance for use with pneumatic compressor, integrated, two full legs and trunk
E0671	Segmental gradient pressure pneumatic appliance, full leg
E0672	Segmental gradient pressure pneumatic appliance, full arm
E0673	Segmental gradient pressure pneumatic appliance, half leg
E0675	Pneumatic compression device, high pressure, rapid inflation/deflation cycle, for arterial insufficiency
E0676	Intermittent limb compression device (includes all accessories), not otherwise specified
E0677	Non-pneumatic sequential compression garment, trunk
E0678	Nonpneumatic sequential compression garment, full leg
E0679	Nonpneumatic sequential compression garment, half leg
E0680	Nonpneumatic compression controller with sequential calibrated gradient pressure
E0681	Nonpneumatic compression controller without calibrated gradient pressure
E0682	Nonpneumatic sequential compression garment, full arm
E0683	Nonpneumatic, nonsequential, peristaltic wave compression pump

Codes Subject to Retrospective Review

N/A

Experimental/Investigational

E0659	Segmental pneumatic appliance for use with pneumatic compressor, integrated, head, neck and chest
E0677	Non-pneumatic sequential compression garment, trunk
E0678	Nonpneumatic sequential compression garment, full leg
E0679	Nonpneumatic sequential compression garment, half leg

E0680	Nonpneumatic compression controller with sequential calibrated gradient pressure
E0681	Nonpneumatic compression controller without calibrated gradient pressure
E0682	Nonpneumatic sequential compression garment, full arm
E0683	Nonpneumatic, nonsequential, peristaltic wave compression pump

Common Diagnosis Codes

~~N/A~~

C50.0 – C50.92 - Malignant neoplasm of breast

C79.81 - Secondary malignant neoplasm of breast

D05.00 – D05.92 - Carcinoma in situ of breast

I89.0 - Lymphedema, not elsewhere classified

I97.2 - Postmastectomy lymphedema syndrome

Q82.0 - Hereditary lymphedema

Common Procedure Codes

N/A

Please refer to the product grid for detailed authorization requirements for specific plans. Codes requiring prior-authorization for some products may require retrospective review for plans that do not require prior-authorization. Common diagnosis codes are included for informational purposes only and every attempt has been made to update and keep these codes accurate. These codes may not be all inclusive. CPT codes are subject to change as replacement codes are adopted by CMS. Any codes related to CMS updates will be adopted and applied to this policy.

Overview

Edema:

Edema is a non-specific term for the accumulation of fluid in tissue, most often in the extremities. There are numerous causes for edema, ranging from systemic disorders (e.g., congestive heart failure, etc.) to local conditions (post-surgery, congenital abnormalities, etc.). (Examples are not all-inclusive).

Lymphedema, as discussed below, is just one group of conditions that can be a cause of accumulation of fluid in the tissue. Lymphedema arises from disorders of the lymphatic system. It is essential to rule out other causes of edema in order to diagnose lymphedema. Edema from other causes is not classified as lymphedema.

Primary Lymphedema

Primary lymphedema is a disorder of the lymphatic system that occurs on its own. It is inherited and uncommon. Examples (not all-inclusive) are:

- congenital lymphedema due to lymphatic aplasia or hypoplasia;
- Milroy's disease, an autosomal dominant familial form of congenital lymphedema;
- lymphedema praecox; or
- lymphedema tarda.

Secondary Lymphedema

Secondary lymphedema is a disorder of lymphatic flow that is caused by some other disease or condition. It is more common than primary lymphedema. It is most commonly caused by surgery (especially lymph node dissection, such as for breast cancer), radiation therapy (especially axillary or inguinal), trauma, lymphatic obstruction by tumor, and, in developing countries, lymphatic filariasis. Secondary lymphedema may also result from compression of the lymphatic and venous channels resulting from leakage of fluid into interstitial tissues in patients with chronic venous insufficiency.

A pneumatic compression device (PCD) uses compression to assist with the elimination of retained excess fluid and swelling. The pump uses a sleeve-type device that mobilizes arm or leg edema through the use of cycled times and pressure.

There are three main types of pneumatic compression devices (PCD) that are described below:

- non-segmented (single chamber non-programmable pump) pneumatic compressor (E0650);
- segmented (multi-chamber non-programmable pump) pneumatic compressor without calibrated gradient pressure (no manual control of pressure) (E0651); and
- segmented (multi-chamber) pneumatic compressor with (manually) calibrated gradient pressure (E0652).

A non-segmented pneumatic compressor/single-chamber non-programmable pump (E0650) is a device that has a single outflow port on the compressor.

A segmented pneumatic compressor (E0651, E0652) is a device that has multiple outflow ports on the compressor that lead to distinct segments of the appliance that inflate sequentially. A segmented device without calibrated gradient pressure (E0651) is one in which either (a) the same pressure is present in each segment or (b) there is a pre-determined pressure gradient in successive segments but no ability to individually set or adjust pressures in each of several segments. In an E0651 device, the pressure is usually set by a single control on the distal segment. A segmented device with calibrated gradient pressure (E0652) is characterized by a manual control on at least three outflow ports that can deliver an individually determined pressure to each segmental unit.

Single-or multi-chamber programmable pumps are similar to the pumps described above except that it is possible to make manual adjustments in the pressure in the individual compartments and/or the length and frequency of the inflation cycles.

Compression appliances include compression bandages, compression garments, and non-elastic binders. Compression garments are made of elastic compression material used to provide static compression to promote venous and/or lymphatic circulation. The compression garment may be prefabricated or custom fabricated for adequate graduated compression. Non-elastic binders provide static compression of the extremity without the use of elastic, but use wraps, adjustable Velcro or buckle straps).

A Non-Pneumatic Compression pumps has ~~recently~~ been approved by the FDA in April 2021. The Koya Dayspring system uses a compression device that uses an alloy of nickel and titanium to create a shape memory that can be programmed with a controller and a mobile phone application to apply active gradient pressure.

Medical Record Documentation Requirements

The determination by the physician of the medical necessity of a pneumatic compression device must include symptoms and objective findings, including measurements which establish the severity of the condition.

The trial of conservative therapy must be thoroughly documented in the medical record before prescribing any type of pneumatic compression device (E0650-E0652).

At a minimum, re-assessments conducted for a trial must include detailed measurements, obtained in the same manner and with reference to the same anatomic landmarks, prior to and at the conclusion of the various trials and therapy, with bilateral comparisons where appropriate.

The trial of conservative therapy must be documented in the customer's medical record before prescribing any type of pneumatic compression device (E0650-E0652). This assessment may be performed by the prescribing physician or any other licensed/certified medical professional (LCMP) directly involved in the beneficiary's lymphedema treatment. The LCMP may not have any financial relationship with the supplier providing the device. If the assessment is performed by an LCMP, the prescribing physician must receive and review the report of the evaluation. In addition, the prescribing physician must sign and date the report, and state concurrence or disagreement with the assessment.

Indications/Criteria

Lymphedema:

Treatment of primary or secondary Lymphedema with a pneumatic compression device (E0650 or E0651) is covered when all the following criteria is met:

- Diagnosis of either primary or secondary lymphedema;

- Persistence of chronic and severe lymphedema as identified by the documented presence of at least one of the following clinical findings:
    - Marked hyperkeratosis with hyperplasia and hyperpigmentation
    - Papillomatosis cutis lymphostatica,
    - Deformity of elephantiasis,
    - Skin breakdown with persisting lymphorrhea,
    - Detailed measurements over time confirming the persistence of the lymphedema with a history evidencing a likely etiology, and

A four-week trial of conservative therapy demonstrating failed response to treatment is required. The four-week trial of conservative therapy must include all of the following:

- Regular and compliant use of an appropriate compression bandage system or compression garment to provide adequate graduated compression.
    - (Adequate compression is defined as (1) sufficient pressure at the lowest pressure point to cause fluid movement and (2) sufficient pressure across the gradient [from highest to lowest pressure point] to move fluid from distal to proximal.) The compression used must not create a tourniquet effect at any point
    - The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression starting with a minimum of 30 mmHg distally
- Regular exercise
- Elevation of the limb

Only when no further improvement has occurred in the most recent four weeks and the above indications/criteria for lymphedema are met, may the lymphedema be considered unresponsive to conservative therapy, and coverage for a pneumatic compression device (E0650, E0651) considered.

At the end of the four-week trial, if there has been improvement, then reimbursement for a PCD is not justified. Where improvement has occurred, the trial of conservative therapy must be continued with subsequent reassessment at intervals at least a week apart.

Chronic Venous Insufficiency With Venous Stasis Ulcers

Treatment of chronic venous insufficiency with venous stasis ulcers with a pneumatic compression device (E0650 or E0651) is covered when all the following criteria is met:

- Edema in the affected lower extremity
- One or more venous stasis ulcer(s)

- A six-month trial of conservative therapy demonstrating failed response to treatment is required.

The six-month trial of conservative therapy must include all of the following:

  - Compliant use of an appropriate compression bandage system or compression garment to provide adequate graduated compression
    - Adequate compression is defined as (1) sufficient pressure at the lowest pressure point to cause fluid movement and (2) sufficient pressure across the gradient [from highest to lowest pressure point] to move fluid from distal to proximal. The compression used must not create a tourniquet effect at any point.
    - The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression starting with a minimum of 30 mmHg distally.
  - Medications as appropriate (e.g., diuretics and/or other treatment of congestive failure, etc.)
  - Regular exercise
  - Elevation of the limb
  - Appropriate wound care for the ulcer (including sharp debridement where appropriate)

Only when no further improvement has occurred for a continuous period of six months and the above indications/criteria chronic venous insufficiency are still met for the use of a pneumatic compression device (E0650, E0651) to treat chronic venous insufficiency is covered.

At the end of the six-month trial, if there has been improvement, then coverage for pneumatic compression device is considered not medically necessary. Where improvement has occurred, the trial of conservative therapy must be continued with subsequent reassessments.

Lymphedema extending Onto The Chest, Trunk, and/or Abdomen

The only time that a segmented, calibrated gradient pneumatic compression device (HCPCS code E0652) would be covered is when the individual has unique characteristics that prevent them from receiving satisfactory pneumatic compression treatment using a non-segmented device in conjunction with a segmented appliance or a segmented compression device without manual control of pressure in each chamber.

Treatment of lymphedema extending onto the chest, trunk and/or abdomen with a pneumatic compression device (E0652) is covered when all the following criteria is met:

- Diagnosis of either primary or secondary lymphedema;

- the above indications/criteria for lymphedema for a pneumatic compression device (E0650 or E0651) are met;
- the lymphedema extends onto the chest, trunk and/or abdomen that extends past the limits of a standard compression sleeve, and the chest, trunk and/or abdominal lymphedema;
- A four-week trial of conservative therapy demonstrating failed response to treatment with and E0650 or E0651 is required. The four-week trial of conservative therapy must include all of the following:
    - At least four weeks of regular, daily, multiple-hour home usage of the E0650 or E0651 after careful, in-person fitting, training and supervision by a technician who is skilled in and who regularly and successfully uses the appliance provided;
    - Compliant use of an appropriate compression bandage system or compression garment to provide adequate graduated compression
    - Adequate compression is defined as (1) sufficient pressure at the lowest pressure point to cause fluid movement and (2) sufficient pressure across the gradient [from highest to lowest pressure point] to move fluid from distal to proximal. The compression used must not create a tourniquet effect at any point. The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression starting with a minimum of 30 mmHg distally;
    - Regular exercise;
    - Elevation where appropriate;
    - Manual lymphatic drainage (where available) and self-manual lymphatic drainage (MLD) for at least 30 minutes per day;
    - Evaluation of diet and implementation of any necessary change;
    - Medications as appropriate (e.g., diuretics and/or other treatment of congestive failure, etc.);
    - Correction (where possible) of anemia and/or hypoproteinemia.

Where improvement has occurred, the trial of conservative therapy must be continued with subsequent reassessment at intervals at least a week apart. When and only when no further improvement has occurred in the most recent four weeks and the above indications/criteria above for lymphedema extending onto the chest, trunk and/or abdomen are met, a pneumatic compression device (E0652) is covered.

At the end of the four-week trial, if there has been any improvement of the lymphedema extending onto the chest, trunk and/or abdomen, then the pneumatic compression device (E0652) is not covered.

For any pneumatic compression device, equipment purchase or equipment rental will be considered on an individual case-by-case basis. A trial of a three-month rental period is required prior to purchase. Continued coverage beyond the first three months requires documented improvement and adherence with use as ordered by the healthcare professional, clinical documentation from the health care professional confirms clinical improvement (e.g., improvement in venous stasis ulcers, decrease in lymphedema). Equipment may be purchased with improvement in condition and adherence.

A non-segmented pneumatic compressor (E0650) is used with appliances/sleeves coded by E0655-E0666 or E0671-E0673. Segmented pneumatic compressors (E0651 or E0652) are used with appliances/sleeves coded by E0667-E0669. Sleeves E0656, ~~and~~ E0657, and E0658 are only used with E0652.

When a foot or hand segment is used in conjunction with any leg or arm appliance respectively, there must be no separate billing for this segment. It is considered included in the code for the leg or arm appliance.

Exclusions

Not meeting criteria under Indications/Criteria in this policy.

Pneumatic compression device (E0562) is not covered for the treatment of lymphedema of the extremities alone even if the above lymphedema indications/criteria are met.

Pneumatic compression device (E0562) is not covered for the treatment of chronic venous insufficiency even if the above chronic venous insufficiency indications/criteria are met.

Pneumatic Compression Devices (E0650 or E0651) used to treat edema from causes other than lymphedema are not covered.

Pneumatic compression devices (E0675 and E0676) have not been proven to be effective in the treatment of other conditions (e.g., peripheral artery disease, arterial ischemic ulcers of the lower extremities, fracture and soft-tissue healing) and in the prevention of venous thromboembolism, including deep vein thrombosis and pulmonary embolism in the home setting.

Non-Pneumatic Compression Devices (Koya Dayspring system - HCPCS codes E0677, E0678, E0680, E0681, E0682) are not covered because there is insufficient evidence in the peer reviewed medical literature to support the safety and effectiveness of these devices.

Nonpneumatic, nonsequential, peristaltic wave compression pump (for example; Venowave VW5 (HCPCS Code E0683) are considered experimental and investigational for any indication because there currently is not enough published peer reviewed medical literature to support the safety and effectiveness of these devices.

Segmented pneumatic appliance for lymphedema treatment of the head, face and neck (e.g., Flexitouch)(HCPC Code: E0659) is experimental and investigational because there is insufficient evidence in the peer-reviewed medical literature to establish the efficacy, clinical value, or safety.

MVP Medicaid Managed Care Variation:

Pneumatic compression devices (lymphedema pumps) are covered for the treatment of generalized or refractory lymphedema, or refractory edema from chronic venous insufficiency, only when all less invasive treatments have been attempted and are unsuccessful.

Pneumatic Compression Devices (HCPCS Codes: E0650 and E0651):

Pneumatic Compression Devices (HCPCS Codes: E0650 and E0651) are covered for Medicaid Managed Care customers when the following coverage criteria are met:

I. Lymphedema

- The member has a diagnosis of lymphedema, and
- Persistence of chronic and severe lymphedema as documented by presence of at least one of the following:
  - Marked hyperkeratosis with hyperplasia and hyperpigmentation
  - Papillomatosis cutis lymphostatica
  - Deformity of limb or involved area - i.e., elephantiasis (measurements to support compared to contralateral limb)
  - Skin breakdown with persisting lymphorrhea
  - Detailed measurements over time confirming the persistence of lymphedema with a history evidencing a likely etiology, and

A documented 4-week trial of conservative therapy demonstrating failed response to the treatment is required. The trial must include ALL the following:

- Regular compliance with an appropriate compression bandage system or compression garment to provide adequate compression. (Adequate compression is defined as having sufficient pressure at lowest pressure point to cause fluid movement, and sufficient pressure across the gradient (from highest to lowest pressure point) to move fluid from distal to proximal.) The compression should not create a tourniquet effect at any point.
- The garment may be prefabricated or custom-fabricated but must provide adequate graduated compression with a minimum of 30mmHg distally.
- Regular exercise program

- Elevation of limb
- Evidence of participation in a manual lymph drainage (MLD) program and results.
- Evidence of appropriate medication treatment for co-morbidities, i.e., congestive heart failure (CHF) and results.

- Symptoms and objective findings, including measurements which establish the severity of the condition
- Reason the device is required, including treatments which have been tried and failed

II. Chronic Venous Insufficiency (CVI)

Pneumatic compression devices (HCPCS codes E0650 or E0651) are covered for treatment of CVI of the lower extremities ONLY if the member has ALL the following:

- Edema in the affected lower extremity
- One or more venous stasis ulcer(s)
- Non-healing ulcers after a six-month trial of conservative therapy directed by the treating practitioner. The six-month trial includes:
  - The 4-week lymphedema trial criteria outlined above; AND
  - Appropriate wound care for the ulcer(s) (including sharp debridement where appropriate)

Segmented, calibrated gradient pneumatic compression devices (HCPCS code E0652):

A segmented, calibrated gradient pneumatic compression device (HCPCS code E0652) is only covered when the Medicaid Managed Care Customer has unique characteristics which prevent them from receiving adequate satisfactory pneumatic compression treatment using a non-segmented device along with a segmented appliance or compression device without manual control of the pressure in each chamber.

A segmented, calibrated gradient pneumatic compression device (HCPCS code E0652) is covered for the treatment of lymphedema extending onto the chest, trunk and/or abdomen when ALL the following are met:

- Diagnosis of lymphedema of an extremity
- Coverage criteria for E0650 and E0651 are met
- The member has lymphedema extending onto the chest, trunk and/or abdomen that extends past the limits of a standard compression sleeve, and the chest, trunk and/or abdominal lymphedema has failed to improve with a four-week trial. 4-week trial includes all the requirements for the 4-week trial outlined above under Lymphedema, AND:

- Manual lymph drainage (MLD) (where available) and self MLD for at least 30 minutes/day
- Evaluation of diet and implementation of necessary changes
- Medications as appropriate (i.e., diuretics and/or treatment of CHF, etc.)
- correction (where possible) of anemia and/or hyponatremia

Coverage criteria are according to the New York State Medicaid Program eMedNY DME Procedure Codes Guidelines and Coverage Guidelines manual.

Medicare

There is a CMS National Coverage Determination (NCD) for Pneumatic Compression Devices (280.6). For full coverage and limitation details refer to: Centers for Medicare & Medicaid Services (CMS). National Coverage Determination (NCD) for Pneumatic Compression Devices (280.6). Effective Date: 01/14/2002. Available: www.cms.gov/

~~There is a CMS Local Coverage Determination (LCD) for Pneumatic Compression Devices. For full coverage and limitation details refer to: Noridian Healthcare Solutions Local Coverage Decision (LCD) LCD ID Number: L33829 Pneumatic Compression Devices RETIREMENT Date:11/14/2024. Available: https://med.noridianmedicare.com/web/jddme/policies/lcd/active~~

Noridian Healthcare Solutions (Medicare) Medical Director Article Pneumatic Compression Devices - Correct Coding and Billing – Revised September 25, 2025 Available: https://med.noridianmedicare.com/web/jddme/policies/dmd-articles/2025

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Customer Product	Medical Management Requirements*
New York Products	
HMO	Prior Auth
PPO In Plan	Prior Auth
PPO OOP	Prior Auth
POS In Plan	Prior Auth
POS OOP	Prior Auth
Essential Plan	Prior Auth
MVP Medicaid Managed Care	Prior Auth
MVP Child Health Plus	Prior Auth
MVP Harmonious Health Care Plan	Prior Auth
MVP Medicare Complete Wellness	Prior Auth
MVP Medicare Preferred Gold HMO POS	Prior Auth
MVP Medicare Secure Plus HMO POS	Prior Auth
MVP Medicare WellSelect PPO	Prior Auth
MVP DualAccess D-SNP HMO	Prior Auth
MVP DualAccess Complete D-SNP HMO	Prior Auth
USA Care	Potential for Retrospective Review
Healthy NY	Prior Auth
MVP Premier	Prior Auth
MVP Premier Plus	Prior Auth
MVP Premier Plus HDHP	Prior Auth
MVP Secure	Prior Auth
MVP EPO	Prior Auth
MVP EPO HDHP	Prior Auth
MVP PPO	Prior Auth
MVP PPO HDHP	Prior Auth
Student Health Plans	Prior Auth
ASO	See SPD
Vermont Products	
POS In Plan	Prior Auth
POS OOP	Prior Auth
MVP VT HMO	Prior Auth
MVP VT HDHP HMO	Prior Auth
MVP VT Plus HMO	Prior Auth
MVP VT Plus HDHP HMO	Prior Auth
MVP Secure	Prior Auth
ASO	See SPD
♦ Note: Prior authorization requirements for HDHP products are the same as the base product (e.g. HDHP HMO auth requirements are the same as listed for HMO).	

***Medical Management Requirements**

Prior Auth	Prior Authorization Required
Potential for Retrospective Review	No Prior Authorization Required. May be subject to Retrospective Review
Retro Review	Retrospective Review Required
Not Covered	Service is not a covered benefit.
See SPD	See Specific Plan Design

Revision History:

8/1/2021 – Annual Review. Updated to new format. No changes to indications or criteria.

8/1/2023 – Annual review, policy name changed to compression devices because policy includes both pneumatic and non-pneumatic compression devices. Koya dayspring added as an exclusion.

01/01/2024 – Updated HCPCS codes, deleted K1024, K1025, K1031, K1032, K1033. Replaced with new HCPCS codes E0678, E0679, E0680, E0681, E0682.

04/01/2024 – Medicaid Managed Care variation updated to reflect new coverage criteria for E0650 – E0652 pneumatic compression devices.

06/01/2025 – Added exclusion for E0683 - Nonpneumatic, nonsequential, peristaltic wave compression pump.

04/01/2026 – Added exclusion for E0659 segmental pneumatic appliance for head, neck and chest. Added E0658 to policy coverage criteria.

MVP Health Care Medical Policy

Electrical Stimulation Devices and Therapies

Type of Policy:	DME/Medical
Prior Approval Date:	11/14/2025
Approval Date:	01/05/2026
Effective Date:	04/01/2026
Related Polices:	Bone Growth Stimulator Deep Brain Stimulation Durable Medical Equipment (DME) Sacral Nerve Stimulation Spinal Cord Stimulator for Intractable Pain

Codes Requiring Prior Authorization

Prior authorization may vary by plan which means the codes listed below may be specific to one product or all products. Please refer to the product grid found at the end of this policy for detailed authorization requirements for specific plans.

HCPCS Codes for all MVP Products: A4540, A4541, A4542, A4543, A4544, E0490, E0491, E0492, E0493, E0721, E0731, E0732, E0733, E0734, E0735, E0740, E0743, E0744, E0745, E0762, E0764, E0765, E0766, E0769, E0770

HCPCS Codes for MVP Medicaid Products and MVP Medicare Products Only: A4555,

Codes Requiring Retrospective Review

N/A

Experimental/Investigational

HCPCS Codes: A4540, A4541, A4542, E0490, E0491, E0492, E0493, E0732, E0733, E0734, E0735, E0744, E0746, E0762, E0765

Common Diagnosis Codes

ICD-10- CM Diagnosis Codes:

G12.2, G12.20, G12.21, G12.22, G12.29, G12.8, G12.9, G21.9, G35, G36, G37, G44.201, G54.0, G54.1, G54.2, G54.3, G54.4, G54.5, G54.6, G54.7, G54.8, G54.9, G83.9, R11.0, R11.1, R11.10, R11.11, R11.12, R11.13, R11.14, R11.2, M15.0, M15.1, M15.2, M15.3, M15.4, M15.8, M15.9, M16.0, M16.1, M16.10, M16.11, M16.12, M16.2, M16.3, M16.30, M16.31, M16.32, M16.4, M16.5, M16.50, M16.51, M16.52, M16.6, M16.7, M16.9, M17.0, M17.1, M17.10, M17.11, M17.12, M17.2, M17.3, M17.30, M17.31, M17.32, M17.4, M17.5, M17.9, M18.0, M18.1, M18.10, M18.11, M18.12, M18.2, M18.3, M18.30, M18.31, M18.32, M18.4, M18.5, M18.50, M18.51, M18.52, M18.9, M19.01, M19.011, M19.012, M19.019, M19.021, M19.022, M19.029, M19.031, M19.032, M19.039, M19.041, M19.042, M19.049, M19.071, M19.072, M19.079, M19.11, M19.111, M19.112, M19.119, M19.121, M19.122, M19.129, M19.131, M19.132, M19.139, M19.141, M19.142, M19.149, M19.171, M19.172, M19.179, M19.211, M19.212, M19,219, M19.221, M19.222, M19.229, M19.231, M19.232, M19.239, M19.241, M19.242, M19.249, M19.271, M19.272, M19.279, M19.90, M19.91, M19.92, M19.93, M53.2x1, M53.2x2, M53.2x4, M53.2x5, M53.2x6, M53.2x7, S53.2x8, M53.2x9, R30.0, R30.1, R30.9, S32.0, S32.9, S53.80, S53.81, S53.82, S53.83, S53.84, S53.85, S53.86, S53.87, S53.88, S53.9

Common Diagnosis Codes associated with this policy have been provided for informational purposes only. The list of codes may not be all-inclusive and may be updated to reflect any applicable revisions to the ICD-10 code sets and/or medical necessity guidelines applied in this policy.

Common Procedure Codes

N/A

Please refer to the product grid for detailed authorization requirements for specific plans. Codes requiring prior-authorization for some products may require retrospective review for plans that do not require prior-authorization. Common diagnosis codes are included for informational purposes only and every attempt has been made to update and keep these codes accurate. These codes may not be all inclusive CPT codes are subject to change as replacement codes are adopted by CMS. Any codes related to CMS updates will be adopted and applied to this policy by MVP.

Overview

Electrical stimulators provide direct, alternating, pulsating and/or pulsed wave energy to accelerate healing of chronic wounds, facilitate functional restoration, treat muscle atrophy and diminish pain. Neuromuscular Electrical Stimulation (NMES), Transcutaneous Electrical Nerve Stimulation (TENS), and Electromagnetic Therapy (ET) are some of the many forms of electrical stimulation that may be provided by indwelling transcutaneous needles or by surface electrodes.

Various devices and treatments are available for patients in an outpatient clinic, a physician's office, or in the patient's home. Some treatments may require surgical implantation of leads and a trial period to ensure efficacy. Electrical stimulation for some conditions may be tried as a last resort when the customer has failed a trial of conservative therapies.

Indications/Criteria

Documentation

Medical record documentation must include all of the following:

- the exact nature of the customer's impairments and functional limitations to be treated;
- medical necessity for the type, frequency and duration of therapy to treat the customer's condition;
- appropriate conservative therapies that have been tried and failed e.g., pharmacological, surgical, physical, or psychological therapies;
- the expected goals for medically necessary therapy(s); and
- when regression or plateaus occur, the reasons for the lack of progress should be noted to justify continued treatment.

Neuromuscular Electrical Stimulation (NMES) (E0745)

Neuromuscular electrical stimulation (NMES) will be covered when used as one component of a comprehensive rehabilitation program for the treatment of disuse atrophy where the nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves, and other non-neurological reasons for disuse atrophy such as casting or splinting of limb, contracture due to scarring of soft tissue as in burn lesions, major knee surgery (e.g., ACL, TKR), or total hip replacement (THR) surgery (until orthotic training begins).

- Coverage of an NMES for more than two months is determined by individual consideration based upon supportive documentation (including current muscle testing) provided by the therapist and/or attending physician.
- An NMES unit will be covered as a rental only.

Functional Electrical Stimulation in Patients with Spinal Cord Injury (SCI) (E0770, E0764)

The type of NMES that is used to enhance the ability to walk of spinal cord injury (SCI) patients is commonly referred to as functional electrical stimulation (FES).

Coverage for the use of NMES/FES is limited to spinal cord injury (SCI) patients for walking who have completed a training program which consists of at least 32 physical therapy sessions with the device over a period of three (3) months. Physical therapy necessary to perform this training must be directly performed by the physical therapist as part of a one-on-one training program.

The goal of physical therapy must be to train SCI patients on the use of FES devices to achieve walking, not to reverse or retard muscle atrophy.

Coverage for functional electrical stimulation (FES) for walking will be covered in spinal cord injury patients with all of the following characteristics:

- persons with intact lower motor units (L1 and below) (both muscle and peripheral nerve);
- persons with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently;
- persons that demonstrate brisk muscle contraction to FES and have sensory perception electrical stimulation sufficient for muscle contraction;
- persons that possess high motivation, commitment and cognitive ability to use such devices for walking;
- persons that can transfer independently and can demonstrate independent standing tolerance for at least 3 minutes;
- persons that can demonstrate hand and finger function to manipulate controls;
- persons with at least six-month post recovery spinal cord injury and restorative surgery;
- persons without hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and
- persons who have demonstrated a willingness to use the device long-term.

Functional electrical stimulation for walking will not be covered in SCI patients with any of the following:

- persons with cardiac pacemakers;
- severe scoliosis or severe osteoporosis;
- skin disease or cancer at area of stimulation;
- irreversible contracture; or
- autonomic dysflexia.

Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-operative Pain (E0720, E0730)

A transcutaneous electrical nerve stimulator (TENS) is covered for the treatment of patients with acute post-operative pain who meet the following criteria:

- medical necessity is limited to 30 days from the day of surgery;
- coverage for more than 30 days is determined by individual consideration based upon supportive documentation provided by the attending physician.

Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Pain (E0720, E0730)

A transcutaneous electrical nerve stimulator (TENS) is covered for the treatment of patients with chronic pain who meet all of the following criteria:

- the medical record must document the location of the pain, the duration of time the patient has had the pain, and the etiology of the pain;
- the pain must have been present for at least 90 days;
- the etiology of the pain must be a type that is accepted as responding to TENS therapy. Examples of conditions for which a TENS unit is not considered to be reasonable and necessary are: headache, visceral abdominal pain, pelvic pain, and temporomandibular joint (TMJ) pain (not all inclusive);
- the TENS unit must be used by the patient on a trial basis for a minimum of 30 days, but not to exceed 60 days. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain;
- the physician must determine that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. The physician's records must document a re-evaluation of the patient at the end of the trial period, must indicate how often the patient used the TENS unit, the typical duration of use each time, and the results;
- a four lead TENS unit may be used with either two leads or four leads, depending on the characteristics of the patient's pain. If it is ordered for use with four leads, the medical record must document why two leads are insufficient to meet the patient's needs; and
- if two TENS leads are reasonable and necessary, then a maximum of one unit of Code A4595 would be allowed per month; if four TENS leads are necessary, a maximum of two units per month would be allowed. If the use of the TENS unit is less than daily, the frequency of billing for the TENS supply code should be reduced proportionally.

The physician ordering the TENS unit must be the attending physician or a consulting physician for the disease or condition resulting in the need for the TENS unit.

<u>Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP)</u>

TENS therapy for CLBP is only covered when all of the following criteria are met:

- the customer has one of the following diagnoses:
    - lumbosacral root lesions, not elsewhere classified; or
    - sacroiliitis, not elsewhere classified; or
    - lumbosacral spondylosis without myelopathy; or
    - thoracic or lumbar spondylosis with myelopathy – lumbar region; or

- lumbar intervertebral disc without myelopathy; or
- lumbosacral intervertebral disc; or
- intervertebral disc disorder myelopathy – lumbar region; or
- post laminectomy syndrome – lumbar region; or
- other and unspecified disc disorders, lumbar region; or
- spinal stenosis, lumbar region without neurogenic claudication; or
- spinal stenosis, lumbar region with neurogenic claudication; or
- lumbago; or
- sciatica; or
- thoracic or lumbosacral neuritis or radiculitis, unspecified, radicular
- syndrome of lower extremities; or
- acquired spondylolisthesis; or
- non-allopathic lesions NEC (not elsewhere classified) – lumbar region; or
- spondylosis, lumbosacral region; or
- spondylolisthesis; or
- fracture of vertebral column without mention of spinal cord injury, lumbar, closed; or
- fracture of vertebral column with mention of spinal cord injury, lumbar, closed; or
- sprains and strains of sacroiliac region – lumbosacral (joint) (ligament); or
- sprains and strains of sacroiliac ligament; or
- sprains and strains of other and unspecified parts of back, lumbar; or
- injury to nerve roots and spinal plexus, lumbar root; and

- the customer is enrolled in an approved clinical study that meets all of the requirements set out in National Coverage Determination (NCD) for Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP) (160.27).[3] (CMS Internet Only Manual 100-3, Chapter 1); and
- the TENS unit must be used by the patient on a trial basis for a minimum of 30 days, but not to exceed 60 days. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain; and
- the physician must determine that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. The physician's records must document a re-evaluation of the patient at the end of the

trial period, must indicate how often the patient used the TENS unit, the typical duration of use each time, and the results; and

- a four lead TENS unit may be used with either two leads or four leads, depending on the characteristics of the patient's pain. If it is ordered for use with four leads, the medical record must document why two leads are insufficient to meet the patient's needs; and

- if two TENS leads are reasonable and necessary, then a maximum of one unit of Code A4595 would be allowed per month; if four TENS leads are necessary, a maximum of two units per month would be allowed. If the use of the TENS unit is less than daily, the frequency of billing for the TENS supply code should be reduced proportionally.

NOTE: TENS units requiring just two leads are not covered for MVP Medicaid Managed Care customers.

The physician ordering the TENS unit must be the attending physician or a consulting physician for the disease or condition resulting in the need for the TENS unit.

TENS therapy for CLBP that does not meet these criteria will be denied as not reasonable and necessary.

Conductive Garment for Use with TENS (E0731)

A conductive garment used with a TENS unit may be covered when all of the following conditions are met:

- it has been prescribed by a physician for use in delivering covered TENS treatment; and
- one of the medical indications outlined below is met:
    - the patient cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires; or
    - the patient cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires; or
    - the patient has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires; or
    - the patient requires electrical stimulation beneath a cast to treat chronic intractable pain, and

- a conductive garment may be covered with a neuromuscular electrical stimulator (NMES) if there is a skin disease or a cancer at the area of stimulation.

A conductive garment is not covered for use with a TENS or an NMES device during the trial period unless:

- the patient has a documented skin problem prior to the start of the trial period; or
- the TENS or NMES is reasonable and necessary for the patient.

Non-Implantable Pelvic Floor Electrical Stimulator (E0740)

- Pelvic floor electrical stimulation with a non-implantable stimulator is covered for the treatment of stress and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training.
- A failed trial of PME training is defined as no clinically significant improvement in urinary continence after completing four weeks of an ordered plan of pelvic muscle exercises designed to increase periurethral muscle strength.

Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds (E0769)

The use of ES and electromagnetic therapy for the treatment of wounds are considered adjunctive therapies and will only be covered when all of the following criteria have been met:

- ES and electromagnetic therapy will be covered for chronic Stage III or Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers;
- chronic ulcers are defined as ulcers that have not healed within 30 days of occurrence. ES or electromagnetic therapy will be covered only after appropriate standard wound therapy has been tried for at least 30 days and there are no measurable signs of improved healing. This 30-day period may begin while the wound is acute;
- standard wound care includes: optimization of nutritional status, debridement by any means to remove devitalized tissue, maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings, and necessary treatment to resolve any infection that may be present. Standard wound care based on the specific type of wound includes: frequent repositioning of a patient with pressure ulcers (usually every 2 hours), offloading of pressure and good glucose control for diabetic ulcers, establishment of adequate circulation for arterial ulcers, and the use of a compression system for patients with venous ulcers;
- measurable signs of improved healing include: a decrease in wound size (either surface area or volume), decrease in amount of exudates, and decrease in amount of necrotic tissue;

- ES or electromagnetic therapy must be discontinued when the wound demonstrates 100% epitheliliazed wound bed;
- continued treatment with ES or electromagnetic therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment;
- ES and electromagnetic therapy services can only be covered when performed by a physician, physical therapist, or a clinician incident to a physician service; and
- unsupervised use of ES or electromagnetic therapy for wound therapy will not be covered, as this use has not been found to be medically reasonable and necessary.

Tumor Treatment Field Therapy (TTFT-E0766) is covered when all of the following criteria are met:

- The member has histologically confirmed (World Health Organization (WHO) grade IV astrocytoma), newly diagnosed, Glioblastoma Multiforme (GBM); and
- The member has received initial treatment with maximal debulking surgery, followed by chemotherapy and radiotherapy; and
- Tumor treatment field therapy is initiated within 7 weeks from the last dose of concomitant chemotherapy or radiotherapy, whichever is later; and
- The member has no evidence of progression by Response Assessment in Neuro-Oncology (RANO) criteria; and
- The member has a Karnofsky Performance Score (KPS) of at least 70; and
- The member will use tumor treatment field therapy (TTFT) for an average of 18 hours per day; and
- The member is 22 years or older and not pregnant
- Absence of intracranial shunt or other implanted intracranial device

Tumor treatment field therapy will be denied as not reasonable and necessary for the treatment of recurrent GBM

Continued coverage of Tumor Treatment Field Therapy beyond the first three months of therapy requires that no sooner than the 60th day but no later than the 91st day after initiating therapy, the treating practitioner must conduct a clinical re-evaluation and document that the beneficiary is continuing to use and is benefiting from TTFT.

Documentation of clinical benefit is demonstrated by:

- Re-evaluation by the treating provider; and
- Objective evidence of adherence to therapy defined as an average usage of 18 hours per day.

Exclusions

- Not meeting criteria listed under Indications/Criteria of this policy.
- A4556 (electrodes), A4630 (replacement batteries), and A4595 (leads) are covered only if the customer's plan has coverage for disposable supplies.
- There is insufficient evidence from well-designed prospective clinical trials that the following devices or therapies have been proven to be medically safe and/or effective for their indicated use compared to current standard interventions and are, therefore, considered investigational.
    - Functional electrical stimulation devices (E0770, E0764) for use in patients without spinal cord injury (see Indications/Criteria of this policy).
    - Functional electrical stimulation exercise devices (i.e., RT300 Electrical Stimulation Bike).
    - Percutaneous electrical nerve stimulation (PENS) and percutaneous neuromodulation therapy (PNT) for the treatment of chronic low back pain, including, but not limited to, diabetic neuropathy, headache, and osteoarthritis of the knee. The evidence in the peer-reviewed literature did not demonstrate Percutaneous electrical nerve stimulation (PENS) and percutaneous neuromodulation therapy (PNT) is effective in the long term and therefore is considered investigational.
    - Transcutaneous Electrical Nerve Stimulation (TENS) (E0765) for the treatment of post-operative nausea and vomiting, chemotherapy induced nausea, nausea and vomiting of pregnancy, motion sickness and all other indications are not covered.
    - Threshold electrical stimulation (TES) as a treatment for motor disorders, including, but not limited to, cerebral palsy, scoliosis, or spina bifida.
    - Interferential stimulators for the treatment of circulation disorders, range of motion, edema, muscle spasms, bone healing, and pain and to promote soft tissue healing.
    - Gastric electrical stimulation for the treatment of obesity.
- Currently no implantable pulse generator, radiofrequency device, or leads are approved by the FDA for peripheral occipital nerve stimulation to treat occipital neuralgia or headaches.
- Transcutaneous electrical joint stimulation devices (E0762) are considered investigational for any indication.

- Electrosleep therapy for the treatment of chronic insomnia, anxiety, depression, psychosomatic disorders, such as asthma, spastic colitis, or tension headache, and for organic disorders including essential hypertension.
- Electrical aversion (electroversion) therapy for the treatment of alcoholism.
- Electrical continence aids which stimulate anal musculature to allow the patient to ambulate without incontinence.
- Electrical stimulation used in the treatment of Bell's palsy, multiple sclerosis and strokes (when there is no potential for restoration of function).
- Scrambler therapy MC-5A CALMARE® (Transcutaneous Electrical Modulation Pain Reprocessing Device) for chronic, intractable pain, post-surgical pain, post-traumatic acute pain, cancer related pain, and reducing peripheral neuropathy caused by chemotherapy.
- Electrical stimulation of muscles for treatment of scoliosis (E0744).
- Electrical Tumor Treatment Field Therapy (E0766) is not covered for any other indication not listed in the Indication/Criteria section.
- Cefaly device for prevention, treatment and other indications for migraine headaches is not covered. There is insufficient evidence in the peer-reviewed literature to support the use of the Cefaly transcutaneous electrical stimulator (TENS) headband for the treatment of migraine headaches, therefore the Cefaly device is considered investigational and not covered.
- GammaCore non-implantable transcutaneous vagus nerve stimulation (tVNS)(E0735) is considered investigational because the long-term outcomes in the published peer-reviewed scientific literature do not support the safety and effectiveness for the acute or chronic treatment of pain associated with episodic cluster headache or migraines in adult patients.
- Cranial Electrotherapy Systems (CES) (E0732) deliver low level electrical stimulation (microcurrent) to the brain through electrodes that are attached to the ear lobes or behind the ears. CES has been proposed for the treatment of anxiety, depression, insomnia, substance abuse, depression, tension headaches, cluster headaches and migraines. CES devices are investigational and not covered for any indication because there is insufficient evidence regarding the safety and effectiveness of Cranial Electrotherapy Systems (CES) for the reduction of pain or improvement in function.
- Remote electrical neuromodulation (REN) (e.g. Nerivio) device proposed as a treatment for episodic or chronic migraine headaches is considered investigational and not covered for all indications because there is insufficient evidence regarding the safety and effectiveness of REN.

- Cala Trio nerve stimulating device (E0734, A4542) proposed as a treatment of essential tremors is considered experimental and investigational because there is insufficient evidence regarding the safety and effectiveness has not been established.

- Monarch external trigeminal nerve stimulation (eTNS) (E0733, A4541) proposed for treatment of pediatric ADHD is considered experimental and investigational because there is insufficient evidence regarding the safety and effectiveness has not been established.

- Electrical stimulation of muscles for treatment of scoliosis (HCPCS E0744) is considered experimental and investigational because there is insufficient evidence regarding the safety of and effectiveness for this treatment has not been established.

- Biofeedback devices (HCPCS E0746) are not covered for home use because they are considered experimental and investigational as there is insufficient evidence in peer-reviewed medical literature regarding effectiveness or proof the technology improves outcomes.

- eXciteOSA Daytime Therapy Device (E0490, E0491, E0492, E0493) for the treatment of obstructive sleep apnea is considered to be experimental and investigational as there is insufficient evidence in peer-reviewed medical literature regarding safety, effectiveness and/or proof the technology improves outcomes.

- The NTX100 Tonic Motor Activation (TOMAC) System (E0743, A4544) for the treatment of restless leg syndrome is considered to be experimental and investigational as there is insufficient evidence in peer-reviewed medical literature regarding safety, effectiveness and/or proof the technology improves outcomes.

- The use of auricular stimulation (E0721, A4543) for, but not limited to, the treatment of opioid withdrawal (e.g., Sparrow Ascent) is considered to be experimental and investigational as there is insufficient evidence in peer-reviewed literature regarding the safety, effectiveness, and/or proof that the technology improves outcomes.

MVP Medicaid Managed Care Variation

Coverage for transcutaneous electrical nerve stimulation (TENS) is limited to customers with a diagnosis of knee pain due to osteoarthritis (ICD-10- Codes: M17.10, M17.9, M17.5, M25.169, M25.869, M25.9). If at least one of these diagnostic codes is not billed with the claim for TENS, the TENS will be denied administratively.

Functional Electrical Stimulation (FES) via transcutaneous, percutaneous, and implanted devices are considered not medically necessary for treatment of spinal cord injury, head injury, cerebral palsy, and upper motor neuron disease and is, therefore, not covered (ICD-10 Codes: B91, G12.0, G12.1, G12.8, G12.21, G12.22, G12.29, G12.8, G12.9, G14, G20,

G21.11, G21.19, G21.8, G35, G36.0, G37.0, G37.1, G37.2, G37.3, G37.5, G37.8, G37.9, G80.0, G80.1, G80.2, G80.8, G80.9, P11.5, S04.9XXS, S06.0X1A, S06.0X2A, S06.0X3A, S06.0X4A, S06.0X5A, S06.0X6A, S06.0X9A, S06.9X9S, S14.109S, S24.109S, S34.109S, S34.139S). If at least one of the diagnostic codes is not billed with the claims for FES, the FES will be denied administratively.

TENS and FES units that are billed with a covered diagnosis must also meet the applicable medical necessity criteria within this policy for that diagnosis.

MVP Medicare Variation

For full coverage details refer to the following Medicare Local Coverage Determination (LCD): Noridian Healthcare Solutions (Medicare) Local Coverage Determination (LCD) for Tumor Treatment field Therapy (TTFT)(L34730). Effective Date: 09/01/19 Available: https://med.noridianmedicare.com/web/jddme/policies/lcd/active

Transcutaneous Electrical Nerve Stimulators (TENS) (E0720, E0730)

A TENS is covered for the treatment of beneficiaries with chronic, intractable pain or acute post-operative pain when one of the following coverage criteria, I-III, are met.

I. Acute Post-operative Pain

TENS is covered for acute post-operative pain. Coverage is limited to 30 days (one month's rental) from the day of surgery. Payment will be made only as a rental.

A TENS unit will be denied as not reasonable and necessary for acute pain (less than three months duration) other than for post-operative pain.

II. Chronic Pain Other than Low Back Pain

TENS is covered for chronic, intractable pain other than chronic low back pain when all of the following criteria must be met:

- The presumed etiology of the pain must be a type that is accepted as responding to TENS therapy. Examples of conditions for which TENS therapy is not considered to be reasonable and necessary are (not all-inclusive):
  - headache
  - visceral abdominal pain
  - pelvic pain
  - temporomandibular joint (TMJ) pain
- The pain must have been present for at least three months
- Other appropriate treatment modalities must have been tried and failed

TENS therapy for chronic pain that does not meet these criteria will be denied as not reasonable and necessary.

III. Chronic Low Back Pain (CLBP) TENS therapy for CLBP is only covered when all of the following criteria are met:

- The Medicare customer has one of the diagnosis codes listed in the Diagnosis Codes that Support Medical Necessity section in the Noridian Healthcare Solutions. Local Coverage Determination (LCD) for Transcutaneous Electrical Nerve Stimulators (TENS) (L33802). Revision Effective Date 10/01/2015. Available: https://med.noridianmedicare.com/web/jddme/policies/lcd/active
- The beneficiary is enrolled in an approved clinical study that meets all of the requirements set out in National Coverage Determination (NCD) for Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP) (160.27) Available: Available: www.cms.gov/

For Medicare full coverage details of Transcutaneous Electrical Nerve Stimulators (TENS) National Coverage Determination (NCD) and Local Coverage Determination (LCD) refer to the links above.

For Medicare products, TENS (E0730) used to treat Chronic Low Back Pain is provided under limited coverage. Reimbursement is only available for beneficiaries who are enrolled in an approved clinical trial. *****

*****Currently there is no Medicare approved clinical trial for TENS therapy for chronic low back pain, therefore the TENS is not covered by MVP Health Care.

Refer to the following links for full Medicare coverage of chronic low back pain:

Noridian Healthcare Solutions. Local Coverage Determination (LCD) for Transcutaneous Electrical Nerve Stimulators (TENS) (L33802). Revision Effective Date 10/01/2019. Available: https://med.noridianmedicare.com/web/jddme/policies/lcd/active

Peripheral Nerve Stimulation (CPT Code: 64555, 64596, 64597, 64598)

For full Medicare coverage details about peripheral nerve stimulation please refer to the following NCD for Medicare Customers: National Coverage Determination (NCD) Electrical Nerve Stimulators (160.7) Effective Date: 08/07/1995 and Medicare LCD: Peripheral Nerve Stimulation A55531 and L37360. Available: MCD Search (cms.gov)

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54. HAYES Evolving Evidence Review eXciteOSA Device (Signifier Medical Technologies LLC) for Treatment of Snoring in Patients With Primary Snoring or Mild Obstructive Sleep Apnea. ©2021 Hayes, Inc, a sympir company. December 12, 2022.

55. Hayes, Inc. Evolving Evidence Review Nidra (Noctrix Health Inc) for Treatment of Restless Legs Syndrome. Hayes, Inc. August 13, 2024.

56. Hayes, Inc. Evolving Analysis Research Brief Sparrow Ascent (Spark Biomedical) for Management of Opioid Withdrawal Symptoms. Hayes, Inc. March 13, 2024.

Customer Product	Medical Management Requirements*
New York Products	
HMO	Prior Auth
PPO in Plan	Prior Auth
PPO OOP	Potential for Retrospective Review
POS in Plan	Prior Auth
POS OOP	Prior Auth
Essential Plan	Prior Auth
MVP Medicaid Managed Care	Prior Auth
MVP Child Health Plus	Prior Auth
MVP Harmonious Health Care Plan	Prior Auth
MVP Medicare Complete Wellness	Prior Auth
MVP Medicare Preferred Gold HMO POS	Prior Auth
MVP Medicare Secure Plus HMO POS	Prior Auth
MVP Medicare WellSelect PPO	Prior Auth
MVP DualAccess D-SNP HMO	Prior Auth
MVP DualAccess Complete D-SNP HMO	Prior Auth
USA Care	Prior Auth
Healthy NY	Prior Auth
MVP Premier	Prior Auth
MVP Premier Plus	Prior Auth
MVP Premier Plus HDHP	Prior Auth
MVP Secure	Prior Auth
MVP EPO	Prior Auth
MVP EPO HDHP	Prior Auth
MVP PPO	Prior Auth
MVP PPO HDHP	Prior Auth
ASO	See SPD
Vermont Products	
POS In Plan	Prior Auth
POS OOP	Prior Auth
MVP VT HMO	Prior Auth
MVP VT HDHP HMO	Prior Auth
MVP VT Plus HMO	Prior Auth
MVP VT Plus HDHP HMO	Prior Auth
MVP Secure	Prior Auth
ASO	See SPD
♦ Note: Prior authorization requirements for HDHP products are the same as the base product (e.g. HDHP HMO auth requirements are the same as listed for HMO).	
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***Medical Management Requirements**

Prior Auth	Prior Authorization Required
Potential for Retrospective Review	No Prior Authorization Required. May be subject to Retrospective Review
Retro Review	Retrospective Review Required
Not Covered	Service is not a covered benefit.
See SPD	See Specific Plan Design

Revision History:

12/01/2021 - remote electrical neuromodulation (REN) electrical stimulation devices (e.g. Neverio) to the list of devices that are investigational for migraine headache treatment.

08/01/2022 – Added Cala Trio device (K1018, K1019), Percutaneous electrical nerve stimulation (PENS), percutaneous electrical nerve field stimulation (PENFS), percutaneous neuromodulation therapy (PNT) or auricular electrostimulation devices (e.g., IB-Stim Device) to exclusions.

02/01/2023 – Adding prior authorization to K1018 and K1019.

06/01/2023 – Exclusions for electrical stimulation of muscles for treatment of scoliosis and biofeedback were removed from another medical policy and moved to this policy. No changes in policy position.

12/01/2023 –Added exclusion for eXciteOSA Daytime Therapy Device (E0490, E0491, K1028, K1029)

01/01/2024- Added new codes A4540, A4541, A4542, E0492, E0493, E0732, E0733, E0734, E0735 to prior authorization. Removed invalid codes K1002, K1016, K1017, K1018, K1019, K1020, K1023, K1028, K1029.

06/01/2024 – Moved Peripheral Nerve Stimulators and CPT Codes: 64555, 64596, 64597, 64598 and references to Hayes from Experimental Investigational Policy.

10/01/2024 – Removed prior authorization from HCPCS Codes: A4556, A4557, A4630, E0720, E0730.

12/01/2024 –Completed formal review of fast-track updates effective 10/01/2024.

2/1/2025 – added NTX100 Tonic Motor Activation (TOMAC) System (E0743, A4544) and auricular stimulation (E0721, A4543) Sparrow Ascent to exclusions as experimental and investigational.

06/01/2025 – ReActiv8 added to exclusions as experimental and investigational.

10/01/2025 – Updated Medicaid coverage of Tumor Treatment Field Therapy.

04/01/2026 – Tumor Treatment Field Therapy criteria for all plans merged to match Medicare/Medicaid criteria, with no variations. Moved CPT Codes: 64555, 64596, 64597, 64598 from this policy to new Peripheral Nerve Stimulators Medical Policy.

MVP Health Care Medical Policy

Electrical Stimulation Devices and Therapies

Type of Policy:	DME/Medical
Prior Approval Date:	11/14/2025
Approval Date:	01/05/2026
Effective Date:	04/01/2026
Related Polices:	Bone Growth Stimulator Deep Brain Stimulation Durable Medical Equipment (DME) Sacral Nerve Stimulation Spinal Cord Stimulator for Intractable Pain

Codes Requiring Prior Authorization

Prior authorization may vary by plan which means the codes listed below may be specific to one product or all products. Please refer to the product grid found at the end of this policy for detailed authorization requirements for specific plans.

HCPCS Codes for all MVP Products: A4540, A4541, A4542, A4543, A4544, E0490, E0491, E0492, E0493, E0721, E0731, E0732, E0733, E0734, E0735, E0740, E0743, E0744, E0745, E0762, E0764, E0765, E0766, E0769, E0770

HCPCS Codes for MVP Medicaid Products and MVP Medicare Products Only: A4555,

Codes Requiring Retrospective Review

N/A

Experimental/Investigational

HCPCS Codes: A4540, A4541, A4542, E0490, E0491, E0492, E0493, E0732, E0733, E0734, E0735, E0744, E0746, E0762, E0765

~~CPT Codes: 64555, 64596, 64597, 64598~~

Common Diagnosis Codes

ICD-10- CM Diagnosis Codes:

G12.2, G12.20, G12.21, G12.22, G12.29, G12.8, G12.9, G21.9, G35, G36, G37, G44.201, G54.0, G54.1, G54.2, G54.3, G54.4, G54.5, G54.6, G54.7, G54.8, G54.9, G83.9, R11.0, R11.1, R11.10, R11.11, R11.12, R11.13, R11.14, R11.2, M15.0, M15.1, M15.2, M15.3, M15.4, M15.8, M15.9, M16.0, M16.1, M16.10, M16.11, M16.12, M16.2, M16.3, M16.30, M16.31, M16.32, M16.4, M16.5, M16.50, M16.51, M16.52, M16.6, M16.7, M16.9, M17.0, M17.1, M17.10, M17.11, M17.12, M17.2, M17.3, M17.30, M17.31, M17.32, M17.4, M17.5, M17.9, M18.0, M18.1, M18.10, M18.11, M18.12, M18.2, M18.3, M18.30, M18.31, M18.32, M18.4, M18.5, M18.50, M18.51, M18.52, M18.9, M19.01, M19.011, M19.012, M19.019, M19.021, M19.022, M19.029, M19.031, M19.032, M19.039, M19.041, M19.042, M19.049, M19.071, M19.072, M19.079, M19.11, M19.111, M19.112, M19.119, M19.121, M19.122, M19.129, M19.131, M19.132, M19.139, M19.141, M19.142, M19.149, M19.171, M19.172, M19.179, M19.211, M19.212, M19,219, M19.221, M19.222, M19.229, M19.231, M19.232, M19.239, M19.241, M19.242, M19.249, M19.271, M19.272, M19.279, M19.90, M19.91, M19.92, M19.93, M53.2x1, M53.2x2, M53.2x4, M53.2x5, M53.2x6, M53.2x7, S53.2x8, M53.2x9, R30.0, R30.1, R30.9, S32.0, S32.9, S53.80, S53.81, S53.82, S53.83, S53.84, S53.85, S53.86, S53.87, S53.88, S53.9

Common Diagnosis Codes associated with this policy have been provided for informational purposes only. The list of codes may not be all-inclusive and may be updated to reflect any applicable revisions to the ICD-10 code sets and/or medical necessity guidelines applied in this policy.

Common Procedure Codes

N/A

Please refer to the product grid for detailed authorization requirements for specific plans. Codes requiring prior-authorization for some products may require retrospective review for plans that do not require prior-authorization. Common diagnosis codes are included for informational purposes only and every attempt has been made to update and keep these codes accurate. These codes may not be all inclusive CPT codes are subject to change as replacement codes are adopted by CMS. Any codes related to CMS updates will be adopted and applied to this policy by MVP.

Overview

Electrical stimulators provide direct, alternating, pulsating and/or pulsed wave energy to accelerate healing of chronic wounds, facilitate functional restoration, treat muscle atrophy and diminish pain. Neuromuscular Electrical Stimulation (NMES), Transcutaneous Electrical Nerve Stimulation (TENS), and Electromagnetic Therapy (ET) are some of the many forms of electrical stimulation that may be provided by indwelling transcutaneous needles or by surface electrodes.

Various devices and treatments are available for patients in an outpatient clinic, a physician's office, or in the patient's home. Some treatments may require surgical implantation of leads and a trial period to ensure efficacy. Electrical stimulation for some conditions may be tried as a last resort when the customer has failed a trial of conservative therapies.

Indications/Criteria

Documentation

Medical record documentation must include all of the following:

- the exact nature of the customer's impairments and functional limitations to be treated;
- medical necessity for the type, frequency and duration of therapy to treat the customer's condition;
- appropriate conservative therapies that have been tried and failed e.g., pharmacological, surgical, physical, or psychological therapies;
- the expected goals for medically necessary therapy(s); and
- when regression or plateaus occur, the reasons for the lack of progress should be noted to justify continued treatment.

Neuromuscular Electrical Stimulation (NMES) (E0745)

Neuromuscular electrical stimulation (NMES) will be covered when used as one component of a comprehensive rehabilitation program for the treatment of disuse atrophy where the nerve supply to the muscle is intact, including brain, spinal cord and peripheral nerves, and other non-neurological reasons for disuse atrophy such as casting or splinting of limb, contracture due to scarring of soft tissue as in burn lesions, major knee surgery (e.g., ACL, TKR), or total hip replacement (THR) surgery (until orthotic training begins).

- Coverage of an NMES for more than two months is determined by individual consideration based upon supportive documentation (including current muscle testing) provided by the therapist and/or attending physician.
- An NMES unit will be covered as a rental only.

Functional Electrical Stimulation in Patients with Spinal Cord Injury (SCI) (E0770, E0764)

The type of NMES that is used to enhance the ability to walk of spinal cord injury (SCI) patients is commonly referred to as functional electrical stimulation (FES).

Coverage for the use of NMES/FES is limited to spinal cord injury (SCI) patients for walking who have completed a training program which consists of at least 32 physical therapy sessions with the device over a period of three (3) months. Physical therapy necessary to perform this training must be directly performed by the physical therapist as part of a one-on-one training program.

The goal of physical therapy must be to train SCI patients on the use of FES devices to achieve walking, not to reverse or retard muscle atrophy.

Coverage for functional electrical stimulation (FES) for walking will be covered in spinal cord injury patients with all of the following characteristics:

- persons with intact lower motor units (L1 and below) (both muscle and peripheral nerve);
- persons with muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently;
- persons that demonstrate brisk muscle contraction to FES and have sensory perception electrical stimulation sufficient for muscle contraction;
- persons that possess high motivation, commitment and cognitive ability to use such devices for walking;
- persons that can transfer independently and can demonstrate independent standing tolerance for at least 3 minutes;
- persons that can demonstrate hand and finger function to manipulate controls;
- persons with at least six-month post recovery spinal cord injury and restorative surgery;
- persons without hip and knee degenerative disease and no history of long bone fracture secondary to osteoporosis; and
- persons who have demonstrated a willingness to use the device long-term.

Functional electrical stimulation for walking will not be covered in SCI patients with any of the following:

- persons with cardiac pacemakers;
- severe scoliosis or severe osteoporosis;
- skin disease or cancer at area of stimulation;
- irreversible contracture; or
- autonomic dysflexia.

Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-operative Pain (E0720, E0730)

A transcutaneous electrical nerve stimulator (TENS) is covered for the treatment of patients with acute post-operative pain who meet the following criteria:

- medical necessity is limited to 30 days from the day of surgery;
- coverage for more than 30 days is determined by individual consideration based upon supportive documentation provided by the attending physician.

Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Pain (E0720, E0730)

A transcutaneous electrical nerve stimulator (TENS) is covered for the treatment of patients with chronic pain who meet all of the following criteria:

- the medical record must document the location of the pain, the duration of time the patient has had the pain, and the etiology of the pain;
- the pain must have been present for at least 90 days;
- the etiology of the pain must be a type that is accepted as responding to TENS therapy. Examples of conditions for which a TENS unit is not considered to be reasonable and necessary are: headache, visceral abdominal pain, pelvic pain, and temporomandibular joint (TMJ) pain (not all inclusive);
- the TENS unit must be used by the patient on a trial basis for a minimum of 30 days, but not to exceed 60 days. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain;
- the physician must determine that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. The physician's records must document a re-evaluation of the patient at the end of the trial period, must indicate how often the patient used the TENS unit, the typical duration of use each time, and the results;
- a four lead TENS unit may be used with either two leads or four leads, depending on the characteristics of the patient's pain. If it is ordered for use with four leads, the medical record must document why two leads are insufficient to meet the patient's needs; and
- if two TENS leads are reasonable and necessary, then a maximum of one unit of Code A4595 would be allowed per month; if four TENS leads are necessary, a maximum of two units per month would be allowed. If the use of the TENS unit is less than daily, the frequency of billing for the TENS supply code should be reduced proportionally.

The physician ordering the TENS unit must be the attending physician or a consulting physician for the disease or condition resulting in the need for the TENS unit.

<u>Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP)</u>

TENS therapy for CLBP is only covered when all of the following criteria are met:

- the customer has one of the following diagnoses:
    - lumbosacral root lesions, not elsewhere classified; or
    - sacroiliitis, not elsewhere classified; or
    - lumbosacral spondylosis without myelopathy; or
    - thoracic or lumbar spondylosis with myelopathy – lumbar region; or

- lumbar intervertebral disc without myelopathy; or
- lumbosacral intervertebral disc; or
- intervertebral disc disorder myelopathy – lumbar region; or
- post laminectomy syndrome – lumbar region; or
- other and unspecified disc disorders, lumbar region; or
- spinal stenosis, lumbar region without neurogenic claudication; or
- spinal stenosis, lumbar region with neurogenic claudication; or
- lumbago; or
- sciatica; or
- thoracic or lumbosacral neuritis or radiculitis, unspecified, radicular
- syndrome of lower extremities; or
- acquired spondylolisthesis; or
- non-allopathic lesions NEC (not elsewhere classified) – lumbar region; or
- spondylosis, lumbosacral region; or
- spondylolisthesis; or
- fracture of vertebral column without mention of spinal cord injury, lumbar, closed; or
- fracture of vertebral column with mention of spinal cord injury, lumbar, closed; or
- sprains and strains of sacroiliac region – lumbosacral (joint) (ligament); or
- sprains and strains of sacroiliac ligament; or
- sprains and strains of other and unspecified parts of back, lumbar; or
- injury to nerve roots and spinal plexus, lumbar root; and

- the customer is enrolled in an approved clinical study that meets all of the requirements set out in National Coverage Determination (NCD) for Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP) (160.27).[3] (CMS Internet Only Manual 100-3, Chapter 1); and
- the TENS unit must be used by the patient on a trial basis for a minimum of 30 days, but not to exceed 60 days. The trial period must be monitored by the physician to determine the effectiveness of the TENS unit in modulating the pain; and
- the physician must determine that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. The physician's records must document a re-evaluation of the patient at the end of the

trial period, must indicate how often the patient used the TENS unit, the typical duration of use each time, and the results; and

- a four lead TENS unit may be used with either two leads or four leads, depending on the characteristics of the patient's pain. If it is ordered for use with four leads, the medical record must document why two leads are insufficient to meet the patient's needs; and

- if two TENS leads are reasonable and necessary, then a maximum of one unit of Code A4595 would be allowed per month; if four TENS leads are necessary, a maximum of two units per month would be allowed. If the use of the TENS unit is less than daily, the frequency of billing for the TENS supply code should be reduced proportionally.

NOTE: TENS units requiring just two leads are not covered for MVP Medicaid Managed Care customers.

The physician ordering the TENS unit must be the attending physician or a consulting physician for the disease or condition resulting in the need for the TENS unit.

TENS therapy for CLBP that does not meet these criteria will be denied as not reasonable and necessary.

Conductive Garment for Use with TENS (E0731)

A conductive garment used with a TENS unit may be covered when all of the following conditions are met:

- it has been prescribed by a physician for use in delivering covered TENS treatment; and
- one of the medical indications outlined below is met:
    - the patient cannot manage without the conductive garment because there is such a large area or so many sites to be stimulated and the stimulation would have to be delivered so frequently that it is not feasible to use conventional electrodes, adhesive tapes, and lead wires; or
    - the patient cannot manage without the conductive garment for the treatment of chronic intractable pain because the areas or sites to be stimulated are inaccessible with the use of conventional electrodes, adhesive tapes, and lead wires; or
    - the patient has a documented medical condition, such as skin problems, that preclude the application of conventional electrodes, adhesive tapes, and lead wires; or
    - the patient requires electrical stimulation beneath a cast to treat chronic intractable pain, and

- a conductive garment may be covered with a neuromuscular electrical stimulator (NMES) if there is a skin disease or a cancer at the area of stimulation.

A conductive garment is not covered for use with a TENS or an NMES device during the trial period unless:

- the patient has a documented skin problem prior to the start of the trial period; or
- the TENS or NMES is reasonable and necessary for the patient.

Non-Implantable Pelvic Floor Electrical Stimulator (E0740)

- Pelvic floor electrical stimulation with a non-implantable stimulator is covered for the treatment of stress and/or urge urinary incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training.
- A failed trial of PME training is defined as no clinically significant improvement in urinary continence after completing four weeks of an ordered plan of pelvic muscle exercises designed to increase periurethral muscle strength.

Electrical Stimulation (ES) and Electromagnetic Therapy for the Treatment of Wounds (E0769)

The use of ES and electromagnetic therapy for the treatment of wounds are considered adjunctive therapies and will only be covered when all of the following criteria have been met:

- ES and electromagnetic therapy will be covered for chronic Stage III or Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers;
- chronic ulcers are defined as ulcers that have not healed within 30 days of occurrence. ES or electromagnetic therapy will be covered only after appropriate standard wound therapy has been tried for at least 30 days and there are no measurable signs of improved healing. This 30-day period may begin while the wound is acute;
- standard wound care includes: optimization of nutritional status, debridement by any means to remove devitalized tissue, maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings, and necessary treatment to resolve any infection that may be present. Standard wound care based on the specific type of wound includes: frequent repositioning of a patient with pressure ulcers (usually every 2 hours), offloading of pressure and good glucose control for diabetic ulcers, establishment of adequate circulation for arterial ulcers, and the use of a compression system for patients with venous ulcers;
- measurable signs of improved healing include: a decrease in wound size (either surface area or volume), decrease in amount of exudates, and decrease in amount of necrotic tissue;

- ES or electromagnetic therapy must be discontinued when the wound demonstrates 100% epitheliliazed wound bed;
- continued treatment with ES or electromagnetic therapy is not covered if measurable signs of healing have not been demonstrated within any 30-day period of treatment;
- ES and electromagnetic therapy services can only be covered when performed by a physician, physical therapist, or a clinician incident to a physician service; and
- unsupervised use of ES or electromagnetic therapy for wound therapy will not be covered, as this use has not been found to be medically reasonable and necessary.

Tumor Treatment Field Therapy (TTFT-E0766) is covered when all of the following criteria are met:

- The member has histologically confirmed (World Health Organization (WHO) grade IV astrocytoma), newly diagnosed, Glioblastoma Multiforme (GBM); and
- The member has received initial treatment with maximal debulking surgery, followed by chemotherapy and radiotherapy; and
- Tumor treatment field therapy is initiated within 7 weeks from the last dose of concomitant chemotherapy or radiotherapy, whichever is later; and
- The member has no evidence of progression by Response Assessment in Neuro-Oncology (RANO) criteria; and
- The member has a Karnofsky Performance Score (KPS) of at least 70; and
- The member will use tumor treatment field therapy (TTFT) for an average of 18 hours per day; and
- The member is 22 years or older and not pregnant
- Absence of intracranial shunt or other implanted intracranial device

Tumor treatment field therapy will be denied as not reasonable and necessary for the treatment of recurrent GBM

Continued coverage of Tumor Treatment Field Therapy beyond the first three months of therapy requires that no sooner than the 60th day but no later than the 91st day after initiating therapy, the treating practitioner must conduct a clinical re-evaluation and document that the beneficiary is continuing to use and is benefiting from TTFT.

Documentation of clinical benefit is demonstrated by:

- Re-evaluation by the treating provider; and
- Objective evidence of adherence to therapy defined as an average usage of 18 hours per day.

~~Electrical Tumor Treatment Field Therapy (E0766)~~

~~Coverage for Electrical Tumor Treatment Field Therapy may be considered when used for adjuvant therapy with temozolomide or when used as monotherapy.~~

- ~~Electrical Tumor Treatment Field Therapy (E0766) used with adjuvant temozolomide may be considered for coverage when all the following criteria are met:~~
  - ~~Customer is ≥ 22 years old;~~
  - ~~Customer has newly diagnosed supratentorial glioblastoma;~~
  - ~~Good performance status (KPS ≥ 60);~~
  - ~~Customer underwent maximal tumor debulking, if possible;~~
  - ~~Customer completed radiation therapy with concurrent temozolomide.~~
- ~~Electrical Tumor Treatment Field Therapy (E0766) used as monotherapy may be considered for coverage on a case-by-case basis when all the following criteria are met:~~
  - ~~Customer is ≥ 22 years old;~~
  - ~~Customer has recurrent supratentorial glioblastoma;~~
  - ~~Customer completed radiation therapy with concurrent temozolomide~~

Exclusions

- Not meeting criteria listed under Indications/Criteria of this policy.
- A4556 (electrodes), A4630 (replacement batteries), and A4595 (leads) are covered only if the customer's plan has coverage for disposable supplies.
- There is insufficient evidence from well-designed prospective clinical trials that the following devices or therapies have been proven to be medically safe and/or effective for their indicated use compared to current standard interventions and are, therefore, considered investigational.
  - Functional electrical stimulation devices (E0770, E0764) for use in patients without spinal cord injury (see Indications/Criteria of this policy).
  - Functional electrical stimulation exercise devices (i.e., RT300 Electrical Stimulation Bike).
  - Percutaneous electrical nerve stimulation (PENS) and percutaneous neuromodulation therapy (PNT) for the treatment of chronic low back pain, including, but not limited to, diabetic neuropathy, headache, and osteoarthritis of the knee. The evidence in the peer-reviewed literature did not demonstrate Percutaneous electrical nerve stimulation (PENS) and

percutaneous neuromodulation therapy (PNT) is effective in the long term and therefore is considered investigational.

- Transcutaneous Electrical Nerve Stimulation (TENS) (E0765) for the treatment of post-operative nausea and vomiting, chemotherapy induced nausea, nausea and vomiting of pregnancy, motion sickness and all other indications are not covered.
- Threshold electrical stimulation (TES) as a treatment for motor disorders, including, but not limited to, cerebral palsy, scoliosis, or spina bifida.
- Interferential stimulators for the treatment of circulation disorders, range of motion, edema, muscle spasms, bone healing, and pain and to promote soft tissue healing.
- Gastric electrical stimulation for the treatment of obesity.

- Currently no implantable pulse generator, radiofrequency device, or leads are approved by the FDA for peripheral occipital nerve stimulation to treat occipital neuralgia or headaches.
- Transcutaneous electrical joint stimulation devices (E0762) are considered investigational for any indication.
- Electrosleep therapy for the treatment of chronic insomnia, anxiety, depression, psychosomatic disorders, such as asthma, spastic colitis, or tension headache, and for organic disorders including essential hypertension.
- Electrical aversion (electroversion) therapy for the treatment of alcoholism.
- Electrical continence aids which stimulate anal musculature to allow the patient to ambulate without incontinence.
- Electrical stimulation used in the treatment of Bell's palsy, multiple sclerosis and strokes (when there is no potential for restoration of function).
- Scrambler therapy MC-5A CALMARE® (Transcutaneous Electrical Modulation Pain Reprocessing Device) for chronic, intractable pain, post-surgical pain, post-traumatic acute pain, cancer related pain, and reducing peripheral neuropathy caused by chemotherapy.
- Electrical stimulation of muscles for treatment of scoliosis (E0744).
- Electrical Tumor Treatment Field Therapy (E0766) is not covered for any other indication not listed in the Indication/Criteria section.
- Cefaly device for prevention, treatment and other indications for migraine headaches is not covered. There is insufficient evidence in the peer-reviewed literature to support the use of the Cefaly transcutaneous electrical stimulator (TENS)

headband for the treatment of migraine headaches, therefore the Cefaly device is considered investigational and not covered.

- GammaCore non-implantable transcutaneous vagus nerve stimulation (tVNS)(E0735) is considered investigational because the long-term outcomes in the published peer-reviewed scientific literature do not support the safety and effectiveness for the acute or chronic treatment of pain associated with episodic cluster headache or migraines in adult patients.

- Cranial Electrotherapy Systems (CES) (E0732) deliver low level electrical stimulation (microcurrent) to the brain through electrodes that are attached to the ear lobes or behind the ears. CES has been proposed for the treatment of anxiety, depression, insomnia, substance abuse, depression, tension headaches, cluster headaches and migraines. CES devices are investigational and not covered for any indication because there is insufficient evidence regarding the safety and effectiveness of Cranial Electrotherapy Systems (CES) for the reduction of pain or improvement in function.

- Remote electrical neuromodulation (REN) (e.g. Nerivio) device proposed as a treatment for episodic or chronic migraine headaches is considered investigational and not covered for all indications because there is insufficient evidence regarding the safety and effectiveness of REN.

- Cala Trio nerve stimulating device (E0734, A4542) proposed as a treatment of essential tremors is considered experimental and investigational because there is insufficient evidence regarding the safety and effectiveness has not been established.

- ~~Percutaneous electrical nerve stimulation (PENS)(CPT Code: 64555), percutaneous electrical nerve field stimulation (PENFS) (CPT Code: 64596, 64597, 64598), percutaneous neuromodulation therapy (PNT) or auricular electrostimulation devices (including all permanent and temporary) are considered experimental, investigational or unproven for any indication, including but not limited to the treatment of acute or chronic pain conditions. Examples of implantable peripheral nerve stimulators for pain relief include: Sprint PNS System, StimQ Peripheral Nerve Stimulator (PNS) System, and StimRouter Neuromodulation System.~~

- ~~Restorative Neurostimulation Therapy (e.g., ReActiv8 64555) are considered experimental, investigational or unproven for any indication, including but not limited to the treatment of acute or chronic pain conditions.~~

- Monarch external trigeminal nerve stimulation (eTNS) (E0733, A4541) proposed for treatment of pediatric ADHD is considered experimental and investigational because there is insufficient evidence regarding the safety and effectiveness has not been established.

- Electrical stimulation of muscles for treatment of scoliosis (HCPCS E0744) is considered experimental and investigational because there is insufficient evidence regarding the safety of and effectiveness for this treatment has not been established.
- Biofeedback devices (HCPCS E0746) are not covered for home use because they are considered experimental and investigational as there is insufficient evidence in peer-reviewed medical literature regarding effectiveness or proof the technology improves outcomes.
- eXciteOSA Daytime Therapy Device (E0490, E0491, E0492, E0493) for the treatment of obstructive sleep apnea is considered to be experimental and investigational as there is insufficient evidence in peer-reviewed medical literature regarding safety, effectiveness and/or proof the technology improves outcomes.
- The NTX100 Tonic Motor Activation (TOMAC) System (E0743, A4544) for the treatment of restless leg syndrome is considered to be experimental and investigational as there is insufficient evidence in peer-reviewed medical literature regarding safety, effectiveness and/or proof the technology improves outcomes.
- The use of auricular stimulation (E0721, A4543) for, but not limited to, the treatment of opioid withdrawal (e.g., Sparrow Ascent) is considered to be experimental and investigational as there is insufficient evidence in peer-reviewed literature regarding the safety, effectiveness, and/or proof that the technology improves outcomes.

MVP Medicaid Managed Care Variation

Coverage for transcutaneous electrical nerve stimulation (TENS) is limited to customers with a diagnosis of knee pain due to osteoarthritis (ICD-10- Codes: M17.10, M17.9, M17.5, M25.169, M25.869, M25.9). If at least one of these diagnostic codes is not billed with the claim for TENS, the TENS will be denied administratively.

Functional Electrical Stimulation (FES) via transcutaneous, percutaneous, and implanted devices are considered not medically necessary for treatment of spinal cord injury, head injury, cerebral palsy, and upper motor neuron disease and is, therefore, not covered (ICD-10 Codes: B91, G12.0, G12.1, G12.8, G12.21, G12.22, G12.29, G12.8, G12.9, G14, G20, G21.11, G21.19, G21.8, G35, G36.0, G37.0, G37.1, G37.2, G37.3, G37.5, G37.8, G37.9, G80.0, G80.1, G80.2, G80.8, G80.9, P11.5, S04.9XXS, S06.0X1A, S06.0X2A, S06.0X3A, S06.0X4A, S06.0X5A, S06.0X6A, S06.0X9A, S06.9X9S, S14.109S, S24.109S, S34.109S, S34.139S). If at least one of the diagnostic codes is not billed with the claims for FES, the FES will be denied administratively.

TENS and FES units that are billed with a covered diagnosis must also meet the applicable medical necessity criteria within this policy for that diagnosis.

~~For MVP Medicaid products, tumor treatment field therapy (E0766) is not covered.~~

MVP Medicare Variation

~~Tumor Treatment Field Therapy (E0766)~~

~~Initial coverage for newly diagnosed glioblastoma multiforme:~~

~~Tumor treatment field therapy (E0766) is covered for the treatment of newly diagnosed Glioblastoma Multiforme (GBM) only when all the following criteria are met:~~

- ~~There is a confirmed (World Health Organization (WHO) grade IV astrocytoma), newly diagnosed, supratentorial GBM; and,~~
- ~~The customer has received initial treatment with maximal debulking surgery (when feasible), followed by chemotherapy and radiotherapy; and,~~
- ~~Tumor treatment field therapy is initiated within 7 weeks from the last dose of concomitant chemotherapy or radiotherapy, whichever is later; and,~~
- ~~The beneficiary has no evidence of progression by Response Assessment in Neuro-Oncology (RANO) criteria; and,~~
- ~~The beneficiary has a Karnofsky Performance Score (KPS) of at least 70; and,~~
- ~~The beneficiary will use TTFT for an average of 18 hours per day.~~

~~Continued coverage for newly diagnosed GBM beyond the first three months of therapy:~~

~~Continued coverage of TTFT (E0766) beyond the first three months of therapy requires that the treating practitioner must conduct a clinical re-evaluation and document that the beneficiary is continuing to use and is benefiting from TTFT.~~

~~Documentation of clinical benefit is demonstrated by:~~

- ~~Face-to-face clinical re-evaluation by the treating practitioner; and,~~
- ~~Objective evidence of adherence to therapy, reviewed by the treating practitioner.~~

~~Adherence to therapy is defined as the use of TTFT for an average of 18 hours per day (excluding days the treating practitioner has documented a medical need to limit or interrupt treatment).~~

~~If the above criteria are not met, continued coverage of TTFT will be denied as not medically necessary.~~

~~Recurrent GMB:~~

~~Tumor treatment field therapy (E0766) is not medically necessary for the treatment of recurrent GBM.~~

~~Other uses:~~

~~The use of TTFT for any indications other than newly diagnosed GBM is not medically necessary.~~

For full coverage details refer to the following Medicare Local Coverage Determination (LCD): Noridian Healthcare Solutions (Medicare) Local Coverage Determination (LCD) for Tumor Treatment field Therapy (TTFT)(L34730). Effective Date: 09/01/19 Available: https://med.noridianmedicare.com/web/jddme/policies/lcd/active

Transcutaneous Electrical Nerve Stimulators (TENS) (E0720, E0730)

A TENS is covered for the treatment of beneficiaries with chronic, intractable pain or acute post-operative pain when one of the following coverage criteria, I-III, are met.

I. Acute Post-operative Pain

TENS is covered for acute post-operative pain. Coverage is limited to 30 days (one month's rental) from the day of surgery. Payment will be made only as a rental.

A TENS unit will be denied as not reasonable and necessary for acute pain (less than three months duration) other than for post-operative pain.

II. Chronic Pain Other than Low Back Pain

TENS is covered for chronic, intractable pain other than chronic low back pain when all of the following criteria must be met:

- The presumed etiology of the pain must be a type that is accepted as responding to TENS therapy. Examples of conditions for which TENS therapy is not considered to be reasonable and necessary are (not all-inclusive):
  - headache
  - visceral abdominal pain
  - pelvic pain
  - temporomandibular joint (TMJ) pain
- The pain must have been present for at least three months
- Other appropriate treatment modalities must have been tried and failed

TENS therapy for chronic pain that does not meet these criteria will be denied as not reasonable and necessary.

III. Chronic Low Back Pain (CLBP) TENS therapy for CLBP is only covered when all of the following criteria are met:

- The Medicare customer has one of the diagnosis codes listed in the Diagnosis Codes that Support Medical Necessity section in the Noridian Healthcare Solutions. Local Coverage Determination (LCD) for Transcutaneous Electrical Nerve Stimulators (TENS) (L33802). Revision Effective Date 10/01/2015. Available: https://med.noridianmedicare.com/web/jddme/policies/lcd/active

- The beneficiary is enrolled in an approved clinical study that meets all of the requirements set out in National Coverage Determination (NCD) for Transcutaneous Electrical Nerve Stimulation (TENS) for Chronic Low Back Pain (CLBP) (160.27) Available: Available: www.cms.gov/

For Medicare full coverage details of Transcutaneous Electrical Nerve Stimulators (TENS) National Coverage Determination (NCD) and Local Coverage Determination (LCD) refer to the links above.

For Medicare products, TENS (E0730) used to treat Chronic Low Back Pain is provided under limited coverage. Reimbursement is only available for beneficiaries who are enrolled in an approved clinical trial. *****

*****Currently there is no Medicare approved clinical trial for TENS therapy for chronic low back pain, therefore the TENS is not covered by MVP Health Care.

Refer to the following links for full Medicare coverage of chronic low back pain:

Noridian Healthcare Solutions. Local Coverage Determination (LCD) for Transcutaneous Electrical Nerve Stimulators (TENS) (L33802). Revision Effective Date 10/01/2019. Available: https://med.noridianmedicare.com/web/jddme/policies/lcd/active

Peripheral Nerve Stimulation (CPT Code: 64555, 64596, 64597, 64598)

For full Medicare coverage details about peripheral nerve stimulation please refer to the following NCD for Medicare Customers: National Coverage Determination (NCD) Electrical Nerve Stimulators (160.7) Effective Date: 08/07/1995 and Medicare LCD: Peripheral Nerve Stimulation A55531 and L37360. Available: MCD Search (cms.gov)

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Customer Product	Medical Management Requirements*
New York Products	
HMO	Prior Auth
PPO in Plan	Prior Auth
PPO OOP	Potential for Retrospective Review
POS in Plan	Prior Auth
POS OOP	Prior Auth
Essential Plan	Prior Auth
MVP Medicaid Managed Care	Prior Auth
MVP Child Health Plus	Prior Auth
MVP Harmonious Health Care Plan	Prior Auth
MVP Medicare Complete Wellness	Prior Auth
MVP Medicare Preferred Gold HMO POS	Prior Auth
MVP Medicare Secure Plus HMO POS	Prior Auth
MVP Medicare WellSelect PPO	Prior Auth
MVP DualAccess D-SNP HMO	Prior Auth
MVP DualAccess Complete D-SNP HMO	Prior Auth
USA Care	Prior Auth
Healthy NY	Prior Auth
MVP Premier	Prior Auth
MVP Premier Plus	Prior Auth
MVP Premier Plus HDHP	Prior Auth
MVP Secure	Prior Auth
MVP EPO	Prior Auth
MVP EPO HDHP	Prior Auth
MVP PPO	Prior Auth
MVP PPO HDHP	Prior Auth
ASO	See SPD
Vermont Products	
POS In Plan	Prior Auth
POS OOP	Prior Auth
MVP VT HMO	Prior Auth
MVP VT HDHP HMO	Prior Auth
MVP VT Plus HMO	Prior Auth
MVP VT Plus HDHP HMO	Prior Auth
MVP Secure	Prior Auth
ASO	See SPD
♦ Note: Prior authorization requirements for HDHP products are the same as the base product (e.g. HDHP HMO auth requirements are the same as listed for HMO).	
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***Medical Management Requirements**

Prior Auth	Prior Authorization Required
Potential for Retrospective Review	No Prior Authorization Required. May be subject to Retrospective Review
Retro Review	Retrospective Review Required
Not Covered	Service is not a covered benefit.
See SPD	See Specific Plan Design

MVP Health Care Medical Policy

Revision History:

12/01/2021 - remote electrical neuromodulation (REN) electrical stimulation devices (e.g. Neverio) to the list of devices that are investigational for migraine headache treatment.

08/01/2022 – Added Cala Trio device (K1018, K1019), Percutaneous electrical nerve stimulation (PENS), percutaneous electrical nerve field stimulation (PENFS) ~~(0720T)~~, percutaneous neuromodulation therapy (PNT) or auricular electrostimulation devices (e.g., IB-Stim Device) to exclusions.

02/01/2023 – Adding prior authorization to K1018 and K1019.

06/01/2023 – Exclusions for electrical stimulation of muscles for treatment of scoliosis and biofeedback were removed from another medical policy and moved to this policy. No changes in policy position.

12/01/2023 –Added exclusion for eXciteOSA Daytime Therapy Device (E0490, E0491, K1028, K1029)

01/01/2024- Added new codes A4540, A4541, A4542, E0492, E0493, E0732, E0733, E0734, E0735 to prior authorization. Removed invalid codes K1002, K1016, K1017, K1018, K1019, K1020, K1023, K1028, K1029.

06/01/2024 – Moved Peripheral Nerve Stimulators and CPT Codes: 64555, 64596, 64597, 64598 and references to Hayes from Experimental Investigational Policy.

10/01/2024 – Removed prior authorization from HCPCS Codes: A4556, A4557, A4630, E0720, E0730.

12/01/2024 –Completed formal review of fast-track updates effective 10/01/2024.

2/1/2025 – added NTX100 Tonic Motor Activation (TOMAC) System (E0743, A4544) and auricular stimulation (E0721, A4543) Sparrow Ascent to exclusions as experimental and investigational.

06/01/2025 – ReActiv8 added to exclusions as experimental and investigational.

10/01/2025 – Updated Medicaid coverage of Tumor Treatment Field Therapy ~~effective 10/1/2025~~.

04/01/2026 – Tumor Treatment Field Therapy ~~C~~criteria for all plans merged to match Medicare/Medicaid criteria, with no variations. -Moved CPT Codes: 64555, 64596, 64597, 64598 from this policy to new Peripheral Nerve Stimulators Medical Policy.

MVP Health Care Medical Policy

Epidermal Nerve Fiber Density Testing ARCHIVE

Type of Policy:	Medical
Prior Approval Date:	02/05/2024
Approval Date:	02/02/2026
Effective Date:	04/01/2026
Related Polices:	N/A

Codes Requiring Prior Authorization

Prior authorization may vary by plan which means the codes listed below may be specific to one product or all products. Please refer to the product grid found at the end of this policy for detailed authorization requirements for specific plans.

N/A

Codes Requiring Retrospective Review

CPT Codes: 88399 - Unlisted surgical pathology procedure

95999 - Unlisted neurological or neuromuscular diagnostic procedure

Experimental/Investigational

N/A

Common Diagnosis Codes

ICD-10-CM Diagnosis Codes: G60.8, G90.0, G90.01, G90.09, G90.1, G90.2, G90.3, G90.4, G90.5, G90.50, G90.51, G90.511, G90.512, G90.513, G90.519, G90.52, G90.521, G90.522, G90.523, G90.529, G90.59, G90.8, G90.9

Common Diagnosis Codes associated with this policy have been provided for informational purposes only. The list of codes may not be all-inclusive and may be updated to reflect any applicable revisions to the ICD-10 code set and/or medical necessity guidelines applied in this policy.

Common Procedure Codes

CPT Code: 88356 - Morphometric analysis; nerve

Please refer to the product grid for detailed authorization requirements for specific plans. Codes requiring prior-authorization for some products may require retrospective review for plans that do not require prior-

authorization. Common diagnosis codes are included for informational purposes only and every attempt has been made to update and keep these codes accurate. These codes may not be all inclusive. CPT codes are subject to change as replacement codes are adopted by CMS. Any codes related to CMS updates will be adopted and applied to this policy by MVP.

Overview

Epidermal Nerve Fiber Density (ENFD) testing is a diagnostic procedure primarily used to evaluate small fiber peripheral neuropathy, a condition that affects the thin, unmyelinated nerve fibers responsible for pain and temperature sensation. These fibers terminate in the epidermis, and their density can be quantified to assess nerve health.

Epidermal Nerve Fiber Density testing is performed in individuals who have sensory symptoms or signs that suggest peripheral neuropathies but with no evidence of large fiber neuropathy on electrodiagnostic studies. Below a normal reference range i.e., four – nine (4-9) fibers per mm, epidermal nerve fiber density is considered confirmation of small fiber peripheral neuropathy. However, epidermal nerve fiber density within the normal range, greater than nine (9) fibers per mm, suggests the need for testing for etiologies other than those known to produce peripheral neuropathy.

Indications/Criteria

Epidermal Nerve Fiber Density testing is considered medically necessary for the diagnosis of small-fiber neuropathy when all of the following criteria have been met:

- the patient presents with painful sensory neuropathy; and
- physical examination shows no evidence of findings consistent with large fiber neuropathy, such as reduced or absent muscle-stretch reflexes or reduced proprioception and vibration sensation; and
- no history of a disorder known to predispose to painful neuropathy (e.g., diabetic neuropathy, toxic neuropathy, HIV neuropathy, celiac neuropathy, inherited neuropathy); *and*
- electromyography (EMG) and nerve-conduction studies are normal and show no evidence of large fiber neuropathy.

Exclusions

1. Requests not meeting medical necessity criteria listed in this policy.

2. The use of epidermal nerve fiber density testing to detect preclinical small fiber neuropathy in asymptomatic patients, who have diabetes, impaired glucose intolerance, complex regional pain syndrome, or other disease known to cause peripheral neuropathy is considered experimental/investigational.

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Customer Product	Medical Management Requirements*
New York Products	
HMO	Retrospective Review
PPO in Plan	Retrospective Review
PPO OOP	Retrospective Review
POS in Plan	Retrospective Review
POS OOP	Retrospective Review
Essential Plan	Retrospective Review
MVP Medicaid Managed Care	Retrospective Review
MVP Child Health Plus	Retrospective Review
MVP Harmonious Health Care Plan	Retrospective Review
MVP Medicare Complete Wellness	Retrospective Review
MVP Medicare Preferred Gold HMO POS	Retrospective Review
MVP Medicare Secure Plus HMO POS	Retrospective Review
MVP Medicare WellSelect PPO	Retrospective Review
MVP DualAccess D-SNP HMO	Retrospective Review
MVP DualAccess Complete D-SNP HMO	Retrospective Review
USA Care PPO	Potential for Retrospective Review
Healthy NY	Retrospective Review
MVP Premier	Retrospective Review
MVP Premier Plus	Retrospective Review
MVP Premier Plus HDHP	Retrospective Review
MVP Secure	Retrospective Review
MVP EPO	Retrospective Review
MVP EPO HDHP	Retrospective Review
MVP PPO	Retrospective Review
MVP PPO HDHP	Retrospective Review
Student Health Plans	Retrospective Review
ASO	See SPD
Vermont Products	
POS in Plan	Retrospective Review
POS OOP	Retrospective Review
MVP VT HMO	Retrospective Review
MVP VT HDHP HMO	Retrospective Review
MVP VT Plus HMO	Retrospective Review
MVP VT Plus HDHP HMO	Retrospective Review
MVP Secure	Retrospective Review
ASO	See SPD
♦ Note: Prior authorization requirements for HDHP products are the same as the base product (e.g., HDHP HMO auth requirements are the same as listed for HMO).	
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***Medical Management Requirements**

Prior Auth	Prior Authorization Required
Potential for Retrospective Review	No Prior Authorization Required. May be subject to Retrospective Review
Retro Review	Retrospective Review Required
Not Covered	Service is not a covered benefit.
See SPD	See Specific Plan Design

Revision History:

04/01/2022 - Annual review. Added criteria to check for contributing history and added exclusion for use to diagnosis complex regional pain syndrome. Eliminated the specialist requirement as this is not in line with Medicare.

04/01/2024 – Annual Review; no changes to the indications or criteria, references reviewed.

04/01/2026 – Policy Archived. See Laboratory Policy Number: AHS – M2112 – Nerve Fiber Density Testing.

MVP Health Care Medical Policy

Gender Affirming Treatment

Type of Policy:	Surgical
Prior Approval Date:	11/17/2025
Approval Date:	02/02/2026
Effective Date:	04/01/2026
Related Polices:	Transgender Hormone Policy Fertility Preservation Services Medical Policy

Codes Requiring Prior Authorization

Prior authorization may vary by plan which means the codes listed below may be specific to one product or all products. Please refer to the product grid found at the end of this policy for detailed authorization requirements for specific plans.

CPT Codes:

55970 - Intersex surgery; male to female

55980 - Intersex surgery; female to male

57291 - Construction of artificial vagina; without graft

57292 - Construction of artificial vagina; with graft

57335 - Vaginoplasty for intersex state

55899 - Unlisted procedure, male genital system

Codes Requiring Administrative Prior Authorization

19303 - Mastectomy (administrative prior authorization required only for gender confirmation surgery)

58150, 58260, 58262, 58275, 58280, 58290, 58291, 58292, 58541, 58542, 58543, 58544, 58550, 58552, 58553, 58554, 58570, 58571, 58572, 58573- Hysterectomy (administrative prior authorization required only for gender confirmation surgery).

58661, 58720 - Salpingo-oophorectomy (administrative prior authorization required only for gender confirmation surgery.

Codes Requiring Retrospective Review

N/A

Experimental/Investigational

N/A

Common Diagnosis Codes

ICD-10- CM Diagnosis Codes: F64.0, F64.1, F64.2, F64.8, F64.9, F66, Z87.890

Common Diagnosis Codes associated with this policy have been provided for informational purposes only. The list of codes may not be all-inclusive and may be updated to reflect any applicable revisions to the ICD-10 code set and/or medical necessity guidelines applied in this policy.

Common Procedure Codes

CPT Codes: 53430, 54520, 54690, 55150, 55180, 56625, 56800, 56805, 57106, 57107, 57110, 57111

Authorization Requirements

MVP Health Care's authorization requirements comply with all relevant statutes and regulations, including but not limited to 42 CFR Part 438, 18 NYCRR 505.2(*l*), the Medicaid Managed Care/Family Health Plus/HIV Special Needs Plan/Health and Recovery Plan Model Contract, 11 NYCRR § 52.75 and New York Insurance Law and Public Health Articles 49;

MVP Health Care's authorization requirements comply with all billing and coverage guidance issued by the NY State Department of Health.

MVP Health Care's coverage complies with all relevant statues and regulations in the State of Vermont Sec. 3.8 V.S.A. §4088m Coverage For Gender-Affirming Health Care Services.

Medical necessity criteria for hormone therapy and puberty blocking agents are found in the MVP Health Care Drug Therapy Transgender Hormone Policy.

MVP Health Care ensures that all service authorization determinations for hormone therapy and surgery for the treatment of gender dysphoria are determined as fast as the customer's condition requires;

MVP Health Care does not include time limits or requirements for submission of clinical documentation in support of a Service Authorization Request that have the effect of delaying or barring access to medically necessary services;

MVP Health Care does provide for at least one attempt to conduct a peer-to-peer consultation with the ordering provider prior to issuing an adverse determination;

MVP Health Care ensures that at least one clinical peer involved in adverse determinations and plan appeals has clinical expertise in the treatment of gender dysphoria; and

In the case of an adverse determination or upheld denial on appeal, MVP Health Care ensures the notice of decision includes:

If the decision is administrative, the specific benefit coverage criteria that has not been met or other specific reason for denial; or

If the decision is based on medical necessity/utilization review, the clinical rationale specifying;

a. How the documentation provided does not support the customer's diagnosis of gender dysphoria, or
b. How the documentation provided does not support the medical necessity of the proposed treatment for the customer's gender dysphoria, or
c. There was not enough information to make a decision, and, for initial adverse determinations, what specific information would be necessary for review on appeal.

Please refer to the product grid for detailed authorization requirements for specific plans. Codes requiring prior-authorization for some products may require retrospective review for plans that do not require prior-authorization. Common diagnosis codes are included for informational purposes only and every attempt has been made to update and keep these codes accurate. These codes may not be all inclusive. CPT codes are subject to change as replacement codes are adopted by CMS. Any codes related to CMS updates will be adopted and applied to this policy by MVP.

Overview

Gender dysphoria refers to the distress that may accompany the incongruence between one's experienced or expressed gender and one's assigned gender. In the *World Professional Association for Transgender Health's (WPATH) Standards of Care-Eighth Edition (SOC-8)* the phrase transgender and gender diverse (TGD) is used to describe "members of the many varied communities that exist globally of people with gender identities or expressions that differ from the gender socially attributed to the sex assigned to them at birth". The WPATH SOC-8 was developed to provide clinical guidance to health care professionals to assist transgender and gender diverse (TGD) people access evidence-based gender-affirming medical and surgical treatments

(GAMSTs) with the goal of optimizing their overall physical health, psychological well-being, and self-fulfillment.

Indications/Criteria

MVP health Care recognizes that gender dysphoria affects people of all genders and is not limited to people with binary gender identities. Coverage of medically necessary services is allowed for binary and non-binary gender identities.

Adult

Assessment of Gender Dysphoria Treatment:

Adult Gender Affirming Services are considered medically necessary when the following are met:

The customer has persistent, well-documented gender dysphoria per DSM-5-TR diagnostic criteria, is associated clinically with significant distress or problems functioning and lasts at least six months' duration; and

a. The customer has received mental health screening and assessment with documentation from a qualified medical or mental health professional as part of a multi-disciplinary team for gender affirming care and with experience in diagnosing and treating gender dysphoria*;* and
b. The licensed health care professional must have at a minimum a masters-level qualification in a clinical field related to transgender health or equivalent further clinical training; (e.g., mental health professionals, general medical practitioner, or other qualified health care professional); and
    - has sufficient expertise to identify gender incongruence, recognize mental health concerns, distinguish between these concerns and gender dysphoria, incongruence, and diversity; and
    - has sufficient expertise to assist a transgender and gender diverse (TGD) person in care planning and preparation for gender-affirming medical and surgical treatments (GAMSTs), and
    - refer to a mental health professional (MHP), if needed; and
c. If significant medical or mental health concerns are present, they must be reasonably well controlled or under treatment so that gender-affirming medical treatment can be provided optimally.

Adult Surgical Gender Confirmation:

In addition to the above criteria, adult gender confirmation surgery is medically necessary when all the following criteria are met:

a. The customer is at least 18 years of age; and
b. Customer has a diagnosis of gender dysphoria and meets the medically necessary criteria listed above; and

c. Gender dysphoria is marked and sustained for at least 6 months' duration; and

d. Customer has received hormone therapy appropriate to the individual's gender goals, which shall be for a minimum of 6 months in the case of an individual seeking genital surgery, unless hormone therapy is medically contraindicated, or the individual is otherwise unable to take hormones. (Hormone therapy is not a prerequisite for mastectomy); and

e. Customer must have the capacity to make a fully informed decision and to consent to treatment; and

f. Other possible causes of apparent gender dysphoria have been identified and excluded; and

g. Customer has no other significant medical or mental health conditions that would contraindicate gender confirmation surgery, or if so, those conditions are reasonably well-controlled prior to surgery; and

h. Customer demonstrates an understanding of the effect of gender-affirming surgical intervention on reproduction and they have explored reproductive options (see Fertility Preservation Medical Policy for coverage criteria); and

Prior to gender-affirming medical and surgical treatments for transgender and gender diverse people, the following documentation is required:

a. One letter from a professional who has competencies in the assessment of transgender and gender diverse people as described above; and
b. Only when requested from a transgender and gender diverse person when their experience of gender incongruence is marked and sustained; and
c. Identifies and excludes other possible causes of apparent gender incongruence prior to the initiation of gender-affirming treatments; and
d. Ensure any mental health and/or physical health conditions that could negatively impact the outcome of gender-affirming treatments are assessed, with risks and benefits, discussed, before a decision is made regarding treatment; and
e. Assess the capacity to consent for the specific physical health treatment prior to the initiation of this treatment, as well as risks and potential for short- and long-tern consequences; and
f. Assess the capacity of the transgender and gender diverse person to understand the effect of gender-affirming treatment on reproduction and explore reproduction options with the individual prior to treatment initiation; and
g. Consideration and discussion of role transition of the transgender and gender diverse individual; and
h. Health care professional liaise with professionals from different disciplines within the field of transgender health for consultation and referral, if required.

Adolescents

WPATH SOC-8 guidelines support an individualized approach to gender affirming services including surgery including a multidisciplinary approach including the individual and family. Gender affirming surgeries for customers under 18 years of age are eligible for coverage when medical necessity and documentation requirements outlined within this policy are met.

Assessment for Gender Dysphoria Treatment:

For adolescents, the customer must have documentation of the following additional assessments and meet all the following criteria:

a. A comprehensive biopsychosocial assessment should be completed by a mental health professional who has training and expertise in general child, adolescent, and family mental health across the developmental spectrum; as well as expertise in gender identity development and gender diversity in children and adolescents in a collaborative and supportive manner; and
b. The customer has adequate home support and involvement of parent(s)/guardian(s) in the assessment process, unless their involvement is determined to be harmful to the adolescent or not feasible; and
c. The customer be informed of the reproductive effects of gender-affirming medical or surgical treatment, including the potential loss of fertility and available options to preserve fertility within the context of the youth's stage of pubertal development (see Fertility Preservation Medical Policy for coverage criteria); and
d. The customer has been evaluated for safety and the customer has been assessed for any co-existing mental health concerns and is not requesting surgery as an initial response to gender dysphoria puberty.

Adolescents Surgical Gender Confirmation:

For Adolescents, the customer must meet the following additional criteria for surgery:

a. Gender diversity/incongruence is marked and sustained over time; and
b. Meets the diagnostic criteria of gender incongruence in situations where a diagnosis is necessary to access health care; and
c. Demonstrates the emotional and cognitive maturity required to provide informed consent/assent for the treatment; and
d. Mental health concerns (if any) that may interfere with diagnostic clarity, capacity to consent, and gender-affirming medical treatments have been addressed; sufficiently so that gender-affirming medical treatment can be provided optimally; and
e. Informed of the reproductive effects on the potential loss of fertility; and
f. At least 12 months of gender-affirming hormone therapy or longer, if required, to achieve the desired surgical result for gender-affirming procedures, including breast augmentation, orchiectomy, vaginoplasty, hysterectomy, phalloplasty,

metoidioplasty, and facial surgery as part of gender-affirming treatment unless hormone therapy is either not desired or is medically contraindicated; and

g. A letter is required to recommend gender-affirming medical and surgical treatment (GAMST), only one letter of assessment from a member of the multidisciplinary team is needed. This letter needs to reflect the assessment and opinion from the team that involves both medical and mental health professionals (MHPs).

Gender Confirmation Surgeries:

MVP Health Care does have administrative prior authorization requirements on select procedures; however, MVP does not conduct utilization review for medical necessity and accepts the customer's treating provider's determination of medical necessity using the documentation listed above.

For procedures that require specific anatomical/body part size, shape, feature, presentation or assessment as part of those procedures' service coverage criteria, MVP Health Care accepts the customer's treating provider's determination of the customer's anatomical/body part size, shape, feature, presentations and/or assessment;

MVP Health Care does not require the evaluation of photographic documentation in the administrative prior authorization processes of procedures that require specific anatomical/body part size, shape, feature, presentation or assessment as part of those procedures' service coverage criteria.

When all of the above criteria are met, the following procedures are covered:

- Orchiectomy (removal of testicles);
- Penectomy (removal of penis);
- Vaginoplasty (creation of vagina);
- Clitoroplasty (creation of clitoris;
- Labiaplasty (creation of labia);
- Electrolysis when required for phalloplasty or vaginoplasty;
- Breast augmentation;
- Mastectomy and/or reduction mammoplasty;
- Hysterectomy (removal of uterus); For Medicaid Managed Care plan customers, if a hysterectomy is being performed, regardless of the purpose, an LDSS-3113, "Acknowledgement of Receipt of Hysterectomy Information," is required. The form is available at:

  Provider Forms Library (mvphealthcare.com)

- Salpingo-oophorectomy (removal of fallopian tubes and ovaries);

- Salpingectomy (removal of fallopian tubes);
- Oophorectomy (removal of ovaries);
- Vaginectomy (removal of vagina);
- Metoidioplasty (creation of micro-penis, using the clitoris);
- Phalloplasty (creation of penis, with or without urethra);
- Urethroplasty (creation of urethra within the penis);
- Scrotoplasty (creation of scrotum);
- Placement of a testicular prostheses (implantation of artificial testes);
- Penile prosthesis;
- Abdominoplasty, blephoraplasty, neck tightening, or removal of redundant skin;
- Breast, brow, face, or forehead lifts;
- Calf, cheek, chin, nose, or pectoral implants;
- Collagen injections;
- Drugs to promote hair growth or loss;
- Electrolysis, (clinically indicated for vaginoplasty or phalloplasty);
- Facial bone reconstruction, reduction, or sculpturing, including jaw shortening and rhinoplasty;
- Gluteal augmentation;
- Hair transplantation;
- Lip reduction;
- Liposuction/Lipofilling;
- Thyroid chondroplasty;
- Voice therapy, voice lessons, speech therapy;
- Voice modification surgery (CPT Codes: 31599, 31899).

Requested services, surgeries, and procedures for the treatment of gender dysphoria shall not be automatically denied on the basis that they are cosmetic in nature but must be reviewed to determine medical necessity for the treatment of the customer's gender dysphoria.

MVP Health Care covers surgical revisions (modifications and/or corrections to a prior surgery) for the treatment of gender dysphoria. MVP handles requests for surgical revisions for the treatment of gender dysphoria in the same manner as initial surgical

requests for the treatment of gender dysphoria. There is no medical necessity review if the request is for a revision surgery, unless it is for a procedure that is not listed above.

Exclusions

- Coverage will not be made for any procedures that are performed solely for the purpose of improving an individual's appearance (i.e., cosmetic procedures), unless the medical necessity criteria above for gender affirming services and surgery has been met;
- Conversion therapy (counseling and psychotherapy to attempt to change an individual's sexuality and/or gender identity) is not considered medically necessary. The medical literature does not support that this treatment is necessary nor is there evidence that sexual orientation or gender identity can be altered through therapy.
- Reversal of genital and/or breast surgery;
- Reversal of surgery to revise secondary sex characteristics;
- Reversal of any procedure resulting in sterilization; and
- Treatment with hormones or medications to reverse a gender transition
- Any other surgeries, services, and procedures in connection with gender confirmation not listed above, or to be performed in situations not described above, including those done to change the customer's physical appearance to more closely conform secondary sex characteristics to those of the customer's identified gender, will be covered if it is demonstrated that such surgery, service, or procedure is medically necessary to treat a particular customer's gender dysphoria, and prior approval is received.

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Customer Product	Medical Management Requirements*
New York Products	
HMO	Prior Auth
PPO in Plan	Prior Auth
PPO OOP	Prior Auth
POS in Plan	Prior Auth
POS OOP	Prior Auth
Essential Plan	Prior Auth
MVP Medicaid Managed Care	Prior Auth
MVP Child Health Plus	Prior Auth
MVP Harmonious Health Care Plan	Prior Auth
MVP Medicare Complete	Prior Auth
MVP Medicare Preferred Gold HMO POS	Prior Auth
MVP Medicare Secure Plus HMO POS	Prior Auth
MVP Medicare WellSelect PPO	Prior Auth
MVP DualAccess D-SNP HMO	Prior Auth
MVP DualAccess Complete D-SNP HMO	Prior Auth
Healthy NY	Prior Auth
MVP Premier	Prior Auth
MVP Premier Plus	Prior Auth
MVP Premier Plus HDHP	Prior Auth
MVP Secure	Prior Auth
MVP EPO	Prior Auth
MVP EPO HDHP	Prior Auth
MVP PPO	Prior Auth
MVP PPO HDHP	Prior Auth
ASO	See SPD
Vermont Products	
POS in Plan	Prior Auth
POS OOP	Prior Auth
MVP VT HMO	Prior Auth
MVP VT HDHP HMO	Prior Auth
MVP VT Plus HMO	Prior Auth
MVP VT Plus HDHP HMO	Prior Auth
MVP Secure	Prior Auth
ASO	See SPD
♦ Note: Prior authorization requirements for HDHP products are the same as the base product (e.g. HDHP HMO auth requirements are the same as listed for HMO).	

Medical Management Requirements

Prior Auth	Prior Authorization Required
Potential for Retrospective Review	No Prior Authorization Required. May be subject to Retrospective Review.
Retro Review	Retrospective Review Required
Not Covered	Service is not a covered benefit.
See SPD	See Specific Plan Design

MVP Health Care Medical Policy

Revision History:

08/01/2022 – Combined separate medical policies for Commercial and Medicaid into one policy.

09/22/2023 - Gender Dysphoria diagnosis criteria moved from overview to indications/criteria section, added criteria for adolescents, added coverage criteria for potentially cosmetic procedures. Added references to VT mandated coverage. Policy approved by NYS/OMH 8/4/2023.

11/17/2025 – Clinical review criteria updated to comply with 2022, Version 8 of the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC 8).

04/01/2026 –Completed formal review of changes effective 11/17/2025.

MVP Health Care Medical Policy

Ground Ambulance Services and Ambulette Services

Type of Policy:	Medical
Prior Approval Date:	02/05/2024
Approval Date:	01/05/2026
Effective Date:	04/01/2026
Related Polices:	Air Medical Transport

Codes Requiring Prior Authorization

Prior authorization may vary by plan which means the codes listed below may be specific to one product or all products. Please refer to the product grid found at the end of this policy for detailed authorization requirements for specific plans.

N/A

Codes Subject to Retrospective Review

N/A

Experimental/Investigational

N/A

Common Diagnosis Codes

N/A

Common Procedure Codes

HCPCS Codes: A0130, A0225, A0380, A0382, A0384, A0390, A0392, A0394, A0396, A0398, A0420, A0422, A0424, A0425, A0426, A0427, A0428, A0429, A0432, A0433, A0434, A0998, A0999

Please refer to the product grid for detailed authorization requirements for specific plans. Codes requiring prior-authorization for some products may require retrospective review for plans that do not require prior-authorization. Common diagnosis codes are included for informational purposes only and every attempt has been made to update and keep these codes accurate. These codes may not be all inclusive. CPT codes are subject to change as replacement codes are adopted by CMS. Any codes related to CMS updates will be adopted and applied to this policy.

Overview

Use of ambulance services are rendered when the condition of the patient requires immediate transport to the appropriate medical facility and, at the time of transport, another means of transportation would be contraindicated. This includes inter-hospital emergency department transfers and trauma scene transports.

Ambulance services may also be used in non-emergent situations such as transporting a customer from a hospital to a skilled nursing facility (SNF) when the condition of the patient requires some medical care.

Ambulette services (a means of transportation for patients that do not need medical care) are not covered except for MVP Medicaid Managed Care. Refer to the MVP Medicaid Managed Care Variation section.

Indications/Criteria

Coverage of ground ambulance services is covered for customers who are non-ambulatory and require transportation in order to receive necessary medical services.

Emergency Ambulance Transportation Services

Emergency ambulance transportation: Services are covered when a medical emergency exists and that lack of immediate medical attention may place the health of the person in serious jeopardy resulting in serious impairment to bodily functions, serious dysfunction to bodily organs or serious disfigurement to the customer.

Transport from one acute facility to the nearest acute facility capable of providing the necessary care related to the customer's condition (e.g., burn unit, cardiac care unit, trauma units, neonatal units).

A patient transport from one hospital to another hospital is covered only if the hospital to which the patient is transferred is the nearest one with appropriate facilities. Coverage is not available for transport from a hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician.

Types of Emergency Transport Services based on medical necessity include the following:

- Advanced Life Support Level 1 (ALS 1);
- Advanced Life Support Level 2 (ALS 2);
- Basic Life Support (BLS);
- Specialty Care Transport (SCT) (hospital to hospital transport of critically injured or ill patient requiring ongoing care during the transport time, beyond the scope of an EMT-Paramedic, furnished by one or more health professionals in an appropriate specialty area. This includes the provision of medically necessary supplies and services.); or

- Paramedic Intercept (PI) Services are ALS services provided by an entity that does not provide the ambulance transport. This type of service is most often provided for an emergency ambulance transport in which a local volunteer ambulance can provide only basic life support (BLS) level of service is dispatched to transport the customer. If the customer needs ALS services such as EKG monitoring, chest decompressions, or I.V. therapy, another entity dispatches a paramedic to meet the BLS ambulance at the scene or once the ambulance is on the way to the hospital. The ALS paramedics then provide services to the customer. (For Air Emergency transport, see MVP's Air Medical Transport policy.)

Non-emergency Ambulance Transfer from Acute Facility to Acute Facility

Transport from one acute facility to the nearest acute facility capable of providing the necessary care related to the customer's condition (e.g., burn unit, cardiac care unit, trauma units, neonatal units, psychiatric center) is covered.

A patient transported from one hospital to another hospital is covered only if the hospital to which the patient is transferred is the nearest one with appropriate facilities. Coverage is not available for transport from a hospital capable of treating the patient because the patient and/or the patient's family prefer a specific hospital or physician.

Non-emergency Ambulance Transport

Non-emergency ambulance transport is covered when the customer's condition is such that the use of any other method of transportation is contraindicated such as when the customer is bed-confined before and after the ambulance trip. The customer is bed-confined if they are unable to get out of bed without assistance, unable to walk, and unable to sit in a chair or wheelchair.

The customer must need either Basic Life Support or Advanced Life Support to be transported.

Ambulance transport is covered (when the above requirements are met) only to the following destinations:

- hospital;
- critical access hospital (CAH);
- skilled nursing facility (SNF);
- customer's home;
- dialysis facility for end stage renal disease (ESRD) patient who requires dialysis; or
- return transport from a hospital, skilled nursing facility, critical access facility, or dialysis facility; or

Only local transportation by ambulance is covered, and therefore, only mileage to the nearest appropriate facility equipped to treat the patient is covered.

Ambulance service from an institution to the customer's home is covered when the home is within the locality of such institution or where the customer's home is outside the locality of such an institution but the institution, in relation to the home, is the nearest one with the appropriate facilities.

Items and services such as oxygen, drugs, extra attendants, supplies, EKG, night differential, and other miscellaneous ambulance services are considered global to the ambulance service. (A0420, A0422, A0424).

Exclusions

- Requests for non-emergency transport not meeting criteria.
- Ambulette services are not covered.

Medicare Variation

Ambulance Treatment without Transport

Ambulance treatment without transport (A0998) is not a covered benefit. The Medicare ambulance benefit is a transportation benefit and without transportation there is no payable service. The customer's condition must require both the ambulance transportation itself and the level of service provided in order for the service to be considered medically necessary.

Paramedic Intercept Services

Paramedic intercept services are covered when all Medicare requirements for paramedic intercept services are met.

When Medicare requirements for paramedic intercept service are not met, the benefit will be denied administratively.

See Publication 100-02, Medicare Benefit Policy Manual, Chapter 10 – Ambulance Services, section 30.1.1 – Ground Ambulance Services for coverage requirements for Paramedic Intercept benefit.

Available: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c15.pdf

Non-emergency transportation is available for Medicare Advantage customers but varies by plan. If the non-emergency transportation benefit is available, it must be provided by the MVP vendor.

MVP Medicaid Managed Care Variation

Non-emergency transportation is not covered by MVP Health Care for MVP Medicaid Managed Care customers. Non-emergency transportation is provided by the NYS DOH transportation vendor, Medical Answering Services.

Emergency transportation is not covered by MVP. Emergency transportation is covered by Medicaid Fee-for-Service (FFS).

MVP Child Health Plus

Transportation Between Hospitals:

When a Child Health Plus enrollee is admitted to a hospital licensed under Article 28 of the Public Health Law, the reimbursement paid to the hospital includes all necessary transportation services for the inpatient. If the admitting hospital sends an inpatient round trip to another hospital for the purposes of obtaining a diagnostic test or therapeutic service, the original admitting hospital is responsible for the provision of the transportation services.

The following ambulance transports are considered emergency transports; therefore, prior authorization is not required:

- Transport from an Emergency Room to a Psychiatric Center

- Transport from an Emergency Room to a Trauma/Cardiac Care/Burn Center.

- Transportation from an Emergency Room to an Emergency Room.

- Transportation from an Emergency Room to Another Facility.

References (Reviewed 2026)

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4. New York State Medicaid Program. Department of Health. Transportation Manual Policy Guidelines. Version 2019-1. February 1, 2019. Available: https://www.emedny.org/ProviderManuals/index.aspx
5. Insurance Law section 3221 (l) (15) for Article 42 Lines of Business.

Customer Product	Medical Management Requirements*
New York Products	
HMO	Potential for Retrospective Review
POS in Plan	Potential for Retrospective Review
POS OOP	Potential for Retrospective Review
Essential Plan	Potential for Retrospective Review
MVP Medicaid Managed Care	Carved out by Medicaid FFS
MVP Child Health Plus	Potential for Retrospective Review
MVP Harmonious Health Care Plan	Carved out by Medicaid FFS
MVP Medicare Complete Wellness	Potential for Retrospective Review
MVP Medicare Preferred Gold HMO POS	Potential for Retrospective Review
MVP Medicare Secure Plus HMO POS	Potential for Retrospective Review
MVP Medicare WellSelect PPO	Potential for Retrospective Review
MVP DualAccess D-SNP HMO	Potential for Retrospective Review
MVP DualAccess Complete D-SNP HMO	Potential for Retrospective Review
USA Care PPO	Potential for Retrospective Review
Healthy NY	Potential for Retrospective Review
MVP Premier	Potential for Retrospective Review
MVP Premier Plus	Potential for Retrospective Review
MVP Premier Plus HDHP	Potential for Retrospective Review
MVP Secure	Potential for Retrospective Review
MVP EPO	Potential for Retrospective Review
MVP EPO HDHP	Potential for Retrospective Review
MVP PPO	Potential for Retrospective Review
MVP PPO HDHP	Potential for Retrospective Review
ASO	See SPD
Vermont Products	
POS in Plan	Potential for Retrospective Review
POS Preferred OOP	Potential for Retrospective Review
MVP VT HMO	Potential for Retrospective Review
MVP VT HDHP HMO	Potential for Retrospective Review
MVP VT Plus HMO	Potential for Retrospective Review
MVP VT Plus HDHP HMO	Potential for Retrospective Review
MVP Secure	Potential for Retrospective Review
ASO	See SPD
♦ Note: Prior authorization requirements for HDHP products are the same as the base product (e.g. HDHP HMO auth requirements are the same as listed for HMO).	

***Medical Management Requirements**

Prior Auth	Prior Authorization Required
Potential for Retrospective Review	No Prior Authorization Required. May be subject to Retrospective Review
Retro Review	Retrospective Review Required
Not Covered	Service is not a covered benefit.
See SPD	See Specific Plan Design

MVP Health Care Medical Policy

Revision History:

02/01/2022 – added Emergency Triage, Treat, and Transport (ET3) model language to Commercial and Medicare coverage.

01/01/2023 – added coverage for non-emergency transportation and transportation between hospitals as part of Child Health Plus carve-in of benefits to managed care plans.

02/01/2024 – Annual review; removed coverage for Emergency Triage, Treat, and Transport (ET3) model language from Commercial and Medicare as CMS has discontinued the program. References reviewed and updated.

04/01/2026 – Annual Review, no changes to indications or criteria.

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MVP Health Care Medical Policy

Investigational Procedures, Devices, Medical Treatments and Tests

Type of Policy:	Medical
Prior Approval Date:	12/22/2025
Approval Date:	02/02/2026
Effective Date:	04/01/2026
Related Policies:	MVP Experimental or Investigational Procedures, Behavioral Health Services, Drugs and Treatment, Off-Label use of FDA Approved Drugs and Clinical Trial Policy

Codes Requiring Prior Authorization

Prior authorization may vary by plan which means the codes listed below may be specific to one product or all products. Please refer to the product grid found at the end of this policy for detailed authorization requirements for specific plans.

CPT Codes: None

For Durable Medical Equipment (DME) that requires Prior Authorization, refer to: Reference Library - MVP Health Care

Codes Subject to Retrospective Review

CPT Code: 0232T, 0594T, 0596T, 0597T, 0598T, 0599T, 0600T, 0601T, 20983, 29999, 31574, 47383, 47384, 49659, 49999, 53451, 53452, 53453, 53454, 55877, 62287, 64454, 64999, 68841,84112, 84999, 91112, 91113, 91117, 91020, 91022, 91299, 92548

HCPCS Code: C9761, C9762, C9763, C9750, M0076, S2348, S9090, 0200T, 0201T, 0509T, 0546T

Experimental/Investigational

CPT Code: 0232T, 0594T, 0598T, 0599T, 0600T, 0601T, 20983, 29999, 33289, 47383, 47384, 49659, 49999, 53451, 53452, 53453, 53454, 55877, 62287, 64454, 64999, 68841, 84112, 84999, 91112, 91113, 91117, 91020, 91022, 91299, 92548, 93264, 97037, 99500

HCPCS Code: C9761, C9762, C9763, E0830, M0076, S2348, S9001, S9090, C9473, 0232T, 0509T, 0546T, C9750

Common Diagnosis Codes

N/A

Common Procedure Codes

N/A

Please refer to the product grid for detailed authorization requirements for specific plans. Codes requiring prior-authorization for some products may require retrospective review for plans that do not require prior-authorization. Common diagnosis codes are included for informational purposes only and every attempt has been made to update and keep these codes accurate. These codes may not be all inclusive. These codes may not be all inclusive. CPT codes are subject to change as replacement codes are adopted by CMS. Any codes related to CMS updates will be adopted and applied to this policy.

Overview

This policy addresses procedures, devices, medical treatments, and tests not covered because they have not been proven to provide long-term safe and effective outcomes indicated by a preponderance of scientific evidence and, therefore, are considered investigational.

The listing provided should not be considered all-inclusive.

The process for evaluation of services not included in this policy to determine if they are investigational can be found in the MVP Experimental or Investigational Procedures, Behavioral Health Services, Drugs and Treatment, Off-Label use of FDA Approved Drugs, and Clinical Trial Policy

Policy

Athletic pubalgia (49659, 49999)

Due to the lack of evidence from the published peer-reviewed literature, the effectiveness of athletic pubalgia surgery has not been established, therefore, all athletic pubalgia surgery is considered investigational.

Immunotherapy for Recurrent Spontaneous Abortion

Due to lack of evidence in the peer reviewed literature, immunotherapy for recurrent spontaneous abortion is considered investigational and, therefore, not medically necessary.

Mechanized Spinal Distraction Therapy (64999, 97799) (E0830 requires prior authorization)

Due to the lack of evidence from peer-reviewed literature, mechanized spinal distraction is considered investigational.

Microsurgical Treatments of Lymphedema

Microsurgical treatments to include but are not limited to microsurgical lymphatico-venous anastomosis, lymphatic-capsular-venous anastomosis, lymphovenous bypass are considered to be investigational for the treatment of customers with chronic obstructive lymphedema because the long-term effectiveness of these procedures has not been established by the peer-reviewed medical literature.

Patient-operated Spinal Unloading Devices (64999, 97799, S9090) (E0830 requires prior authorization)

Due to the lack of evidence from peer-reviewed literature demonstrating improved patient outcomes, patient operated spinal unloading devices are considered investigational.

Platelet-rich plasma injections (0232T, G0460)

There is insufficient evidence in the peer-reviewed literature that platelet-rich plasma injections for any indication, including ligament injuries, tendon injuries, or wound healing, results in proven beneficial outcomes and are, therefore, considered investigational.

Medicare Variation

Centers for Medicare & Medicaid Services (CMS) will cover autologous platelet-rich plasma for the treatment of chronic non-healing diabetic wounds for a duration of 20 weeks, when prepared by devices whose Food and Drug Administration-cleared indications include the management of exuding cutaneous wounds, such as diabetic ulcers.

Platelet rich plasma injections and/or applications are considered not medically reasonable and necessary for any use outside of the National Coverage Determination (NCD) 270.3 Blood-Derived Products for Chronic Non-Healing Wounds.

This Medicare criteria is based on the full Local Coverage Determination (LCD): Blood-Derived Products for Chronic Non-Healing Wounds (270.3) Effective Date: 04/13/2021 Available: MCD Search (cms.gov)PAMG-1 (84112)

Rupture of Membranes (ROM) Testing in Pregnancy

Rupture of Membranes (ROM) Testing in Pregnancy (AmniSure ROM Test [PAMG-1], ROM Plus® Fetal Membrane Rupture test [PP12, AFP], and Actim® PROM [GFBP-1] test for Detection of Fetal Membrane Rupture (CPT 84112):

There is insufficient evidence in the peer-reviewed literature to support that AmniSure ROM Test [PAMG-1, ROM Plus Fetal Membrane Rupture test [PP12, AFP], and Actim PROM [GFBP-1] for the detection of fetal membrane rupture improves outcomes and therefore, is considered investigational.

Medicaid Managed Care Variation:

PAMG-1 or Rupture of Membranes (ROM) Testing is a covered service for Medicaid Managed Care customers.

Prolotherapy (M0076)

Due to the lack of peer reviewed scientific literature demonstrating effectiveness of prolotherapy for the treatment of joint and ligament instability, prolotherapy is considered investigational for any indication including joint and ligament instability.

Shoulder Resurfacing for Treatment of Arthritis and Degenerative Joint Disease

There is no reliable evidence for the use of humeral resurfacing in the existing literature and, therefore, it is considered investigational.

Thermal Intradiscal procedures (62287, S2348)

There is insufficient evidence in peer reviewed literature that thermal intradiscal procedures result in proven beneficial outcomes and, therefore, are considered not medically necessary.

Although not intended to be an all-inclusive list, Thermal Intradiscal Procedures (TIPs) are commonly identified as intradiscal electrothermal therapy (IDET), intradiscal thermal annuloplasty (IDTA), percutaneous intradiscal radiofrequency thermocoagulation (PIRFT), radiofrequency annuloplasty (RA), intradiscal biacuplasty (IDB), percutaneous (or plasma) disc decompression (PDD) or coblation, or targeted disc decompression (TDD). At times, TIPs are identified or labeled based on the name of the catheter/probe that is used (e.g., SpineCath, discTRODE, SpineWand, Accutherm, or TransDiscal electrodes).

This determination is based on the Medicare National Coverage Determination (NCD) for Thermal Intradiscal Procedures (TIPs) (150.11) for coverage conditions available at: https://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx

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Gastrointestinal transit and pressure measurement with wireless capsule (CPT code 91112)

Due to insufficient evidence in the medical literature, wireless capsule for the evaluation of suspected gastric motility disorders (SmartPill GI Monitoring System) is considered investigational and, therefore, not medically necessary for all indications.

Medicare variation

A Wireless Gastrointestinal Motility Monitoring System using a wireless capsule is considered medically necessary when:

- It is used to evaluate and/or treat Customers with suspected gastroparesis
- It is used to evaluate colonic transit in patients with chronic idiopathic constipation lasting over 6 months.

- Basic clinical investigations, including endoscopy, have failed to elucidate a diagnosis.

For full details refer to the Medicare Local Coverage Determination (LCD): Wireless Gastrointestinal Motility Monitoring Systems (L33455).

Gastrointestinal tract imaging (e.g., wireless capsule endoscopy) of the colon (CPT code 91113)

Gastrointestinal tract imaging, intraluminal (e.g., wireless capsule endoscopy), of the colon is considered investigational and not medically necessary for evaluation of all conditions including but not limited to colorectal cancer screening, detecting colorectal polyps or in evaluating the colon.

Medicare Variation

Diagnostic and/or surveillance (performed for signs/symptoms of disease) colon capsule colonoscopy (CCE) is medically necessary for the detection of colon polyps.

For full details refer to the Medicare Local Coverage Determination (LCD): National Government Services (NGS, Inc.) LCD for Colon Capsule Endoscopy (CCE) (L38571).

Bioimpedance Devices and Bioimpedance Spectroscopy for Detection of Lymphedema (e.g., ImpediMed LDex™) (93702)

Bioimpedance devices for detection of lymphedema are not covered and considered investigational for the diagnosis or management of lymphedema. There is insufficient evidence in the peer reviewed medical literature to support the efficacy of bioimpedance devices for detection of lymphedema.

The AngelMed® Guardian System

The AngelMed® Guardian System (Angel Medical Systems, Inc., Shrewsbury, NJ) is an intracardiac ST-segment electrogram device currently being manufactured as an intracardiac ischemic monitoring system (C9750). The Guardian detects acute ischemic events by analyzing ST-segment shifts which are typically identified by electrocardiography (ECG) in the emergency room setting after the onset of symptoms, such as chest pain, shortness of breath, nausea, diaphoresis (sweating), etc. Intracardiac ischemia monitoring is considered investigational and not medically necessary for all indications including, but not limited to, detection of acute myocardial ischemic events.

Home Uterine Monitoring (99500, S9001)

Home uterine monitoring is used to continuously monitor pregnancy at home for the detection of early-stage uterine contractions suggestive of pre-mature labor. Home uterine activity monitoring is considered investigational as the peer-reviewed medical literature has not proven the procedure to improve health outcomes over standard high-risk obstetric care and therefore is not covered.

Computerized Dynamic Posturography (CDP) (92548)

Computerized Dynamic Posturography (CDP) is a technique used for evaluation and treatment of balance disorders. Computerized Dynamic Posturography (CDP) is considered investigational because it is unproven for evaluating and treating any condition including but not limited to balance disorders due to insufficient evidence of efficacy.

Medicare Variation

Computerized Dynamic Posturography (CDP) is covered for Medicare Customers when performed only by licensed audiologists with a physician's order; by a licensed physician, preferably with certification by the American Board of Medical Specialties in Otolaryngology, Neurology or Otology/Neurology; or other providers licensed to practice medicine under the personal supervision of an appropriate physician as described in the Code of Federal Register (CFR).

This Medicare criteria is based on the Local Coverage Article (LCA): Billing and Coding: Vestibular Function Testing (A56497) Effective Date: 01/01/2021 Available: MCD Search (cms.gov)

Electroretinography

PERG or pattern electroretinography (PERG) (Code: 0509T) for all indications (e.g., glaucoma, optic neuropathies, primary ganglion cell diseases, amblyopia, macular degeneration) is considered experimental and investigational as the available published clinical evidence does not support clinical value.

The use of other forms of electroretinography (ERG), (e.g., fERG, mfERG, ffERG) are medically necessary.

Medicare Variation

The use of all forms of electroretinography (ERG), (e.g., PERG, fERG, mfERG, ffERG) are covered for Medicare plans according to Medicare criteria. This Medicare criteria is based on the Local Coverage Determination (LCD): Visual Electrophysiology Testing (L36831) and Local Coverage Article (LCA): Billing and Coding: Visual Electrophysiology Testing (A57060) Effective Date: 10/01/2023 Available: MCD Search

Radiofrequency Spectroscopy for intraoperative margin assessment (0546T)

There is insufficient evidence in peer reviewed literature that radiofrequency spectroscopy results in proven beneficial outcomes or has had an effect on subsequent clinical management and, therefore, is considered investigational.

Drug-Eluting Devices

Drug-eluting devices have been developed using such medications as Dextenza (dexamethasone ophthalmic insert) 0.4mg Ocular Therapeutic™ (Therapeutix Inc. Bedford, MA) which are inserted into the canaliculus to improve pain following ocular surgery. These drug-eluting punctual plugs made of resorbable material are inserted into the lacrimal punctum (tear duct) and purportedly emit sustained release medications for a 30-60-day period until degrading and exiting via the nasolacrimal system. Drug-eluting ocular devices (CPT code 68841) implanted into the lacrimal canaliculus are experimental and investigational for the treatment of post-surgical ocular pain for all indications because its effectiveness has not been established.

Medicare Variation:

Medicare considers the use of the Dextenza® dexamethasone insert reasonable and necessary for the treatment of ocular inflammation and pain following ophthalmic surgery.

Iliopsoas tendon release (Tenotomy)

Iliopsoas tendon release (tenotomy) is a surgical procedure proposed to relieve tension through arthroscopic lengthening of the iliopsoas tendon to address contracture or snapping hip syndrome and is considered to be investigational.

Vocal Cord Paralysis Treatment

Injections of bulking agents [e.g., Prolaryn Gel or Prolaryn Plus (31574, C1878) is medically necessary for customers with unilateral vocal cord paralysis. One treatment (either left or right) is allowed to be performed per calendar year. Injections of bulking agents into vocal cords determined to have bilateral or permanent paralysis is experimental and investigational because their effectiveness has only been established for unilateral paralysis.

Percutaneous Ultrasonic Ablation of Soft Tissue

Percutaneous ultrasonic ablation of soft tissue utilizing Tenex treatment procedure is considered investigational for the treatment of any condition.

Trochleoplasty in patellofemoral instability

Trochleoplasty used for any indications, including patellofemoral instability or recurrent patellar instability is considered investigational, experimental or unproven because there is a lack of evidence from peer-reviewed literature demonstrating improved patient outcomes and no support in professional medical clinical practice guidelines and position statements.

Non-Contact Real-Time Fluorescent Wound Imaging (NCRFI) (0598T, 0599T)

Non-Contact Real-Time Fluorescent Wound Imaging (NCRFI) is a medical imaging technique that is used to visualize and monitor wounds in real time using fluorescent light. Non-Contact Real-Time Fluorescent Wound Imaging is considered investigational, experimental, or unproven because there is a lack of evidence from peer-reviewed literature demonstrating improved patient outcomes and no support in professional medical clinical practice guidelines and position statements.

Percutaneous peripheral nerve stimulation (PNS) (CPT - 64555)

Percutaneous peripheral nerve stimulation is considered experimental, investigational or unproven for any indication, including but not limited to the treatment of acute or chronic pain conditions.

Medicare Variation

Medicare plans have coverage for percutaneous peripheral nerve stimulation.

For full Medicare coverage details about peripheral nerve stimulation please refer to the following NCD for Medicare Customers: National Coverage Determination (NCD) Electrical Nerve Stimulators (160.7) Effective Date: 08/07/1995. Available: https://www.cms.gov/medicare-coverage-database

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Low Level Laser Therapy (LLLT) (CPT Code: 97037)

Low Level Laser Therapy (LLLT), (CPT Code: 97037) also known as cold laser, photobiomodulation therapy, or high-power laser therapy for any indication is considered experimental and investigational because there is inadequate evidence of the effectiveness of these treatments in nationally recognized peer-reviewed medical literature.

High Resolution Esophageal Pressure Topography

High Resolution Esophageal Pressure Topography (EndoFlip; CPT code: 91299) for any indication is considered experimental and investigational because there is a lack of evidence from peer-reviewed literature demonstrating improved patient outcomes and no support in professional medical clinical practice guidelines and position statements.

Cryosurgical Tumor Ablation

Cryosurgical tumor ablation is considered investigational as a treatment method for any other tumor other than renal and non-small cell lung cancer (NSCLC), including but not limited to, primary/metastatic liver malignancies, breast tumors (benign and malignant), and pancreatic cancer (CPT Codes: 20983, 47383).

Adjustable Balloon Continence Devices

Transperineal Implantation of Permanent Adjustable Balloon Continence Devices are experimental and investigational because there is insufficient evidence to support the

use of adjustable continence therapy devices (e.g., including but not limited to ProACT Therapy System, ACT) that have been proposed as minimally invasive urological devices designed to treat persons with stress urinary incontinence (SUI). (CPT Code: 53451, 53452, 53453, 53454)

Gastrointestinal Manometry (Motility Testing) (CPT Codes 91117, 91020, 91022)

Gastrointestinal manometry is a diagnostic test that records intraluminal pressure or contraction activity in the gastrointestinal tract. There is insufficient evidence regarding the effectiveness of gastrointestinal manometry or motility testing. Patient selection criteria and the role of manometry in the management of motility abnormalities (e.g., refractory constipation) must be better defined in well-designed studies. (This does not apply to esophageal motility testing)

Vacuum Aspiration Kidney Stone Collection Systems (Procedure Code: C9761)

Cystourethroscopy with lithotripsy using a steerable urethral catheter and vacuum aspiration kidney collecting system (such as but not limited to Calyxo CVAC Aspiration System or the ClearPetra® Suction Stone Extraction System (Procedure Code: C9761)) is considered investigational for urinary stone removal. This is due to a lack of published, peer-reviewed evidence supporting the effectiveness of vacuum aspiration kidney stone collection systems compared with established treatment methods.

Knee Implanted Shock Absorbers (Procedure Code: C8003)

The use of a medial knee implanted shock absorber (e.g., Misha™ Knee System) for any indication, including the management of osteoarthritis, is considered experimental, investigational or unproven.

Irreversible Electroporation (IRE)(Procedure Code: 0600T, 0601T)

The use of irreversible electroporation (e.g., Nanoknife™) for any indication, including treatment of prostate cancer, is considered experimental, investigational or unproven.

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Customer Product	Medical Management Requirements*
New York Products	
HMO	Retrospective Review E&I
PPO in Plan	Retrospective Review E&I
PPO OOP	Retrospective Review E&I
POS in Plan	Retrospective Review E&I
POS OOP	Retrospective Review E&I
Essential Plan	Retrospective Review E&I
MVP Medicaid Managed Care	Retrospective Review E&I
MVP Child Health Plus	Retrospective Review E&I
MVP Harmonious Health Care Plan	Retrospective Review E&I
MVP Medicare Complete Wellness	Retrospective Review E&I
MVP Medicare Preferred Gold HMO POS	Retrospective Review E&I
MVP Medicare Secure HMO POS	Retrospective Review E&I
MVP Medicare Secure Plus HMO POS	Retrospective Review E&I
MVP Medicare WellSelect PPO	Retrospective Review E&I
MVP SmartFund MSA	Potential for Retrospective Review
MVP DualAccess D-SNP HMO	Retrospective Review E&I
MVP DualAccess Complete D-SNP HMO	Retrospective Review E&I
USA Care	Potential for Retrospective Review
Healthy NY	Retrospective Review E&I
MVP Premier	Retrospective Review E&I
MVP Premier Plus	Retrospective Review E&I
MVP Premier Plus HDHP	Retrospective Review E&I
MVP Secure	Retrospective Review E&I
MVP EPO	Retrospective Review E&I
MVP EPO HDHP	Retrospective Review E&I
ASO	See SPD
Vermont Products	
POS in Plan	Retrospective Review E&I
POS OOP	Retrospective Review E&I
MVP SmartFund MSA	Potential for Retrospective Review
MVP VT HMO	Retrospective Review E&I
MVP VT HDHP HMO	Retrospective Review E&I
MVP VT Plus HMO	Retrospective Review E&I
MVP VT Plus HDHP HMO	Retrospective Review E&I
MVP Secure	Retrospective Review E&I
ASO	See SPD
♦ Note: Prior authorization requirements for HDHP products are the same as the base product (e.g. HDHP HMO auth requirements are the same as listed for HMO).	
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***Medical Management Requirements**

Prior Auth	Prior Authorization Required
Potential for Retrospective Review	No Prior Authorization Required. May be subject to Retrospective Review
Retro Review	Retrospective Review Required
Not Covered	Service is not a covered benefit
See SPD	See Specific Plan Design

Revision History:

06/01/2021 - Gastrointestingal Pathogen Nucleic Acid Detection Panels, Respiratory Pathogen Nucleic Acid Detection Panels and Pharmacogenetic testing for CYP2D6 gene variants for opioid treatment added to policy.

08/01/2021 - Removed Total Ankle Joint Replacement (27702) and added to coverage for all LOB, added Rupture of Membranes testing to coverage for Medicaid Managed Care (MMC) plans, moved transcatheter tricuspid valve replacement procedure (0569T, 0570T) from TAVR policy to this policy.

12/01/2021 – Add Genicular Nerve Rhizotomy/Peripheral Nerve Ablation for the Treatment of Osteoarthritic Knee Pain as experimental and investigational.

02/01/2022 – Added Medicare variations to investigational procedures for genicular nerve ablation, high intensity focused ultrasound (HIFU), and Dextenza for use in drug eluting stents. SpaceOAR moved into its own policy. Format of references updated to correspond to the investigational procedure that is addressed in the policy.

10/01/2022 – Added 0404T, 30468, 58674, 64640 to policy.

02/01/2023 – Added Percutaneous ultrasonic ablation of soft tissue utilizing Tenex treatment.

04/01/2023 – Moved 55880 to the Prostate Cancer Interventions Policy.

06/01/2023 – Added Non-Contact Real time Fluorescent Wound Imaging (0598T and 0599T) to policy.

12/1/2023 – Percutaneous Peripheral Nerve Stimulator added, CPT 64555 to policy. Removed A9291.

01/01/2024 – 0404T deleted, replaced with CPT code 58580.

06/01/2024 – Moved Percutaneous Peripheral Nerve Stimulator (CPT 64555) to the Electrical Stimulation policy. 58580 no longer investigational and removed from policy. Sonata system uses transcervical radiofrequency ablation for the treatment of uterine fibroids is no longer investigational.

08/01/2024 – Removed absorbable nasal implants (CPT 30468) and moved into the sinus surgery medical policy. ChemoFx In vitro chemosensitivity assays (CPT Code: 81535, 81536) has been removed and is now managed in the In Vitro Chemoresistance and Chemosensitivity Assays Payment Policy. OVA1™ Overa™ (CPT Code: 81503) has been moved to the Serum Tumor Markers for Malignancies Payment Policy. Removed the Autoimmune (rheumatoid arthritis), analysis of 12 biomarkers using immunoassays (CPT Code: 81490) and now managed in the Multi-biomarker for Rheumatoid Arthritis Payment Policy. Percutaneous Pulmonary Valve Implantation (CPT 33477) is no longer investigational with coverage criteria added to the Cardiac Procedures Medical Policy, Respiratory Pathogen Nucleic Acid Detection Panels (87632, 87633, 0115U) have been moved to the Pathogen Panel Testing Payment Policy. Respiratory Pathogen Nucleic Acid Detection Panels (0202U, 0223U, 0225U) have been moved to the Coronavirus Testing in the Outpatient Setting Payment Policy. Added and Low Level Laser Therapy (LLLT), (CPT Code: 97037) and High Resolution Esophageal Pressure Topography (EndoFlip; CPT code: 91299).

09/15/2024 – Removed HCPCS Code S3722 for dose optimization by area under the curve (AUC) analysis, for infusional 5-fluorouracil because this is now managed in a payment policy Therapeutic Drug Monitoring for 5-Fluorouracil.

10/01/2024 – Added cryosurgical tumor ablation (CPT codes: 20983, 47383). Removed CPT Code: 32994 ablation therapy for pulmonary tumors. Added language excluding adjustable balloon continence devices. Added coverage for 0509T to Medicare plans.

02/01/2025 – Added Gastrointestinal Manometry (Motility Testing) (CPT Codes 91117, 91020, 91022).

06/01/2025- Removed CardioMems from this policy and put into Ambulatory Holter Monitors, removed Transcatheter Tricuspid Valve Procedures and moved them in the Cardiac Procedures Medical Policy, added CVAC Aspiration System (Calyxo CVAC System) All-in-One Kidney Stone Treatment C9761).

12/01/2025 - Updated section on electroretinography for clarity, updated section on vacuum aspiration kidney stone collection systems for clarity to make it general and not product specific, added exclusion for knee implanted shock absorbers.

02/01/2026 - 0029U, 0070U, 0071U, 0072U, 0073U, 0074U, 0075U, 0076U moved to M2021 Pharmacogenetic Testing Genetics Policy. CPT 88299 moved to M2146 General Genetic Testing, Somatic Disorders Genetics Policy. Gastrointestinal Pathogen Nucleic Detection Panels moved to M2149 Pathogen Panel Testing.

04/01/2026 – Genicular nerve blocks and other peripheral nerve destruction techniques (Code 0441T, 64624, 64640) moved to new policy Peripheral Nerve Destruction (Neurolysis) for Chronic Pain. Added reference for Nanoknife.

0029U

MVP Health Care Medical Policy

Investigational Procedures, Devices, Medical Treatments and Tests

Type of Policy:	Medical
Prior Approval Date:	12/22/2025
Approval Date:	01/05/2026
Effective Date:	04/01/2026
Related Policies:	MVP Experimental or Investigational Procedures, Behavioral Health Services, Drugs and Treatment, Off-Label use of FDA Approved Drugs and Clinical Trial Policy

Codes Requiring Prior Authorization

Prior authorization may vary by plan which means the codes listed below may be specific to one product or all products. Please refer to the product grid found at the end of this policy for detailed authorization requirements for specific plans.

CPT Codes: None

For Durable Medical Equipment (DME) that requires Prior Authorization, refer to: Reference Library - MVP Health Care

Codes Subject to Retrospective Review

CPT Code: 0232T, 0594T, 0596T, 0597T, 0598T, 0599T, 0600T, 0601T, 20983, 29999, 31574, 47383, 47384, 49659, 49999, 53451, 53452, 53453, 53454, 55877, 62287, 64454, ~~64624, 64640,~~ 64999, 68841,84112, 84999, ~~88299,~~ 91112, 91113, 91117, 91020, 91022, 91299, 92548,

HCPCS Code: C9761, C9762, C9763, C9750, M0076, S2348, S9090, 0200T, 0201T, ~~0441T,~~ 0509T, 0546T

~~PLU Code: 0029U, 0070U, 0071U, 0072U, 0073U, 0074U, 0075U, 0076U, 0097U~~

Experimental/Investigational

CPT Code: 0232T, 0594T, 0598T, 0599T, 0600T, 0601T, 20983, 29999, 33289, 47383, 47384, 49659, 49999, 53451, 53452, 53453, 53454, 55877, 62287, 64454, ~~64624, 64640,~~ 64999, 68841, 84112, 84999, ~~88299,~~ 91112, 91113, 91117, 91020, 91022, 91299, 92548, 93264, 97037, 99500

HCPCS Code: C9761, C9762, C9763, E0830, M0076, S2348, S9001, S9090, C9473, 0232T, ~~0441T,~~ 0509T, 0546T, C9750

~~PLU Code: 0029U, 0070U, 0071U, 0072U, 0073U, 0074U, 0075U, 0076U, 0097U~~

Common Diagnosis Codes

N/A

Common Procedure Codes

N/A

Please refer to the product grid for detailed authorization requirements for specific plans. Codes requiring prior-authorization for some products may require retrospective review for plans that do not require prior-authorization. Common diagnosis codes are included for informational purposes only and every attempt has been made to update and keep these codes accurate. These codes may not be all inclusive. These codes may not be all inclusive. CPT codes are subject to change as replacement codes are adopted by CMS. Any codes related to CMS updates will be adopted and applied to this policy.

Overview

This policy addresses procedures, devices, medical treatments, and tests not covered because they have not been proven to provide long-term safe and effective outcomes indicated by a preponderance of scientific evidence and, therefore, are considered investigational.

The listing provided should not be considered all-inclusive.

The process for evaluation of services not included in this policy to determine if they are investigational can be found in the MVP Experimental or Investigational Procedures, Behavioral Health Services, Drugs and Treatment, Off-Label use of FDA Approved Drugs, and Clinical Trial Policy

Policy

Athletic pubalgia (49659, 49999)

Due to the lack of evidence from the published peer-reviewed literature, the effectiveness of athletic pubalgia surgery has not been established, therefore, all athletic pubalgia surgery is considered investigational.

~~Tumor In Vitro Chemosensitivity and Chemoresistance Assays~~

~~**ChemoFx**® (88299)~~

~~There is insufficient evidence in the peer-reviewed literature that ChemoFx results in proven beneficial outcomes and is, therefore, considered investigational.~~

~~**Fluorescent Cytoprint Assay** (88299)~~

~~There is insufficient evidence in the peer-reviewed literature that Fluorescent Cytoprint Assay results in proven beneficial outcomes and is, therefore, considered investigational.~~

~~**Human Tumor Stem Cell Drug Sensitivity Assays** (88299)~~

~~There is insufficient evidence in the peer-reviewed literature that human tumor stem cell drug sensitivity assays result in proven beneficial outcomes and are, therefore, considered investigational.~~

Immunotherapy for Recurrent Spontaneous Abortion

Due to lack of evidence in the peer reviewed literature, immunotherapy for recurrent spontaneous abortion is considered investigational and, therefore, not medically necessary.

Mechanized Spinal Distraction Therapy (64999, 97799) (E0830 requires prior authorization)

Due to the lack of evidence from peer-reviewed literature, mechanized spinal distraction is considered investigational.

Microsurgical Treatments of Lymphedema

Microsurgical treatments to include but are not limited to microsurgical lymphatico-venous anastomosis, lymphatic-capsular-venous anastomosis, lymphovenous bypass are considered to be investigational for the treatment of customers with chronic obstructive lymphedema because the long-term effectiveness of these procedures has not been established by the peer-reviewed medical literature.

Patient-operated Spinal Unloading Devices (64999, 97799, S9090) (E0830 requires prior authorization)

Due to the lack of evidence from peer-reviewed literature demonstrating improved patient outcomes, patient operated spinal unloading devices are considered investigational.

~~Genicular nerve blocks/Genicular Nerve Rhizotomy/Peripheral Nerve Ablation (64624, 64454)~~

~~Due to lack of evidence in the peer reviewed literature, genicular nerve blocks, genicular nerve rhizotomy and genicular peripheral nerve ablation for any indication including, but not limited to, the treatment of osteoarthritic knee pain is considered investigational and, therefore, not medically necessary.~~

~~Genicular nerve blocks are considered medically necessary for peri-operative analgesia and/or surgical anesthesia for postoperative pain management.~~

~~Cryoneurolysis, also referred to as cryoanalgesia, such as the Iovera System, is investigational for any indication including, but not limited to, knee osteoarthritis or before/during/after total knee replacement surgery. (CPT Code 64640, 0441T)~~

~~Implantable peripheral nerve stimulation (PNS) and peripheral nerve stimulation (PNFS) are considered experimental, investigational for any indication but not limited to the treatment of acute or chronic pain conditions.~~

~~Medicare Variation~~

~~Genicular Nerve Rhizotomy/Peripheral Nerve Ablation and Genicular Nerve Block are a covered benefit for Medicare plans according to the Medicare Local Coverage Determination (LCD) for Peripheral Nerve Blocks (L36850).~~

~~Cryoneurolysis is a covered benefit for Medicare plans according to the Medicare Local Coverage Determination (LCD) Nerve Blockade for Treatment of Chronic Pain and Neuropathy (L35456) by Noridian Healthcare Solutions.~~

Platelet-rich plasma injections (0232T, G0460)

There is insufficient evidence in the peer-reviewed literature that platelet-rich plasma injections for any indication, including ligament injuries, tendon injuries, or wound healing, results in proven beneficial outcomes and are, therefore, considered investigational.

Medicare Variation

Centers for Medicare & Medicaid Services (CMS) will cover autologous platelet-rich plasma for the treatment of chronic non-healing diabetic wounds for a duration of 20 weeks, when prepared by devices whose Food and Drug Administration-cleared indications include the management of exuding cutaneous wounds, such as diabetic ulcers.

Platelet rich plasma injections and/or applications are considered not medically reasonable and necessary for any use outside of the National Coverage Determination (NCD) 270.3 Blood-Derived Products for Chronic Non-Healing Wounds.

This Medicare criteria is based on the full Local Coverage Determination (LCD): Blood-Derived Products for Chronic Non-Healing Wounds (270.3) Effective Date: 04/13/2021 Available: MCD Search (cms.gov)PAMG-1 (84112)

Rupture of Membranes (ROM) Testing in Pregnancy

Rupture of Membranes (ROM) Testing in Pregnancy (AmniSure ROM Test [PAMG-1], ROM Plus® Fetal Membrane Rupture test [PP12, AFP], and Actim® PROM [GFBP-1] test for Detection of Fetal Membrane Rupture (CPT 84112):

There is insufficient evidence in the peer-reviewed literature to support that AmniSure ROM Test [PAMG-1, ROM Plus Fetal Membrane Rupture test [PP12, AFP], and Actim PROM [GFBP-1] for the detection of fetal membrane rupture improves outcomes and therefore, is considered investigational.

Medicaid Managed Care Variation:

PAMG-1 or Rupture of Membranes (ROM) Testing is a covered service for Medicaid Managed Care customers.

Prolotherapy (M0076)

Due to the lack of peer reviewed scientific literature demonstrating effectiveness of prolotherapy for the treatment of joint and ligament instability, prolotherapy is considered investigational for any indication including joint and ligament instability.

Shoulder Resurfacing for Treatment of Arthritis and Degenerative Joint Disease

There is no reliable evidence for the use of humeral resurfacing in the existing literature and, therefore, it is considered investigational.

Thermal Intradiscal procedures (62287, S2348)

There is insufficient evidence in peer reviewed literature that thermal intradiscal procedures result in proven beneficial outcomes and, therefore, are considered not medically necessary.

Although not intended to be an all-inclusive list, Thermal Intradiscal Procedures (TIPs) are commonly identified as intradiscal electrothermal therapy (IDET), intradiscal thermal annuloplasty (IDTA), percutaneous intradiscal radiofrequency thermocoagulation (PIRFT), radiofrequency annuloplasty (RA), intradiscal biacuplasty (IDB), percutaneous (or plasma) disc decompression (PDD) or coblation, or targeted disc decompression (TDD). At times, TIPs are identified or labeled based on the name of the catheter/probe that is used (e.g., SpineCath, discTRODE, SpineWand, Accutherm, or TransDiscal electrodes).

This determination is based on the Medicare National Coverage Determination (NCD) for Thermal Intradiscal Procedures (TIPs) (150.11) for coverage conditions available at: https://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx

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Gastrointestinal transit and pressure measurement with wireless capsule (CPT code 91112)

Due to insufficient evidence in the medical literature, wireless capsule for the evaluation of suspected gastric motility disorders (SmartPill GI Monitoring System) is considered investigational and, therefore, not medically necessary for all indications.

Medicare variation

A Wireless Gastrointestinal Motility Monitoring System using a wireless capsule is considered medically necessary when:

- It is used to evaluate and/or treat Customers with suspected gastroparesis
- It is used to evaluate colonic transit in patients with chronic idiopathic constipation lasting over 6 months.
- Basic clinical investigations, including endoscopy, have failed to elucidate a diagnosis.

For full details refer to the Medicare Local Coverage Determination (LCD): Wireless Gastrointestinal Motility Monitoring Systems (L33455).

Gastrointestinal tract imaging (e.g., wireless capsule endoscopy) of the colon (CPT code 91113)

Gastrointestinal tract imaging, intraluminal (e.g., wireless capsule endoscopy), of the colon is considered investigational and not medically necessary for evaluation of all conditions including but not limited to colorectal cancer screening, detecting colorectal polyps or in evaluating the colon.

Medicare Variation

Diagnostic and/or surveillance (performed for signs/symptoms of disease) colon capsule colonoscopy (CCE) is medically necessary for the detection of colon polyps.

For full details refer to the Medicare Local Coverage Determination (LCD): National Government Services (NGS, Inc.) LCD for Colon Capsule Endoscopy (CCE) (L38571).

Bioimpedance Devices and Bioimpedance Spectroscopy for Detection of Lymphedema (e.g., ImpediMed LDex™) (93702)

Bioimpedance devices for detection of lymphedema are not covered and considered investigational for the diagnosis or management of lymphedema. There is insufficient evidence in the peer reviewed medical literature to support the efficacy of bioimpedance devices for detection of lymphedema.

The AngelMed® Guardian System

The AngelMed® Guardian System (Angel Medical Systems, Inc., Shrewsbury, NJ) is an intracardiac ST-segment electrogram device currently being manufactured as an intracardiac ischemic monitoring system (C9750). The Guardian detects acute ischemic events by analyzing ST-segment shifts which are typically identified by electrocardiography (ECG) in the emergency room setting after the onset of symptoms, such as chest pain, shortness of breath, nausea, diaphoresis (sweating), etc. Intracardiac ischemia monitoring is considered investigational and not medically necessary for all indications including, but not limited to, detection of acute myocardial ischemic events.

Home Uterine Monitoring (99500, S9001)

Home uterine monitoring is used to continuously monitor pregnancy at home for the detection of early-stage uterine contractions suggestive of pre-mature labor. Home uterine activity monitoring is considered investigational as the peer-reviewed medical literature has not proven the procedure to improve health outcomes over standard high-risk obstetric care and therefore is not covered.

Computerized Dynamic Posturography (CDP) (92548)

Computerized Dynamic Posturography (CDP) is a technique used for evaluation and treatment of balance disorders. Computerized Dynamic Posturography (CDP) is considered investigational because it is unproven for evaluating and treating any condition including but not limited to balance disorders due to insufficient evidence of efficacy.

Medicare Variation

Computerized Dynamic Posturography (CDP) is covered for Medicare Customers when performed only by licensed audiologists with a physician's order; by a licensed physician, preferably with certification by the American Board of Medical Specialties in Otolaryngology, Neurology or Otology/Neurology; or other providers licensed to practice medicine under the personal supervision of an appropriate physician as described in the Code of Federal Register (CFR).

This Medicare criteria is based on the Local Coverage Article (LCA): Billing and Coding: Vestibular Function Testing (A56497) Effective Date: 01/01/2021 Available: MCD Search (cms.gov)

Electroretinography

PERG or pattern electroretinography (PERG) (Code: 0509T) for all indications (e.g., glaucoma, optic neuropathies, primary ganglion cell diseases, amblyopia, macular degeneration) is considered experimental and investigational as the available published clinical evidence does not support clinical value.

The use of other forms of electroretinography (ERG), (e.g., fERG, mfERG, ffERG) are medically necessary.

Medicare Variation

The use of all forms of electroretinography (ERG), (e.g., PERG, fERG, mfERG, ffERG) are covered for Medicare plans according to Medicare criteria. This Medicare criteria is based on the Local Coverage Determination (LCD): Visual Electrophysiology Testing (L36831) and Local Coverage Article (LCA): Billing and Coding: Visual Electrophysiology Testing (A57060) Effective Date: 10/01/2023 Available: MCD Search

Radiofrequency Spectroscopy for intraoperative margin assessment (0546T)

There is insufficient evidence in peer reviewed literature that radiofrequency spectroscopy results in proven beneficial outcomes or has had an effect on subsequent clinical management and, therefore, is considered investigational.

Drug-Eluting Devices

Drug-eluting devices have been developed using such medications as Dextenza (dexamethasone ophthalmic insert) 0.4mg Ocular Therapeutic™ (Therapeutix Inc. Bedford, MA) which are inserted into the canaliculus to improve pain following ocular surgery. These drug-eluting punctual plugs made of resorbable material are inserted into the lacrimal punctum (tear duct) and purportedly emit sustained release medications for a 30-60-day period until degrading and exiting via the nasolacrimal system. Drug-eluting ocular devices (CPT code 68841) implanted into the lacrimal canaliculus are experimental and investigational for the treatment of post-surgical ocular pain for all indications because its effectiveness has not been established.

Medicare Variation:

Medicare considers the use of the Dextenza® dexamethasone insert reasonable and necessary for the treatment of ocular inflammation and pain following ophthalmic surgery.

Iliopsoas tendon release (Tenotomy)

Iliopsoas tendon release (tenotomy) is a surgical procedure proposed to relieve tension through arthroscopic lengthening of the iliopsoas tendon to address contracture or snapping hip syndrome and is considered to be investigational.

Vocal Cord Paralysis Treatment

Injections of bulking agents [e.g., Prolaryn Gel or Prolaryn Plus (31574, C1878) is medically necessary for customers with unilateral vocal cord paralysis. One treatment (either left or right) is allowed to be performed per calendar year. Injections of bulking agents into vocal cords determined to have bilateral or permanent paralysis is experimental and investigational because their effectiveness has only been established for unilateral paralysis.

~~Gastrointestinal Pathogen Nucleic Acid Detection Panels (0097U)~~

~~Infectious pathogen detection using nucleic acid panels that are detecting more than 12 gastrointestinal infections (e.g., FilmArray by BioFire PLU Code: 0097U) is considered investigational and experimental when being done in the outpatient setting. The clinical utility of panel testing for greater than 12 gastrointestinal infectious pathogens in the outpatient setting has not been established in the published, peer-reviewed medical literature.~~

~~**Medicare variation:**~~

~~Medicare customers who are immune competent are covered up to 5 bacterial agents (87505). When there is clinical concern for Clostridium difficile colitis, Medicare customers may be covered up to 11 targets if Clostridium difficile is one of the organisms tested for (87506). Testing for 12 or more organisms (87507, 0097U) will only be covered in critically ill or immunosuppressed patients (e.g., receiving cancer treatment, organ transplant recipient).~~

~~Pharmacogenetic testing for *CYP2D6* gene variants for opioid treatment (0029U, 0070U, 0071U, 0072U, 0073U, 0074U, 0075U, 0076U)~~

~~Opioid-related genetic testing is considered experimental/investigational.~~

Percutaneous Ultrasonic Ablation of Soft Tissue

Percutaneous ultrasonic ablation of soft tissue utilizing Tenex treatment procedure is considered investigational for the treatment of any condition.

Trochleoplasty in patellofemoral instability

Trochleoplasty used for any indications, including patellofemoral instability or recurrent patellar instability is considered investigational, experimental or unproven because there is a lack of evidence from peer-reviewed literature demonstrating improved patient outcomes and no support in professional medical clinical practice guidelines and position statements.

Non-Contact Real-Time Fluorescent Wound Imaging (NCRFI) (0598T, 0599T)

Non-Contact Real-Time Fluorescent Wound Imaging (NCRFI) is a medical imaging technique that is used to visualize and monitor wounds in real time using fluorescent light. Non-Contact Real-Time Fluorescent Wound Imaging is considered investigational, experimental, or unproven because there is a lack of evidence from peer-reviewed literature demonstrating improved patient outcomes and no support in professional medical clinical practice guidelines and position statements.

Percutaneous peripheral nerve stimulation (PNS) (CPT - 64555)

Percutaneous peripheral nerve stimulation is considered experimental, investigational or unproven for any indication, including but not limited to the treatment of acute or chronic pain conditions.

Medicare Variation:

Medicare plans have coverage for percutaneous peripheral nerve stimulation.

For full Medicare coverage details about peripheral nerve stimulation please refer to the following NCD for Medicare Customers: National Coverage Determination (NCD) Electrical Nerve Stimulators (160.7) Effective Date: 08/07/1995. Available: https://www.cms.gov/medicare-coverage-database

Low Level Laser Therapy (LLLT) (CPT Code: 97037)

Low Level Laser Therapy (LLLT), (CPT Code: 97037) also known as cold laser, photobiomodulation therapy, or high-power laser therapy for any indication is considered experimental and investigational because there is inadequate evidence of the effectiveness of these treatments in nationally recognized peer-reviewed medical literature.

High Resolution Esophageal Pressure Topography

High Resolution Esophageal Pressure Topography (EndoFlip; CPT code: 91299) for any indication is considered experimental and investigational because there is a lack of evidence from peer-reviewed literature demonstrating improved patient outcomes and no support in professional medical clinical practice guidelines and position statements.

Cryosurgical Tumor Ablation

Cryosurgical tumor ablation is considered investigational as a treatment method for any other tumor other than renal and non-small cell lung cancer (NSCLC), including but not limited to, primary/metastatic liver malignancies, breast tumors (benign and malignant), and pancreatic cancer (CPT Codes: 20983, 47383).

Adjustable Balloon Continence Devices

Transperineal Implantation of Permanent Adjustable Balloon Continence Devices are experimental and investigational because there is insufficient evidence to support the use of adjustable continence therapy devices (e.g., including but not limited to ProACT Therapy System, ACT) that have been proposed as minimally invasive urological devices designed to treat persons with stress urinary incontinence (SUI). (CPT Code: 53451, 53452, 53453, 53454)

Gastrointestinal Manometry (Motility Testing) (CPT Codes 91117, 91020, 91022)

Gastrointestinal manometry is a diagnostic test that records intraluminal pressure or contraction activity in the gastrointestinal tract. There is insufficient evidence regarding the effectiveness of gastrointestinal manometry or motility testing. Patient selection criteria and the role of manometry in the management of motility abnormalities (e.g., refractory constipation) must be better defined in well-designed studies. (This does not apply to esophageal motility testing)

Vacuum Aspiration Kidney Stone Collection Systems (Procedure Code: C9761)

Cystourethroscopy with lithotripsy using a steerable urethral catheter and vacuum aspiration kidney collecting system (such as but not limited to Calyxo CVAC Aspiration System or the ClearPetra® Suction Stone Extraction System (Procedure Code: C9761)) is considered investigational for urinary stone removal. This is due to a lack of published,

peer-reviewed evidence supporting the effectiveness of vacuum aspiration kidney stone collection systems compared with established treatment methods.

Knee Implanted Shock Absorbers (Procedure Code: C8003)

The use of a medial knee implanted shock absorber (e.g., Misha™ Knee System) for any indication, including the management of osteoarthritis, is considered experimental, investigational or unproven.

Irreversible Electroporation (IRE)(Procedure Code: 0600T, 0601T)

The use of irreversible electroporation (e.g., Nanoknife™) for any indication, including treatment of prostate cancer, is considered experimental, investigational or unproven.

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~~109.~~

Customer Product	Medical Management Requirements*
New York Products	
HMO	Retrospective Review E&I
PPO in Plan	Retrospective Review E&I
PPO OOP	Retrospective Review E&I
POS in Plan	Retrospective Review E&I
POS OOP	Retrospective Review E&I
Essential Plan	Retrospective Review E&I
MVP Medicaid Managed Care	Retrospective Review E&I
MVP Child Health Plus	Retrospective Review E&I
MVP Harmonious Health Care Plan	Retrospective Review E&I
MVP Medicare Complete Wellness	Retrospective Review E&I
MVP Medicare Preferred Gold HMO POS	Retrospective Review E&I
MVP Medicare Secure HMO POS	Retrospective Review E&I
MVP Medicare Secure Plus HMO POS	Retrospective Review E&I
MVP Medicare WellSelect PPO	Retrospective Review E&I
MVP SmartFund MSA	Potential for Retrospective Review
MVP DualAccess D-SNP HMO	Retrospective Review E&I
MVP DualAccess Complete D-SNP HMO	Retrospective Review E&I
USA Care	Potential for Retrospective Review
Healthy NY	Retrospective Review E&I
MVP Premier	Retrospective Review E&I
MVP Premier Plus	Retrospective Review E&I
MVP Premier Plus HDHP	Retrospective Review E&I
MVP Secure	Retrospective Review E&I
MVP EPO	Retrospective Review E&I
MVP EPO HDHP	Retrospective Review E&I
ASO	See SPD
Vermont Products	
POS in Plan	Retrospective Review E&I
POS OOP	Retrospective Review E&I
MVP SmartFund MSA	Potential for Retrospective Review
MVP VT HMO	Retrospective Review E&I
MVP VT HDHP HMO	Retrospective Review E&I
MVP VT Plus HMO	Retrospective Review E&I
MVP VT Plus HDHP HMO	Retrospective Review E&I
MVP Secure	Retrospective Review E&I
ASO	See SPD
♦ Note: Prior authorization requirements for HDHP products are the same as the base product (e.g. HDHP HMO auth requirements are the same as listed for HMO).	

***Medical Management Requirements**

Prior Auth	Prior Authorization Required
Potential for Retrospective Review	No Prior Authorization Required. May be subject to Retrospective Review
Retro Review	Retrospective Review Required
Not Covered	Service is not a covered benefit
See SPD	See Specific Plan Design

Revision History:

06/01/2021 - Gastrointestingal Pathogen Nucleic Acid Detection Panels, Respiratory Pathogen Nucleic Acid Detection Panels and Pharmacogenetic testing for CYP2D6 gene variants for opioid treatment added to policy.

08/01/2021 - Removed Total Ankle Joint Replacement (27702) and added to coverage for all LOB, added Rupture of Membranes testing to coverage for Medicaid Managed Care (MMC) plans, moved transcatheter tricuspid valve replacement procedure (0569T, 0570T) from TAVR policy to this policy.

12/01/2021 – Add Genicular Nerve Rhizotomy/Peripheral Nerve Ablation for the Treatment of Osteoarthritic Knee Pain as experimental and investigational.

02/01/2022 – Added Medicare variations to investigational procedures for genicular nerve ablation, high intensity focused ultrasound (HIFU), and Dextenza for use in drug eluting stents. SpaceOAR moved into its own policy. Format of references updated to correspond to the investigational procedure that is addressed in the policy.

10/01/2022 – Added 0404T, 30468, 58674, 64640 to policy.

02/01/2023 – Added Percutaneous ultrasonic ablation of soft tissue utilizing Tenex treatment.

04/01/2023 – Moved 55880 to the Prostate Cancer Interventions Policy.

06/01/2023 – Added Non-Contact Real time Fluorescent Wound Imaging (0598T and 0599T) to policy.

12/1/2023 – Percutaneous Peripheral Nerve Stimulator added, CPT 64555 to policy. Removed A9291.

01/01/2024 – 0404T deleted, replaced with CPT code 58580.

06/01/2024 – Moved Percutaneous Peripheral Nerve Stimulator (CPT 64555) to the Electrical Stimulation policy. 58580 no longer investigational and removed from policy. Sonata system uses transcervical radiofrequency ablation for the treatment of uterine fibroids is no longer investigational.

08/01/2024 – Removed absorbable nasal implants (CPT 30468) and moved into the sinus surgery medical policy. ChemoFx In vitro chemosensitivity assays (CPT Code: 81535, 81536) has been removed and is now managed in the In Vitro Chemoresistance and Chemosensitivity Assays Payment Policy. OVA1™ Overa™ (CPT Code: 81503) has been moved to the Serum Tumor Markers for Malignancies Payment Policy. Removed the Autoimmune (rheumatoid arthritis), analysis of 12 biomarkers using immunoassays (CPT Code: 81490) and now managed in the Multi-biomarker for Rheumatoid Arthritis Payment Policy. Percutaneous Pulmonary Valve Implantation (CPT 33477) is no longer investigational with coverage criteria added to the Cardiac Procedures Medical Policy, Respiratory Pathogen Nucleic Acid Detection Panels (87632, 87633, 0115U) have been moved to the Pathogen Panel Testing Payment Policy. Respiratory Pathogen Nucleic Acid Detection Panels (0202U, 0223U, 0225U) have been moved to the Coronavirus Testing in the Outpatient Setting Payment Policy. Added and Low Level Laser Therapy (LLLT), (CPT Code: 97037) and High Resolution Esophageal Pressure Topography (EndoFlip; CPT code: 91299).

09/15/2024 – Removed HCPCS Code S3722 for dose optimization by area under the curve (AUC) analysis, for infusional 5-fluorouracil because this is now managed in a payment policy Therapeutic Drug Monitoring for 5-Fluorouracil.

10/01/2024 – Added cryosurgical tumor ablation (CPT codes: 20983, 47383). Removed CPT Code: 32994 ablation therapy for pulmonary tumors. Added language excluding adjustable balloon continence devices. Added coverage for 0509T to Medicare plans.

02/01/2025 – Added Gastrointestinal Manometry (Motility Testing) (CPT Codes 91117, 91020, 91022).

06/01/2025- Removed CardioMems from this policy and put into Ambulatory Holter Monitors, removed Transcatheter Tricuspid Valve Procedures and moved them in the Cardiac Procedures Medical Policy, added CVAC Aspiration System (Calyxo CVAC System) All-in-One Kidney Stone Treatment C9761).

12/01/2025 - Updated section on electroretinography for clarity, updated section on vacuum aspiration kidney stone collection systems for clarity to make it general and not product specific, added exclusion for knee implanted shock absorbers.

01/01/2026 - 0029U, 0070U, 0071U, 0072U, 0073U, 0074U, 0075U, 0076U moved to M2021 Pharmacogenetic Testing Genetics Policy. CPT 88299 moved to M2146 General Genetic Testing, Somatic Disorders Genetics Policy. Gastrointestinal Pathogen Nucleic Detection Panels moved to M2149 Pathogen Panel Testing.

04/01/2026 – Genicular nerve blocks and other peripheral nerve destruction techniques (Code 0441T, 64624, 64640) moved to new policy Peripheral Nerve Destruction (Neurolysis) for Chronic Pain. Added reference for Nanoknife.

MVP Health Care Medical Policy

Lymphedema Compression Garments
Compression Stockings

Type of Policy:	DME
Prior Approval Date:	03/21/2024
Approval Date:	03/02/2026
Effective Date:	04/01/2026
Related Polices:	Pneumatic Compression Devices

Codes Requiring Prior Authorization

Prior authorization may vary by plan which means the codes listed below may be specific to one product or all products. Please refer to the product grid found at the end of this policy for detailed authorization requirements for specific plans.

A6593 - Accessory for gradient compression garment or wrap with adjustable straps, not otherwise specified

A6609 - Gradient compression bandaging supply, not otherwise specified

A9999 - Miscellaneous DME supply or accessory, not otherwise specified

A9900 - Miscellaneous DME supply, accessory, and/or service component of another HCPCS code

See MVP Durable Medical Equipment (DME) Prior Authorization List

https://www.mvphealthcare.com/utilization

Codes Requiring Retrospective Review

N/A

Experimental/Investigational

N/A

Common Diagnosis Codes

I87.2 – Venous insufficiency

I83.001 – I83.899 – Varicose veins

I89.0 – I89.9 – Other noninfective disorders of lymphatic vessels and lymph nodes

I95.1 – Orthostatic hypotension

I97.2 – Postmastectomy lymphedema syndrome

I97.89 Other postprocedural complications and disorders of the circulatory system, not elsewhere classified

Q82.0 – Hereditary lymphedema

Common Diagnosis Codes associated with this policy have been provided for informational purposes only. The list of codes may not be all-inclusive and may be updated to reflect any applicable revisions to the ICD-10 code set and/or medical necessity guidelines applied in this policy.

Common Procedure Codes

HCPCS Codes: A4465, A6515, A6516, A6517, A6518, A6519, A6520, A6521, A6522, A6523, A6524, A6525, A6526, A6527, A6528, A6529, A6530, A6531, A6532, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6544, A6545, A6552, A6553, A6554, A6555, A6556, A6557, A6558, A6559, A6560, A6561, A6562, A6563, A6564, A6565, A6566, A6567, A6568, A6569, A6570, A6571, A6572, A6573, A6574, A6575, A6576, A6577, A6578, A6579, A6580, A6581, A6582, A6583, A6584, A6585, A6586, A6587, A6588, A6589, A6593, A6594, A6595, A6596, A6597, A6598, A6599, A6600, A6601, A6602, A6603, A6604, A6605, A6606, A6607, A6608, A6609, A6610, A6611, S8420, S8421, S8422, S8423, S8424, S8425, S8426, S8427, S8428

Please refer to the product grid for detailed authorization requirements for specific plans. Codes requiring prior-authorization for some products may require retrospective review for plans that do not require prior-authorization. Common diagnosis codes are included for informational purposes only and every attempt has been made to update and keep these codes accurate. These codes may not be all inclusive. CPT codes are subject to change as replacement codes are adopted by CMS. Any codes related to CMS updates will be adopted and applied to this policy by MVP.

Overview

Lymphedema is a chronic condition characterized by the accumulation of lymph fluid in tissues, typically in the arms or legs. It occurs when the lymphatic system, which helps remove waste and excess fluid from the body, is impaired or damaged. The most common cause of lymphedema is the removal or damage of lymph nodes and vessels, often as a result of surgery or radiation therapy for cancer. Lymphedema compression garments are used for the purpose of preventing an increase in lymphedema and maintaining the reduction of lymphedema after treatment.

Lymphedema compression appliances include lymphedema compression garments, sleeves, gloves, and non-elastic binders. Gradient compression stockings or garments are made of elastic compression material used to provide static compression to

promote venous and/or lymphatic circulation. Gradient compression wraps, bandaging rolls, and supplies are also used to promote venous and/or lymphatic circulation.

Surgical stockings, also known as compression stockings or support stockings, are specialized hosiery garments designed to provide graduated compression to the legs. They are commonly used to improve blood circulation, reduce swelling, and prevent blood clots in the lower extremities. These stockings are commonly prescribed for individuals who have conditions like venous insufficiency, varicose veins, deep vein thrombosis (DVT), or those who have undergone surgery. They can be worn during and after surgical procedures to support recovery and minimize the risk of blood clots.

Surgical and gradient compression stockings have the greatest amount of compression at the ankle and gradually decrease as the garment comes up the leg towards the heart. Compression stockings will have at least 18 mmHg of compression to a maximum of 50 mmHg. There are many different compression stocking lengths available, such as above the knee, thigh length, below the knee, and full length. There are also many types of surgical stockings ranging in size and custom made. Compression stockings or garments are also known by various brand names such as Sigvaris, Mediven, Juzo, Jobst, Tribute (Solaris), and others.

A sleeve may be needed for lymphedema of the arm, and a glove or gauntlet may also be used if lymphedema is present in the hand. The compression garment may be prefabricated or custom fabricated for adequate graduated compression. Non-elastic binders provide static compression of the extremity without the use of elastic, but use wraps, adjustable velcro, or buckle straps.

Indications/Criteria:

Unless otherwise stipulated in the benefit plan language, compression stockings and compression garments are covered under the core medical benefits of the plan.

Graduated-compression garments (18 mmHg to 50 mmHg) are considered medically necessary for the following indications:

- Venous insufficiency
- Ulceration due to chronic venous insufficiency
- Varicose veins
- Phlebitis/Thrombophlebitis
- Deep vein thrombosis (DVT) prophylaxis during pregnancy and postpartum, or immobilization due to surgery, trauma, or debilitation;
- Orthostatic hypotension
- Edema following surgery, fracture, burns or other trauma.
- Postmastectomy lymphedema

Coverage is for both standard and custom fitted gradient compression garments of the extremities when the above criteria is met.

Custom compression stockings/garments are covered when:

- There is vascular impairment that requires compression garments.
- The customer's limb/body measurements are outside the manufacturer's parameters for ready-made or off-the-shelf garments.

Use of zippered gradient compression stockings is covered when:

- Customer meets coverage criteria for custom compression stockings/garments. The presence of an open wound or inability to don/doff non-zippered stockings if caregivers are not available.
- Detailed documentation of customer's dexterity/ability to don/doff zippered stockings if caregivers are not available.

A lymphedema compression garment for the upper extremities (e.g., sleeve, gauntlet, or stocking) is considered medically necessary for the treatment of chronic lymphedema and intractable lymphedema of the upper extremity after lymph node dissection related to cancer surgery. Custom lymphedema garments are covered when the customer's limb/body measurements are outside the manufacturer's parameters for the ready-made or off-the-shelf garments.

Non-elastic binders (e.g., Reidsleeve, Circaid) are covered for lymphedema which has failed a four (4) week course of treatment including a compression bandage garment, exercise, and elevation of the limb.

Coverage for lymphedema compression treatment items, when medically necessary, includes the following:

- Standard daytime gradient compression garments
- Custom daytime gradient compression garments
- Nighttime gradient compression garments
- Gradient compression wraps
- Accessories, such as zippers, linings, paddings, or fillers, necessary for the effective use of a gradient compression garment or wrap
- Compression bandaging systems and supplies

Custom-fitted or non-standard garments are uniquely sized and shaped to fit the exact dimensions of the affected extremity of a person to give accurate gradient compression to treat lymphedema. Gradient compression garments are designed differently for daytime or nighttime use. Daytime garments give a higher level of compression. Nighttime garments offer milder compression and are less snug against the skin.

The frequency limitations for replacement of lymphedema compression treatment items are:

- Once every 6 months for 3 gradient compression garments or wraps with adjustable straps per each affected extremity or part of the body
- Once every 2 years for 2 nighttime garments per each affected extremity or part of the body

A gradient compression stocking, below the knee, is a covered benefit for all MVP customers when it is used in the treatment of an open venous stasis ulcer.

The following gradients may be covered:

- 30-40mm/Hg (A6531); or
- 40-50mm/hg (A6532).

A non-elastic gradient compression wrap described by code A6545 is a covered benefit for all MVP customers when it is used in the treatment of an open venous stasis ulcer that is below the knee.

Exclusions

Gradient compression stockings are a disposable supply. If a product excludes coverage for a disposable supply, it is not covered, and medical policy criteria do not apply.

MVP Medicaid Managed Care (including CHP/HARP plans)

Providers are no longer able to bill MVP Managed Medicaid or HARP members for pharmacy and pharmacy related durable medical equipment and supplies because NYS Medicaid covers these items. This includes certain surgical stockings including A4495, A4500, and A4510 as designated by the New York State Department of Health.

The full list of codes that must be billed to Medicaid Fee-For-Service is located at https://www.emedny.org/ProviderManuals/DME/PDFS/MedicalSupply_Procedure_Codes.pdfProviders should bill these directly to New York State Medicaid Fee-For-Service using the Medicaid member client identification number (CIN) after 04/01/2023. Claims submitted directly to MVP for items that are carved out to Fee-For-Service will deny as not a covered benefit.

Compression Supports are covered for venous or lymphatic impairment covered by MVP Managed Medicaid.
Non-Custom
- Prefabricated elastic support garment that applies varying pressure gradients to an area.

- Prefabricated garments are available in various sizes, and different levels of compression.

- Prefabricated garments with appropriate level of compression (determined by the ordering provider) should be requested before custom is considered if the member's limb measurements fit within the size ranges specified by the manufacturers of the garment. Various manufacturers should be explored.

Custom

- Custom-made gradient compression stockings/garments are fabricated to the exact specifications of an individual.

- Custom made are considered medically necessary when the degree of gradient pressure is one that cannot be provided in a prefabricated garment, or the measurements fall outside the ranges of prefabricated garments.

- Custom HCPCS codes and fees include zippered compression garments.

Documentation Requirements

• A physician's fiscal order indicating the specific level of compression in mm/Hg, specific style, type, and hosiery knit, and any additional accessories/options

• Ordering provider's letter of medical necessity should include medical history, related diagnoses, duration, and extent of current symptoms, any neurological involvement of affected limbs, ambulation status and degree of assistance required.

• Current and previous decompression treatment modalities utilized, member's compliance with the modalities, and medical outcomes

• Detailed limb/body measurements obtained from a certified fitter or LANA certified therapist, and date measured. Indicate the location and degree of edematous lobules if present. Custom items require measurements documented by a certified fitter or LANA certified therapist.

- Plan of care for use of garments and goals.

Medicaid coverage for lymphedema garments and compression stockings is allowed twice per year.

Please note Medicaid does not provide coverage for the following compression garments: A6515, A6516, A6517, A6518, A6520, A6521, A6522, A6523, A6524, A6525, A6526, A6527, A6528, A6529, A6566, A6567, A6570, A6571, A6589, A6594, A6595,

A6596, A6597, A6598, A6599, A6600, A6601, A6602, A6603, A6604, A6605, A6606, A6607, A6608, A6609, A6611

MVP Medicare Plans Variation:

Medicare Advantage Plans cover compression treatment items only for the treatment of lymphedema, including postmastectomy lymphedema.

These items include lymphedema compression garments for the arms and legs and must be prescribed by a physician (or a physician assistant, nurse practitioner, or a clinical nurse specialist).

A lymphedema compression garment for the upper extremities (e.g., sleeve, gauntlet, or stocking) is considered medically necessary for the treatment of chronic lymphedema and intractable lymphedema of the upper extremity after lymph node dissection related to cancer surgery. Custom lymphedema garments are covered when the customer's limb/body measurements are outside the manufacturer's parameters for the ready-made or off-the-shelf garments.

Coverage for lymphedema compression treatment items, when medically necessary, includes the following:

- Standard daytime gradient compression garments [3 per body area once every six (6) months]
- Custom daytime gradient compression garments
- Nighttime gradient compression garments [2 per body area once every two (2) years]
- Gradient compression wraps
- Accessories, such as zippers, linings, paddings, or fillers, necessary for the effective use of a gradient compression garment or wrap
- Compression bandaging systems and supplies

A gradient compression stocking, below the knee, is a covered benefit for all MVP Medicare customers when it is used in the treatment of an open venous stasis ulcer.

The following gradients may be covered:

- 30-40mm/Hg (A6531); or
- 40-50mm/hg (A6532).

A non-elastic gradient compression wrap described by code A6545 is a covered benefit for all MVP Medicare customers when it is used in the treatment of an open venous stasis ulcer that is below the knee.

For additional information see the Noridian Healthcare Solutions Durable Medical Equipment Medicare Administrative Contractor, Local Coverage Article (LCA) A54563. Revision Effective Date: 05/01/2021. Available: MCD Search (cms.gov)

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4. New York State Medicaid Program. Durable Medical Equipment Orthotics, Prosthetics, and Supplies. Procedure Codes and Coverage Guidelines. Version 2.0(10/01/2025) Available: www.emedny.org/ProviderManuals/index.html

5. Federal Consolidated Appropriations Act, 2023. H.R. 2617-2 Title IV Section 4133 Available: BILLS-117hr2617enr.pdf (congress.gov)

6. Medicare Learning Network (MLN) Matters® Articles MM13286, November 9, 2023, Effective Date: January 1, 2025 Available: https://www.cms.gov/files/document/mm13286-lymphedema-compression-treatment-items-implementation.pdf

Customer Product	Medical Management Requirements*
New York Products	
HMO	Prior Auth
PPO In Plan	Prior Auth
PPO OOP	Prior Auth
POS In Plan	Prior Auth
POS OOP	Prior Auth
Essential Plan	Prior Auth
MVP Medicaid Managed Care	Prior Auth
MVP Child Health Plus	Prior Auth
MVP Harmonious Health Care Plan	Prior Auth
MVP Medicare Complete Wellness	Prior Auth
MVP Medicare Preferred Gold HMO POS	Prior Auth
MVP Medicare Secure Plus HMO POS	Prior Auth
MVP Medicare WellSelect PPO	Prior Auth
MVP DualAccess D-SNP HMO	Prior Auth
MVP DualAccess Complete D-SNP HMO	Prior Auth
Healthy NY	Prior Auth
MVP Premier	Prior Auth
MVP Premier Plus	Prior Auth
MVP Premier Plus HDHP	Prior Auth
MVP Secure	Prior Auth
MVP EPO	Prior Auth
MVP EPO HDHP	Prior Auth
MVP PPO	Prior Auth
MVP PPO HDHP	Prior Auth
ASO	See SPD
Vermont Products	
POS In Plan	Prior Auth
POS OOP	Prior Auth
MVP VT HMO	Prior Auth
MVP VT HDHP HMO	Prior Auth
MVP VT Plus HMO	Prior Auth
MVP VT Plus HDHP HMO	Prior Auth
MVP Secure	Prior Auth
ASO	See SPD
♦ Note: Prior authorization requirements for HDHP products are the same as the base product (e.g., HDHP HMO auth requirements are the same as listed for HMO).	

***Medical Management Requirements**

Prior Auth	Prior Authorization Required
Potential for Retrospective Review	No Prior Authorization Required. May be subject to Retrospective Review
Retro Review	Retrospective Review Required
Not Covered	Service is not a covered benefit.
See SPD	See Specific Plan Design

Revision History:

12/01/2022 – Annual review; added postmastectomy lymphedema to indications; added clarification language for MVP CHP and Medicare plan exclusions.

01/01/2023 – Added coverage to Child Health Plans (CHP).

01/01/2024 – Added Medicare Advantage Plan coverage of certain lymphedema compression treatment items: A4465, A6520, A6521, A6522, A6523, A6524, A6525, A6526, A6527, A6528, A6529, A6530, A6531, A6532, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6544, A6545, A6549, A6552, A6553, A6554, A6555, A6556, A6557, A6558, A6559, A6560, A6561, A6562, A6563, A6564, A6565, A6566, A6567, A6568, A6569, A6570, A6571, A6572, A6573, A6574, A6575, A6576, A6577, A6578, A6579, A6580, A6581, A6582, A6583, A6584, A6585, A6586, A6587, A6588, A6589, A6593, A6594, A6595, A6596, A6597, A6598, A6599, A6600, A6601, A6602, A6603, A6604, A6605, A6606, A6607, A6608, A6609, A6610. Added prior authorization to A6593 and A6609.

04/01/2024 - update to reflect carve out to original Medicaid of burn garments and surgical stockings and to be consistent with new Medicaid policy coverage guidelines which were just introduced effective 4/1/24.

04/01/2026 – Annual review; added A6515, A6516, A6517 to common codes, added codes to Medicaid that NYS does not cover, added quantities to Medicare allowable, updated links and references.

MVP Health Care Medical Policy

Lymphedema Compression Garments
Compression Stockings

Type of Policy:	DME
Prior Approval Date:	03/21/2024
Approval Date:	03/02/2026
Effective Date:	04/01/2026
Related Polices:	Pneumatic Compression Devices

Codes Requiring Prior Authorization

Prior authorization may vary by plan which means the codes listed below may be specific to one product or all products. Please refer to the product grid found at the end of this policy for detailed authorization requirements for specific plans.

A6593 - Accessory for gradient compression garment or wrap with adjustable straps, not otherwise specified

A6609 - Gradient compression bandaging supply, not otherwise specified

A9999 - Miscellaneous DME supply or accessory, not otherwise specified

A9900 - Miscellaneous DME supply, accessory, and/or service component of another HCPCS code

See MVP Durable Medical Equipment (DME) Prior Authorization List

https://www.mvphealthcare.com/utilization

Codes Requiring Retrospective Review

N/A

Experimental/Investigational

N/A

Common Diagnosis Codes

I87.2 – Venous insufficiency

I83.001 – I83.899 – Varicose veins

I89.0 – I89.9 – Other noninfective disorders of lymphatic vessels and lymph nodes

I95.1 – Orthostatic hypotension

I97.2 – Postmastectomy lymphedema syndrome

I97.89 Other postprocedural complications and disorders of the circulatory system, not elsewhere classified

Q82.0 – Hereditary lymphedema

Common Diagnosis Codes associated with this policy have been provided for informational purposes only. The list of codes may not be all-inclusive and may be updated to reflect any applicable revisions to the ICD-10 code set and/or medical necessity guidelines applied in this policy.

Common Procedure Codes

HCPCS Codes: A4465, A6515, A6516, A6517, A6518, A6519, A6520, A6521, A6522, A6523, A6524, A6525, A6526, A6527, A6528, A6529, A6530, A6531, A6532, A6533, A6534, A6535, A6536, A6537, A6538, A6539, A6540, A6541, A6544, A6545, ~~A6549,~~ A6552, A6553, A6554, A6555, A6556, A6557, A6558, A6559, A6560, A6561, A6562, A6563, A6564, A6565, A6566, A6567, A6568, A6569, A6570, A6571, A6572, A6573, A6574, A6575, A6576, A6577, A6578, A6579, A6580, A6581, A6582, A6583, A6584, A6585, A6586, A6587, A6588, A6589, A6593, A6594, A6595, A6596, A6597, A6598, A6599, A6600, A6601, A6602, A6603, A6604, A6605, A6606, A6607, A6608, A6609, A6610, A6611, S8420, S8421, S8422, S8423, S8424, S8425, S8426, S8427, S8428

Please refer to the product grid for detailed authorization requirements for specific plans. Codes requiring prior-authorization for some products may require retrospective review for plans that do not require prior-authorization. Common diagnosis codes are included for informational purposes only and every attempt has been made to update and keep these codes accurate. These codes may not be all inclusive. CPT codes are subject to change as replacement codes are adopted by CMS. Any codes related to CMS updates will be adopted and applied to this policy by MVP.

Overview

Lymphedema is a chronic condition characterized by the accumulation of lymph fluid in tissues, typically in the arms or legs. It occurs when the lymphatic system, which helps remove waste and excess fluid from the body, is impaired or damaged. The most common cause of lymphedema is the removal or damage of lymph nodes and ~~vessels~~vessels, often as a result of surgery or radiation therapy for cancer. Lymphedema compression garments are used for the purpose of preventing an increase in lymphedema and maintaining the reduction of lymphedema after treatment.

Lymphedema compression appliances include lymphedema compression garments, sleeves, gloves, and non-elastic binders. Gradient compression stockings or garments are made of elastic compression material used to provide static compression to

promote venous and/or lymphatic circulation. . Gradient compression wraps, bandaging rollsrolls, and supplies are also used to promote venous and/or lymphatic circulation.

Surgical stockings, also known as compression stockings or support stockings, are specialized hosiery garments designed to provide graduated compression to the legs. They are commonly used to improve blood circulation, reduce swelling, and prevent blood clots in the lower extremities. These stockings are commonly prescribed for individuals who have conditions like venous insufficiency, varicose veins, deep vein thrombosis (DVT), or those who have undergone surgery. They can be worn during and after surgical procedures to support recovery and minimize the risk of blood clots.

Surgical and gradient compression stockings have the greatest amount of compression at the ankle and gradually decrease as the garment comes up the leg towards the heart. Compression stockings will have at least 18 mmHg of compression to a maximum of 50 mmHg. There are many different compression stocking lengths available, such as above the knee, thigh length, below the knee, and full length. There are also many types of surgical stockings ranging in size and custom made. Compression stockings or garments are also known by various brand names such as Sigvaris, Mediven, Juzo, Jobst, Tribute (Solaris), and others.

A sleeve may be needed for lymphedema of the armarm, and a glove or gauntlet may also be used if lymphedema is present in the hand. The compression garment may be prefabricated or custom fabricated for adequate graduated compression. Non-elastic binders provide static compression of the extremity without the use of elastic, but use wraps, adjustable velcro, or buckle straps.

Indications/Criteria:

Unless otherwise stipulated in the benefit plan language, compression stockings and compression garments are covered under the core medical benefits of the plan.

Graduated-compression garments (18 mmHg to 50 mmHg) are considered medically necessary for the following indications:

- Venous insufficiency
- Ulceration due to chronic venous insufficiency
- Varicose veins
- Phlebitis/Thrombophlebitis
- Deep vein thrombosis (DVT) prophylaxis during pregnancy and postpartum, or immobilization due to surgery, traumatrauma, or debilitation;
- Orthostatic hypotension
- Edema following surgery, fracture, burns or other trauma.
- Postmastectomy lymphedema

Coverage is for both standard and custom fitted gradient compression garments of the extremities when the above criteria is met.

Custom compression stockings/garments are covered when:

- There is vascular impairment that requires compression garments.
- The customer's limb/body measurements are outside the manufacturer's parameters for ready-made or off-the-shelf garments.

Use of zippered gradient compression stockings is covered when:

- Customer meets coverage criteria for custom compression stockings/garments. The presence of an open wound or inability to don/doff non-zippered stockings if caregivers are not available.
- Detailed documentation of customer's dexterity/ability to don/doff zippered stockings if caregivers are not available.

A lymphedema compression garment for the upper extremities (e.g., sleeve, gauntlet, or stocking) is considered medically necessary for the treatment of chronic lymphedema and intractable lymphedema of the upper extremity ~~subsequent to~~after lymph node dissection related to cancer surgery. Custom lymphedema garments are covered when the customer's limb/body measurements are outside the manufacturer's parameters for the ready-made or off-the-shelf garments.

Non-elastic binders (e.g., Reidsleeve, Circaid) are covered for lymphedema which has failed a four (4) week course of treatment including a compression bandage garment, ~~exercise~~exercise, and elevation of the limb.

Coverage for lymphedema compression treatment items, when medically necessary, includes the following:

- Standard daytime gradient compression garments
- Custom daytime gradient compression garments
- ~~Nighttime~~Nighttime gradient compression garments
- Gradient compression wraps
- Accessories, such as zippers, linings, paddings, or fillers, necessary for the effective use of a gradient compression garment or wrap
- Compression bandaging systems and supplies

Custom-fitted or non-standard garments are uniquely sized and shaped to fit the exact dimensions of the affected extremity of a person to give accurate gradient compression to treat lymphedema. Gradient compression garments are designed differently for daytime or nighttime use. Daytime garments give a higher level of compression. Nighttime garments offer milder compression and are less snug against the skin.

The frequency limitations for replacement of lymphedema compression treatment items are:

- Once every 6 months for 3 gradient compression garments or wraps with adjustable straps per each affected extremity or part of the body
- Once every 2 years for 2 nighttime garments per each affected extremity or part of the body

A gradient compression stocking, below the knee, is a covered benefit for all MVP customers when it is used in the treatment of an open venous stasis ulcer.

The following gradients may be covered:

- 30-40mm/Hg (A6531); or
- 40-50mm/hg (A6532).

A non-elastic gradient compression wrap described by code A6545 is a covered benefit for all MVP customers when it is used in the treatment of an open venous stasis ulcer that is below the knee.

Exclusions

Gradient compression stockings are a disposable supply. If a product excludes coverage for a disposable supply, it is not covered, and medical policy criteria do not apply.

MVP Medicaid Managed Care (including CHP/HARP plans)

~~Effective April 1, 2023, p~~Providers are no longer able to bill MVP Managed Medicaid or HARP members for pharmacy and pharmacy related durable medical equipment and supplies because NYS Medicaid covers these items. This includes certain surgical stockings including A4495, A4500, and A4510 as designated by the New York State Department of Health.

The full list of codes that must be billed to Medicaid Fee-For-Service is located at ~~https://www.emedny.org/ProviderManuals/Pharmacy/index.aspx - See the OTC and Supply Fee Schedule.~~ https://www.emedny.org/ProviderManuals/DME/PDFS/MedicalSupply_Procedure_Codes.pdf

Providers should bill these directly to New York State Medicaid Fee-For-Service using the Medicaid member client identification number (CIN) after 04/01/2023. Claims submitted directly to MVP for items that are carved out to Fee-For-Service will deny as not a covered benefit.

Compression Supports are cCovered for venous or lymphatic impairment covered by MVP Managed Medicaid.

Non-Custom

- Prefabricated elastic support garment that applies varying pressure gradients to an area.

- Prefabricated garments are available in various sizes, and different levels of compression.

- Prefabricated garments with appropriate level of compression (determined by the ordering provider) should be requested before custom is considered if the member's limb measurements fit within the size ranges specified by the manufacturers of the garment. Various manufacturers should be explored.

Custom

- Custom-made gradient compression stockings/garments are fabricated to the exact specifications of an individual.

- Custom made are considered medically necessary when the degree of gradient pressure is one that cannot be provided in a prefabricated garment, or the measurements fall outside the ranges of prefabricated garments.

- Custom HCPCS codes and fees include zippered compression garments.

Documentation Requirements

• A physician's fiscal order indicating the specific level of compression in mm/Hg, specific style, type, and hosiery knit, and any additional accessories/options

• Ordering provider's letter of medical necessity should ~~include:~~include medical history, related diagnoses, ~~duration~~duration, and extent of current symptoms, any neurological involvement of affected limbs, ambulation status and degree of assistance required.

• Current and previous decompression treatment modalities utilized, ~~and member's compliance~~member's compliance with the modalities, and medical outcomes

• Detailed limb/body measurements obtained from a certified fitter or LANA certified therapist, and date measured. Indicate the location and degree of edematous ~~lobules, if~~lobules if present. Custom items require measurements documented by a certified fitter or LANA certified therapist.

- Plan of care for use of garments and goals.

Medicaid coverage for lymphedema garments and compression stockings is allowed ~~for 2 pairs~~ twice per year~~, one to wash and one to wear.~~

Please note Medicaid does not provide coverage for the following compression garments: A6515, A6516, A6517, A6518, A6520, A6521, A6522, A6523, A6524, A6525, A6526, A6527, A6528, A6529, A6566, A6567, A6570, A6571, A6589, A6594, A6595, A6596, A6597, A6598, A6599, A6600, A6601, A6602, A6603, A6604, A6605, A6606, A6607, A6608, A6609, A6611

MVP Medicare Plans Variation:

Medicare Advantage Plans cover compression treatment items only for the treatment of lymphedema, including postmastectomy lymphedema.

These ~~items,~~items include lymphedema compression garments for the arms and ~~legs, and~~legs and must be prescribed by a physician (or a physician assistant, nurse practitioner, or a clinical nurse specialist).

A lymphedema compression garment for the upper extremities (e.g., sleeve, gauntlet, or stocking) is considered medically necessary for the treatment of chronic lymphedema and intractable lymphedema of the upper extremity after lymph node dissection related to cancer surgery. Custom lymphedema garments are covered when the customer's limb/body measurements are outside the manufacturer's parameters for the ready-made or off-the-shelf garments.

Coverage for lymphedema compression treatment items, when medically necessary, includes the following:

- Standard daytime gradient compression garments [3 per body area once every six (6) months]
- Custom daytime gradient compression garments
- Nighttime gradient compression garments [2 per body area once every two (2) years]
- Gradient compression wraps
- Accessories, such as zippers, linings, paddings, or fillers, necessary for the effective use of a gradient compression garment or wrap
- Compression bandaging systems and supplies

A gradient compression stocking, below the knee, is a covered benefit for all MVP Medicare customers when it is used in the treatment of an open venous stasis ulcer.

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For additional information see the Noridian Healthcare Solutions Durable Medical Equipment Medicare Administrative Contractor, Local Coverage Article (LCA) A54563. Revision Effective Date: 05/01/2021. Available: MCD Search (cms.gov)

Medicare Learning Network (MLN) Matters® Articles MM13286, November 9, 2023, Effective Date: January 1, 2024 Available: lymphedema-compression-treatment-items-implementation.pdf

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References (Reviewed 2023):

1. Centers For Medicare & Medicaid Services (CMS) Palmetto GBA. Lymphedema Compression Treatment Items – Correct Coding and Billing – Revised. ©2025 Palmetto GBA, LLC. Available: https://www.dmepdac.com/palmetto/PDACv2.nsf/DID/32JJ9E1H3K

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MVP Harmonious Health Care Plan	Prior Auth
MVP Medicare Complete Wellness	Prior Auth
MVP Medicare Preferred Gold HMO POS	Prior Auth
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MVP Premier	Prior Auth
MVP Premier Plus	Prior Auth
MVP Premier Plus HDHP	Prior Auth
MVP Secure	Prior Auth
MVP EPO	Prior Auth
MVP EPO HDHP	Prior Auth
MVP PPO	Prior Auth
MVP PPO HDHP	Prior Auth
Student Health Plans	Prior Auth
ASO	See SPD
Vermont Products	
POS In Plan	Prior Auth
POS OOP	Prior Auth
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♦ Note: Prior authorization requirements for HDHP products are the same as the base product (e.g., HDHP HMO auth requirements are the same as listed for HMO).	

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Potential for Retrospective Review	No Prior Authorization Required. May be subject to Retrospective Review
Retro Review	Retrospective Review Required
Not Covered	Service is not a covered benefit.
See SPD	See Specific Plan Design

Revision History:

12/01/2022 – Annual review; added postmastectomy lymphedema to indications; added clarification language for MVP CHP and Medicare plan exclusions.

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04/01/2026 – Annual review; added A6515, A6516, A6517 to common codes, added codes to Medicaid that NYS does not cover, added quantities to Medicare allowable, updated links and references.

MVP Health Care Medical Policy

Medical Policy Development, Implementation and Review Process

Type of Policy:	N/A
Prior Approval Date:	02/05/2024
Approval Date:	01/05/2026
Effective Date:	04/01/2026
Related Polices:	Pharmacy Programs Administration
	Evaluation of New Technology, Procedures, Behavioral Health Services, and Programs

Objective

The purpose of medical policies is to provide criteria for determining coverage for new and existing technologies including medical/surgical procedures, drugs, behavioral health procedures, and medical devices.

The process for evaluating pharmaceuticals can be found in the Pharmacy Programs Administration Policy.

Policy

Medical policies are based on the most recent evidence-based literature and research available. The indications/criteria and the exclusions/limitations listed within each medical policy should not be considered all inclusive. Medical Directors review indications for any service on an individual basis for medical necessity taking into consideration the individual circumstances of the customer and the capabilities of the local delivery system.

The MVP Medical Affairs Department is responsible for research and assessment of new and existing medical technologies, drugs, devices, and behavioral health treatments. The Medical Affairs Department develops and modifies policies with consideration of input from network providers. All medical policies are approved through the organization's Quality Improvement structure.

If there are any conflicts between medical policy guidelines and applicable contract language, the contract language takes precedence. Medical policy is not intended to override the health insurance contract that defines the insured's benefits, nor is it intended to dictate to providers how to practice medicine.

Procedure

Standard Review of New Medical Policies

1. Requests for the development of a new medical policy or evaluation of technology may come from internal or external sources.

   Internal sources include:

   - Sales/Marketing based upon product development;
   - Customer Care Center based on benefit questions from customers;
   - Case/Disease Management staff based on customer issues during care management;
   - Utilization Management based on recurring authorization issues;
   - Behavioral Health based on new standards of care;
   - Provider Services, Provider Network, and Utilization Management based on practitioner trends;
   - Medical Policy Task Force based on ongoing review of the medical literature; and
   - Pharmacy Management based on new technology or standards of care related to medication therapies.

   External sources include:

   - contracted at-risk entities and hospital delivery systems;
   - plan providers;
   - regional IPAs;
   -
   - healthcare delivery systems;
   - physicians

   Internal and external requests for policy development or technology assessment are referred to the Chairperson of the Medical Policy Task Force. (See the Evaluation of New Technology, Procedures, Behavioral Health Services and Programs Policy in the Benefits Interpretation Manual.)

2. An extensive review of the medical literature is completed. Information is obtained from various sources. Examples include:

- Contracted research company (Symplr Software LLC. formally Hayes Inc.);
- Centers for Medicare and Medicaid Services (CMS) Policy and Coverage Analysis, National Coverage Determinations (NCD), and Local Coverage Determinations (LCD);
- Peer-reviewed publications;
- Websites (e.g.., UpToDate, MEDLINE, AIDSLINE, CANCERLINK);
- National Institute of Health (NIH), Centers for Disease Control (CDC), and Food and Drug Administration (FDA);
- Evidence-based clinical practice guidelines developed by national organizations and other recognized authorities such as The United States Preventative Services Task Force (USPSTF), American Medical Association (AMA), American College of Physicians, the American College of Obstetricians and Gynecologists (ACOG), American Academy of Pediatrics (AAP), American Psychiatric Association (APA) and American Academy of Child and Adolescent Psychiatry.

3. Specialty and panel physician opinion is sought. Providers are consulted virtually, electronically, and through written communication.
4. A policy is drafted and reviewed by the Medical Policy Task Force. The draft policy is sent for internal and external review. This review typically is done over a 14-day period. External opinions are sought from at-risk entities, panel physicians. Internal opinions are sought from a variety of areas including opinions from the Regional and IPA/Provider Organization Medical Directors, Quality, Pharmacy, Utilization Management, Operations, the Legal Department and Professional Relations.
5. Comments provided during the External and Internal Review are considered by the Medical Policy Task Force and incorporated into the policy as deemed appropriate.
6. The updated policy is presented to the Medical Management Committee for review and recommendation.
7. Policies recommended by the Medical Management Committee are presented to the Quality Improvement Committee for review and approval at the next Quality Improvement Committee meeting.
8. New and revised policies are communicated to practitioners by Provider Bulletin/Newsletter or FastFax memo after approval by the Quality Improvement Committee. Upon request, copies of a benefit interpretation used to make a determination are forwarded to the requesting provider.

Standard Review of Existing Medical Policies

All existing medical policies are reviewed at least annually by a Medical Director, undergo 14-day review and are presented to the Medical Management Committee and

the Quality Improvement Committee. Input from MVP internal departments, panel providers including experts in selected specialties, and the Medical Policy Task Force is sought to determine which policies require a full comprehensive review. A comprehensive review will be done on each policy at least once every two years but may occur any time when new evidence is available in the medical literature.

1. The policies identified for comprehensive review follow the same review process documented for new medical policies (14-day review and MMC and QIC committee process) when there has been a significant change in medical evidence or change in criteria. The policies that are reviewed during the comprehensive process and are not changed by medical evidence or do not have a significant change in criteria, content or wording, may be endorsed by Medical Directors.
2. Policies recommended by the Medical Management Committee are communicated to the Quality Improvement Committee at the next Quality Improvement Committee meeting.
3. Policy approval is communicated throughout the organization and appropriate medical management activities are implemented. Appropriate notice is given to plan providers.
4. New or revised clinical review criteria for any gender-affirming treatments must be submitted to New York State Office of Mental Health no later than 60 days prior to the date of implementation. New or revised review criteria for any gender-affirming treatments in any MVP medical policies may not be implemented without prior approval from New York State Office of Mental Health.

Fast Track Review of New and Existing Medical Policies

An expedited review of a new medical policy or revisions to an existing policy is necessary for the following:

- when the standard review time would be detrimental to MVP customers;
- clarification of an existing policy interpretation;
- coverage of a technology that is not available in a medical policy or in the customer contract; or
- Government mandates.

Policies appropriate for Fast Track Review may come from internal or external sources including:

- Customer Services or Customer Appeals;
- Legal;
- Medical Directors;
- Utilization Management;

- ongoing review of the medical literature;
- Pharmacy Management; or
- Network Providers.

Process for Fast Track

1. Two MVP Healthcare Medical Directors will review the medical policy, and the clinical information prepared by staff. Appropriate provider review will be obtained.
2. The proposed benefit interpretation will be sent to all Medical Directors via email for immediate review with an expected date of reply not to exceed 10 business days.
3. After Medical Director Review, revisions will be incorporated into the medical policy as appropriate.
4. The medical policy will be implemented with provisional approval.

The policy will then follow the standard comprehensive review process and will be presented to the Medical Management Committee for recommendation and the Quality Improvement Committee for full approval.

Revision History:

04/01/2022 - updated medical literature references that are reviewed, removed references to senior medical director.

04/01/2024 – Annual review; added contract references to overview, removed external sources that no longer exist, updated external review sources.

04/01/2026 – Annual review; updated external review resources, removed references to eviCore, updated resource used for clinical guideline review.

MVP Health Care Medical Policy

Medical Policy Development, Implementation and Review Process

Type of Policy:	N/A
Prior Approval Date:	02/05/2024
Approval Date:	01/05/2026
Effective Date:	04/01/2026
Related Polices:	Pharmacy Programs Administration
	Evaluation of New Technology, Procedures, Behavioral Health Services, and Programs

Objective

The purpose of medical policies is to provide criteria for determining coverage for new and existing technologies including medical/surgical procedures, drugs, behavioral health procedures, and medical devices.

The process for evaluating pharmaceuticals can be found in the Pharmacy Programs Administration Policy.

Policy

Medical policies are based on the most recent evidence-based literature and research available. The indications/criteria and the exclusions/limitations listed within each medical policy should not be considered all inclusive. Medical Directors review indications for any service on an individual basis for medical necessity taking into consideration the individual circumstances of the customer and the capabilities of the local delivery system.

The MVP Medical Affairs Department is responsible for research and assessment of new and existing medical technologies, drugs, devices, and behavioral health treatments. The Medical Affairs Department develops and modifies policies with consideration of input from network providers. All medical policies are approved through the organization's Quality Improvement structure.

If there are any conflicts between medical policy guidelines and applicable contract language, the contract language takes precedence. Medical policy is not intended to override the health insurance contract that defines the insured's benefits, nor is it intended to dictate to providers how to practice medicine.

Procedure

Standard Review of New Medical Policies

1. Requests for the development of a new medical policy or evaluation of technology may come from internal or external sources.

   Internal sources include:

   - Sales/Marketing based upon product development;
   - Customer Care Center based on benefit questions from customers;
   - Case/Disease Management staff based on customer issues during care management;
   - Utilization Management based on recurring authorization issues;
   - Behavioral Health based on new standards of care;
   - Provider Services, Provider Network, and Utilization Management based on practitioner trends;
   - Medical Policy Task Force based on ongoing review of the medical literature; and
   - Pharmacy Management based on new technology or standards of care related to medication therapies.

   External sources include:

   - contracted at-risk entities and hospital delivery systems;
   - ~~CTAAB (Community Technology Assessment Advisory Board);~~
   - plan providers;
   - regional IPAs;
   - ~~physician hospital organizations;~~
   - healthcare delivery systems;
   - ~~eviCore©; and~~
   - physician~~s organizations~~

   Internal and external requests for policy development or technology assessment are referred to the ~~Chairman~~Chairperson of the Medical Policy Task Force. (See the Evaluation of New Technology, Procedures, Behavioral Health Services and Programs Policy in the Benefits Interpretation Manual.)

2. An extensive review of the medical literature is completed. Information is obtained from various sources. Examples include:
    - Contracted research company (Symplr Software LLC. formally Hayes Inc.);
    - Centers for Medicare and Medicaid Services (CMS) Policy and Coverage Analysis, National Coverage Determinations (NCD~~)~~), and Local Coverage Determinations (LCD);
    - Peer-reviewed publications;
    - ~~Internet~~ Websites (e.g.~~,~~ i.e., ~~Physician On-line,~~ UpToDate, MEDLINE, AIDSLINE, CANCERLINK);
    - National Institute of Health (NIH), Centers for Disease Control (CDC), and Food and Drug Administration (FDA);
    - Evidence-based clinical practice guidelines developed by national organizations and other recognized authorities such as ~~the~~ The United States Preventative Services Task Force (USPSTF), American Medical Association (AMA), American College of Physicians, the American College of Obstetricians and Gynecologists (ACOG), American Academy of Pediatrics (AAP), American Psychiatric Association (APA) and American Academy of Child and Adolescent Psychiatry.
3. Specialty and panel physician opinion is sought. Providers are consulted virtually, ~~electronically, and~~electronically, and through written communication.
4. A policy is drafted and reviewed by the Medical Policy Task Force. The draft policy is sent for internal and external review. This review typically is done over a 14-day period. External opinions are sought from at-risk entities, panel physicians. Internal opinions are sought from a variety of areas including opinions from the Regional and IPA/Provider Organization Medical Directors, Quality, Pharmacy, Utilization Management, Operations, the Legal Department and Professional Relations.
5. Comments provided during the External and Internal Review are considered by the Medical Policy Task Force and incorporated into the policy as deemed appropriate.
6. The updated policy is presented to the Medical Management Committee for review and recommendation.
7. Policies recommended by the Medical Management Committee are presented to the Quality Improvement Committee for review and approval at the next Quality Improvement Committee meeting.
8. New and revised policies are communicated to practitioners by Provider Bulletin/Newsletter or FastFax memo after approval by the Quality Improvement Committee. Upon request, copies of a benefit interpretation used to make a determination are forwarded to the requesting provider.

Standard Review of Existing Medical Policies

All existing medical policies are reviewed at least annually by a Medical Director, undergo 14-day review and are presented to the Medical Management Committee and the Quality Improvement Committee. Input from MVP internal departments, panel providers including experts in selected specialties, and the Medical Policy Task Force is sought to determine which policies require a full comprehensive review~~.~~. A comprehensive review will be done on each policy at least once every two years but may occur any time when new evidence is available in the medical literature.

1. The policies identified for comprehensive review follow the same review process documented for new medical policies (14-day review and MMC and QIC committee process) when there has been a significant change in medical evidence or change in criteria. The policies that are reviewed during the comprehensive process and are not changed by medical evidence or do not have a significant change in criteria, content or wording, may be endorsed by ~~two senior level~~ Medical Directors.
2. Policies recommended by the Medical Management Committee are communicated to the Quality Improvement Committee at the next Quality Improvement Committee meeting.
3. Policy approval is communicated throughout the organization and appropriate medical management activities are implemented. Appropriate notice is given to plan providers.
4. New or revised clinical review criteria for any gender-affirming ~~treatments,~~treatments must be submitted to New York State Office of Mental Health no later than 60 days prior to the date of implementation. New or revised review criteria for any gender-affirming treatments in any MVP medical policies may not be implemented without prior approval from New York State Office of Mental Health.

Fast Track Review of New and Existing Medical Policies

An expedited review of a new medical policy or revisions to an existing policy is necessary for the following:

- when the standard review time would be detrimental to MVP customers;
- clarification of an existing policy interpretation;
- coverage of a technology that is not available in a medical policy or in the customer contract; or
- Government mandates.

Policies appropriate for Fast Track Review may come from internal or external sources including:

- Customer Services or Customer Appeals;

- Legal;
- Medical Directors;
- Utilization Management;
- ongoing review of the medical literature;
- Pharmacy Management; or
- Network Providers.

Process for Fast Track

1. Two MVP Healthcare Medical Directors will review the medical policy, and the clinical information prepared by staff. Appropriate provider review will be obtained.
2. The proposed benefit interpretation will be sent to all Medical Directors via email for immediate review with an expected date of reply not to exceed 10 business days.
3. After Medical Director Review, revisions will be incorporated ~~in~~into the medical policy as appropriate.
4. The medical policy will be implemented with provisional approval.

The policy will then follow the standard comprehensive review process and will be presented to the Medical Management Committee for recommendation and the Quality Improvement Committee for full approval.

Revision History:

04/01/2022 - updated medical literature references that are reviewed, removed references to senior medical director.

04/01/2024 – Annual review; added contract references to overview, removed external sources that no longer exist, updated external review sources.

04/01/2026 – Annual review; updated external review resources, removed references to eviCore, updated resource used for clinical guideline review.

MVP Health Care Medical Policy

Needle-Free Insulin Injectors

Type of Policy:	DME
Prior Approval Date:	02/05/2024
Approval Date:	01/05/2026
Effective Date:	04/01/2026
Related Polices:	N/A

Codes Requiring Prior Authorization

Prior authorization may vary by plan which means the codes listed below may be specific to one product or all products. Please refer to the product grid found at the end of this policy for detailed authorization requirements for specific plans.

N/A

Codes Subject to Retrospective Review

HCPCS code	Description
A4210	Needle-free injection device, each

Experimental/Investigational

Experimental codes are not covered.

N/A

Common Diagnosis Codes

N/A

Common Procedure Codes

N/A

Please refer to the product grid for detailed authorization requirements for specific plans. Codes requiring prior-authorization for some products may require retrospective review for plans that do not require prior-authorization. Common diagnosis codes are included for informational purposes only and every attempt has been made to update and keep these codes accurate. These codes may not be all inclusive. CPT codes are subject to change as replacement codes are adopted by CMS. Any codes related to CMS updates will be adopted and applied to this policy.

Overview

These injectors are needle-free devices that inject insulin, under pressure, through the skin and into the subcutaneous tissue. They deliver a micro-fine jet of insulin when the tip is placed against the injection site and the button is pressed.

Indications/Criteria

Needle-free insulin injectors are considered not medically necessary as there are other alternatives for insulin administration available.

Medicare Variation

Medical supplies directly associated with delivering insulin to the body, including syringes, needles, alcohol swabs, gauze, and insulin injection delivery devices not otherwise covered under Medicare Part B, such as insulin pens, pen supplies, and needle-free syringes, can satisfy the definition of a Part D drug.

Exclusions

See Medicare Variation above.

References (Reviewed 2026)

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Customer Product	Medical Management Requirements*
New York Products	
HMO	Retrospective Review
PPO in Plan	Retrospective Review
PPO OOP	Retrospective Review
POS in Plan	Retrospective Review
POS OOP	Retrospective Review
Essential Plan	Retrospective Review
MVP Medicaid Managed Care	Retrospective Review
MVP Child Health Plus	Retrospective Review
MVP Harmonious Health Care Plan	Retrospective Review
MVP Medicare Complete Wellness	Retrospective Review
MVP Medicare Preferred Gold HMO POS	Retrospective Review
MVP Medicare Secure Plus HMO POS	Retrospective Review
MVP Medicare WellSelect PPO	Retrospective Review
MVP DualAccess D-SNP HMO	Retrospective Review
MVP DualAccess Complete D-SNP HMO	Retrospective Review
USA Care PPO	Potential for Retrospective Review
Healthy NY	Retrospective Review
MVP Premier	Retrospective Review
MVP Premier Plus	Retrospective Review
MVP Premier Plus HDHP	Retrospective Review
MVP EPO	Retrospective Review
MVP EPO HDHP	Retrospective Review
MVP PPO	Retrospective Review
MVP PPO HDHP	Retrospective Review
ASO	See SPD
Vermont Products	
POS in Plan	Retrospective Review
POS OOP	Retrospective Review
Gold AnyWhere PPO	Retrospective Review
MVP VT HMO	Retrospective Review
MVP VT HDHP HMO	Retrospective Review
MVP VT Plus HMO	Retrospective Review
MVP VT Plus HDHP HMO	Retrospective Review
ASO	See SPD
♦ Note: Prior authorization requirements for HDHP products are the same as the base product (e.g. HDHP HMO auth requirements are the same as listed for HMO).	

***Medical Management Requirements**

Prior Auth	Prior Authorization Required
Potential for Retrospective Review	No Prior Authorization Required. May be subject to Retrospective Review
Retro Review	Retrospective Review Required
Not Covered	Service is not a covered benefit.
See SPD	See Specific Plan Design

Review History:

02/01/2022 – Annual review with no changes to the indications or criteria in the policy.

04/01/2024 – Annual review with no changes to criteria.

04/01/2026 – Annual review with no changes to criteria, update to links.

MVP Health Care Medical Policy

Peripheral Nerve Destruction (Neurolysis) for Chronic Pain

Type of Policy:	Surgical
Prior Approval Date:	n/a
Approval Date:	01/05/2026
Effective Date:	04/01/2026
Related Polices:	none

Codes Requiring Prior Authorization

Prior authorization may vary by plan which means the codes listed below may be specific to one product or all products. Please refer to the product grid found at the end of this policy for detailed authorization requirements for specific plans.

None

Codes Requiring Retrospective Review

0440T - Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve

0441T - Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve

0442T - Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (e.g., brachial plexus, pudendal nerve)

C9808 - Nerve cryoablation probe (e.g., cryoICE, cryoSPHERE, cryoSPHERE MAX, cryo2), including probe and all disposable system components, nonopioid medical device

C9809 - Cryoablation needle (e.g., iovera system), including needle/tip and all disposable system components, nonopioid medical device

64624 - Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed

64632 - Destruction by neurolytic agent; plantar common digital nerve

64640 - Destruction by neurolytic agent; other peripheral nerve or branch

64999 - Unlisted procedure, nervous system

Experimental/Investigational

0440T - Ablation, percutaneous, cryoablation, includes imaging guidance; upper extremity distal/peripheral nerve

0441T - Ablation, percutaneous, cryoablation, includes imaging guidance; lower extremity distal/peripheral nerve

0442T - Ablation, percutaneous, cryoablation, includes imaging guidance; nerve plexus or other truncal nerve (e.g., brachial plexus, pudendal nerve)

C9808 - Nerve cryoablation probe (e.g., cryoICE, cryoSPHERE, cryoSPHERE MAX, cryo2), including probe and all disposable system components, nonopioid medical device

C9809 - Cryoablation needle (e.g., iovera system), including needle/tip and all disposable system components, nonopioid medical device

64624 - Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed

64632 - Destruction by neurolytic agent; plantar common digital nerve(s)

64640 - Destruction by neurolytic agent; other peripheral nerve or branch

64999 - Unlisted procedure, nervous system

Common Diagnosis Codes

Common Diagnosis Codes associated with this policy have been provided for informational purposes only. The list of codes may not be all-inclusive and may be updated to reflect any applicable revisions to the ICD-10 code set and/or medical necessity guidelines applied in this policy.

Common Procedure Codes

CPT Codes: 61790, 61791, 64600, 64605, 64610

HCPCS Codes: none

Please refer to the product grid for detailed authorization requirements for specific plans. Codes requiring prior-authorization for some products may require retrospective review for plans that do not require prior-authorization. Common diagnosis codes are included for informational purposes only and every attempt has been made to update and keep these codes accurate. These codes may not be all inclusive. CPT codes are subject to change as replacement codes are adopted by CMS. Any codes related to CMS updates will be adopted and applied to this policy by MVP.

Overview

Peripheral nerve destruction may be performed using cryoablation/cryoneurolysis, electrical, laser, chemical, and radiofrequency ablation, either alone or in combination, for the treatment of many chronic pain conditions including sacroiliac joint, knee, and foot pain, headache, and/or trigeminal neuralgia. These techniques are used to address

pain resulting from complex regional pain syndrome, peripheral nerve entrapment or compression, and peripheral neuropathies.

Peripheral nerve blocks with local anesthetic (e.g., lidocaine) and/or steroids are not neurolysis.

Indications/Criteria

Peri-operative blocks (with local anesthetic and/or steroid)

Peri-operative blocks (i.e., Genicular nerve block) are considered medically necessary for peri-operative analgesia and/or surgical anesthesia for postoperative pain management.

Trigeminal neuralgia

Peripheral nerve destruction using ablation is considered medically necessary for treatment of trigeminal neuralgia refractory to other alternative treatments (e.g., medication, microdecompression).

Exclusions

Not meeting criteria under indications criteria in this policy.

Other peripheral nerve destruction

Peripheral nerve destruction using cryoablation, laser, electrical, chemical or radiofrequency ablation is considered experimental and investigational for treatment of ANY of the following conditions, including but not limited to:

- sacroiliac joint pain
- knee pain
- hip pain
- shoulder pain
- foot/heel pain
- Morton's neuroma
- headache
- occipital neuralgia
- intercostal neuralgia
- lower extremity pain resulting from any of the following:
    - complex regional pain syndrome
    - peripheral nerve entrapment/compression (e.g., tarsal tunnel syndrome, sciatica)
    - peripheral neuropathy

Percutaneous cryoneurolysis (e.g., Iovera System) is investigational for any indication (other than trigeminal neuralgia) including, but not limited to, knee osteoarthritis or before/during/after total knee replacement surgery. (HCPCS Code: C9809)

Medicare Variation

Neurolysis is a covered benefit for Medicare plans according to the Noridian Healthcare Solutions, LLC Medicare Local Coverage Determination (LCD) Nerve Blockade for Treatment of Chronic Pain and Neuropathy (L35456).

For Monton's neuroma see Noridian Healthcare Solutions, LLC Medicare Local Coverage Determination (LCD) and (ACD) Injections - Tendon, Ligament, Ganglion Cyst, Tunnel Syndromes and Morton's Neuroma (L34218 & A57079).

Genicular Nerve Rhizotomy/Peripheral Nerve Ablation and Genicular Nerve Block are a covered benefit for Medicare plans according to the National Government Services (NGS) Medicare Local Coverage Determination (LCD) for Peripheral Nerve Blocks (L36850).

References (2026)

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Member Product	Medical Management Requirements*
New York Products	
HMO	Potential for Retrospective Review
PPO in Plan	Potential for Retrospective Review
PPO OOP	Potential for Retrospective Review
POS in Plan	Potential for Retrospective Review
POS OOP	Potential for Retrospective Review
Essential Plan	Potential for Retrospective Review
MVP Medicaid Managed Care	Potential for Retrospective Review
MVP Child Health Plus	Potential for Retrospective Review
MVP Harmonious Health Care Plan	Potential for Retrospective Review
MVP Medicare Complete Wellness	Potential for Retrospective Review
MVP Medicare Preferred Gold HMO POS	Potential for Retrospective Review
MVP Medicare Secure Plus HMO POS	Potential for Retrospective Review
MVP Medicare WellSelect PPO	Potential for Retrospective Review
USA Care PPO	Potential for Retrospective Review
MVP DualAccess D-SNP HMO	Potential for Retrospective Review
MVP DualAccess Complete D-SNP HMO	Potential for Retrospective Review
Healthy NY	Potential for Retrospective Review
MVP Premier	Potential for Retrospective Review
MVP Premier Plus	Potential for Retrospective Review
MVP Premier Plus HDHP	Potential for Retrospective Review
MVP Secure	Potential for Retrospective Review
MVP EPO	Potential for Retrospective Review
MVP EPO HDHP	Potential for Retrospective Review
MVP PPO	Potential for Retrospective Review
MVP PPO HDHP	Potential for Retrospective Review
ASO	See SPD
Vermont Products	
POS in Plan	Potential for Retrospective Review
POS OOP	Potential for Retrospective Review
MVP VT HMO	Potential for Retrospective Review
MVP VT HDHP HMO	Potential for Retrospective Review
MVP VT Plus HMO	Potential for Retrospective Review
MVP VT Plus HDHP HMO	Potential for Retrospective Review
MVP Secure	Potential for Retrospective Review
ASO	See SPD
♦ Note: Prior authorization requirements for HDHP products are the same as the base product (e.g., HDHP HMO auth requirements are the same as listed for HMO).	

***Medical Management Requirements**

Prior Auth	Prior Authorization Required
Potential for Retrospective Review	No Prior Authorization Required. May be subject to Retrospective Review.
Retro Review	Retrospective Review Required
Not Covered	Service is not a covered benefit.
See SPD	See Specific Plan Design

Revision History:

04/01/2026 – New Policy Effective.

MVP Health Care Medical Policy

Peripheral Nerve Stimulators (Percutaneous/Implanted)

Type of Policy:	Surgical
Prior Approval Date:	n/a
Approval Date:	01/05/2026
Effective Date:	04/01/2026
Related Polices:	Electrical Nerve Stimulators Sacral Nerve Stimulation and Percutaneous Nerve Stimulation Vagus Nerve Stimulation

Codes Requiring Prior Authorization

Prior authorization may vary by plan which means the codes listed below may be specific to one product or all products. Please refer to the product grid found at the end of this policy for detailed authorization requirements for specific plans.

None

Codes Requiring Retrospective Review

64555 - Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)

64575 - Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)

64585 - Revision or removal of peripheral neurostimulator electrode array

64596 - Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array

64597 - Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; each additional electrode array

64598 - Revision or removal of neurostimulator electrode array, peripheral nerve, with integrated neurostimulator

64687 - Percutaneous electrical nerve field stimulation, cranial nerves, without implantation**Experimental/Investigational**

64555 - Percutaneous implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)

64575 - Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve)

64585 - Revision or removal of peripheral neurostimulator electrode array

64596 - Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; initial electrode array

64597 - Insertion or replacement of percutaneous electrode array, peripheral nerve, with integrated neurostimulator, including imaging guidance, when performed; each additional electrode array

64598 - Revision or removal of neurostimulator electrode array, peripheral nerve, with integrated neurostimulator

64687 - Percutaneous electrical nerve field stimulation, cranial nerves, without implantation

Common Diagnosis Codes

All Diagnosis Codes

Common Diagnosis Codes associated with this policy have been provided for informational purposes only. The list of codes may not be all-inclusive and may be updated to reflect any applicable revisions to the ICD-10 code set and/or medical necessity guidelines applied in this policy.

Common Procedure Codes

CPT Codes:

64553 - Percutaneous implantation of neurostimulator electrode array; cranial nerve

HCPCS Codes:

L8680 - Implantable neurostimulator electrode, each

L8682 - Implantable neurostimulator radiofrequency receiver

L8683 - Radiofrequency transmitter (external) for use with implantable neurostimulator radiofrequency receiver

C1778 – Lead, neurostimulator (implantable)

C1816 - Receiver and/or transmitter, neurostimulator (implantable)

Please refer to the product grid for detailed authorization requirements for specific plans. Codes requiring prior-authorization for some products may require retrospective review for plans that do not require prior-authorization. Common diagnosis codes are included for informational purposes only and every attempt has been made to update and keep these codes accurate. These codes may not be all inclusive. CPT codes are subject to change as replacement codes are adopted by CMS. Any codes related to CMS updates will be adopted and applied to this policy by MVP.

Overview

Chronic Pain is difficult to manage, but treatment options include physical therapy, medications (topical, oral, injectable), and non-surgical approaches like chiropractic care, acupuncture, and ergonomic changes. Electrical stimulation devices—ranging from surface to implanted—are also used, though permanent implants carry risks like lead migration and device-related pain.

Peripheral nerve stimulation (PNS) differs from TENS by using implanted electrodes near specific nerves, controlled by an external pulse generator. A trial is typically required.

The SPRINT PNS system (SPR Therapeutics, FDA-cleared in 2018) is a temporary, percutaneous device placed without incisions or anesthesia, used for up to 60 days. In contrast, Freedom (formally StimQ)(FDA-cleared 2016) and ReActiv8 (FDA-cleared 2020) are permanent implants for chronic pain, with Freedom (formally StimQ) targeting peripheral nerves and ReActiv8 addressing multifidus muscle related low back pain.

Experimental, Investigational and Not Medically Necessary:

- Implantable peripheral nerve stimulation (PNS) is considered experimental, investigational or unproven for any indication, including but not limited to the treatment of acute or chronic pain conditions.
- Percutaneous electrical nerve stimulation (PENS), percutaneous electrical nerve field stimulation (PENFS), percutaneous neuromodulation therapy (PNT) or auricular electrostimulation devices (including all permanent and temporary) are considered experimental, investigational or unproven for any indication, including but not limited to the treatment of acute or chronic pain conditions.
- Restorative Neurostimulation Therapy (e.g., ReActiv8) is considered experimental, investigational or unproven for any indication, including but not limited to the treatment of acute or chronic pain conditions.

Medicare

Medicare has coverage for peripheral nerve stimulators for intractable chronic pain according to the following NCD:
Electrical Nerve Stimulators National Coverage Determination (NCD)(160.7.).

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from the COMFORT-randomized controlled trial. Reg Anesth Pain Med. 2024b Nov 20: Epub ahead of print.

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Member Product	Medical Management Requirements*
New York Products	
HMO	Potential for Retrospective Review
PPO in Plan	Potential for Retrospective Review
PPO OOP	Potential for Retrospective Review
POS in Plan	Potential for Retrospective Review
POS OOP	Potential for Retrospective Review
Essential Plan	Potential for Retrospective Review
MVP Medicaid Managed Care	Potential for Retrospective Review
MVP Child Health Plus	Potential for Retrospective Review
MVP Harmonious Health Care Plan	Potential for Retrospective Review
MVP Medicare Complete Wellness	Potential for Retrospective Review
MVP Medicare Preferred Gold HMO POS	Potential for Retrospective Review
MVP Medicare Secure Plus HMO POS	Potential for Retrospective Review
MVP Medicare WellSelect PPO	Potential for Retrospective Review
USA Care PPO	Potential for Retrospective Review
MVP DualAccess D-SNP HMO	Potential for Retrospective Review
MVP DualAccess Complete D-SNP HMO	Potential for Retrospective Review
Healthy NY	Potential for Retrospective Review
MVP Premier	Potential for Retrospective Review
MVP Premier Plus	Potential for Retrospective Review
MVP Premier Plus HDHP	Potential for Retrospective Review
MVP Secure	Potential for Retrospective Review
MVP EPO	Potential for Retrospective Review
MVP EPO HDHP	Potential for Retrospective Review
MVP PPO	Potential for Retrospective Review
MVP PPO HDHP	Potential for Retrospective Review
ASO	See SPD
Vermont Products	
POS in Plan	Potential for Retrospective Review
POS OOP	Potential for Retrospective Review
MVP VT HMO	Potential for Retrospective Review
MVP VT HDHP HMO	Potential for Retrospective Review
MVP VT Plus HMO	Potential for Retrospective Review
MVP VT Plus HDHP HMO	Potential for Retrospective Review
MVP Secure	Potential for Retrospective Review
ASO	See SPD
♦ Note: Prior authorization requirements for HDHP products are the same as the base product (e.g. HDHP HMO auth requirements are the same as listed for HMO).	

***Medical Management Requirements**

Prior Auth	Prior Authorization Required
Potential for Retrospective Review	No Prior Authorization Required. May be subject to Retrospective Review.
Retro Review	Retrospective Review Required
Not Covered	Service is not a covered benefit.
See SPD	See Specific Plan Design

Revision History:

04/01/2026 – New Policy Effective

MVP Health Care Medical Policy

Skin Endpoint Titration

Type of Policy:	Diagnostic Testing
Prior Approval Date:	02/05/2024
Approval Date:	02/02/2026
Effective Date:	04/01/2026
Related Polices:	Allergy Testing

Codes Requiring Prior Authorization

Prior authorization may vary by plan which means the codes listed below may be specific to one product or all products. Please refer to the product grid found at the end of this policy for detailed authorization requirements for specific plans.

Codes Requiring Retrospective Review

N/A

Experimental/Investigational

N/A

Common Diagnosis Codes

N/A

Common Procedure Codes

CPT Code: 95017, 95018, 95027

Please refer to the product grid for detailed authorization requirements for specific plans. Codes requiring prior-authorization for some products may require retrospective review for plans that do not require prior-authorization. Common diagnosis codes are included for informational purposes only and every attempt has been made to update and keep these codes accurate. These codes may not be all inclusive. CPT codes are subject to change as replacement codes are adopted by CMS. Any codes related to CMS updates will be adopted and applied to this policy by MVP.

Overview

Skin endpoint titration (SET) testing, also called serial dilution or threshold dilution testing, is done by administering a specific antigen (allergen) at various strengths to determine how sensitive a patient is to that antigen or what concentration of the antigen is required to produce a reaction. Skin endpoint titration is performed by producing wheals (an elevation in the skin accompanied by itching) of identical size on the superficial layers of the skin. The first wheal is made with a dilution too weak to produce symptoms. Successive wheals are then produced with a dilution five times stronger than the previous one until a positive response is produced. SET tests can identify the species specificity of venom sensitization; however, they do not reliably predict severity of the sting reaction.

Indication/Criteria

Coverage for skin endpoint titration will be considered as indicated below.

- Severe systemic allergic reactions to insect stings, hen's egg based vaccines or drugs including anaphylaxis, angioedema, bronchospasm, or obstructive edema of the upper airway must be documented indicating an anaphylactic or systemic allergic reaction.
- For customers for whom skin endpoint titration is being requested for possible egg protein containing vaccine allergic reaction, the purpose of the testing must be used to identify the risk of vaccine reaction. In addition, these customers must meet medical necessity criteria for the immunization.
- For customers with drug allergic reactions, the purpose of skin endpoint titration must be to identify the risk of drug reaction. In addition, these customers must meet medical necessity for the drug and documentation must state that there are no appropriate drug alternatives.
- Allergens (a substance that causes sensitization) must be approved by the FDA Center for Biologics Evaluation and Research. Standardized FDA approved allergens can be found at the following site: https://www.fda.gov/vaccines-blood-biologics/allergenics/injectable-allergen-extracts-standardized
- Skin endpoint titration testing may only be performed by a qualified physician (Allergist, Clinical and Laboratory Immunologist and Otolaryngologists (ENT)) who has the appropriate emergency medication/equipment in their office to manage the patient if they experience anaphylaxis during titration testing.

Exclusions

Skin endpoint titration is considered not medically necessary if:

- requests for services do not meet criteria under Indications/Criteria of this policy;

- a customer has a large local reaction, where swelling occurs at the site of the sting only. This is not usually reason to perform venom testing or to administer venom allergy shots;
- a customer under age 16 has generalized skin symptoms such as hives and swelling after an insect sting;
- skin endpoint titration is used as allergy therapy or as food or environmental allergy testing;
- allergens not approved by the FDA Center for Biologics Evaluation and Research.

References (Reviewed 2025)

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Customer Product	Medical Management Requirements*
New York Products	
HMO	Potential for Retrospective Review
PPO in Plan	Potential for Retrospective Review
PPO OOP	Potential for Retrospective Review
POS in Plan	Potential for Retrospective Review
POS OOP	Potential for Retrospective Review
Essential Plan	Potential for Retrospective Review
MVP Medicaid Managed Care	Potential for Retrospective Review
MVP Child Health Plus	Potential for Retrospective Review
MVP Harmonious Health Care Plan	Potential for Retrospective Review
MVP Medicare Complete Wellness	Potential for Retrospective Review
MVP Medicare Preferred Gold HMO POS	Potential for Retrospective Review
MVP Medicare Secure Plus HMO POS	Potential for Retrospective Review
MVP Medicare WellSelect PPO	Potential for Retrospective Review
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MVP DualAccess Complete D-SNP HMO	Potential for Retrospective Review
USA Care PPO	Potential for Retrospective Review
Healthy NY	Potential for Retrospective Review
MVP Premier	Potential for Retrospective Review
MVP Premier Plus	Potential for Retrospective Review
MVP Premier Plus HDHP	Potential for Retrospective Review
MVP Secure	Potential for Retrospective Review
MVP EPO	Potential for Retrospective Review
MVP EPO HDHP	Potential for Retrospective Review
MVP PPO	Potential for Retrospective Review
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USA Care PPO	Potential for Retrospective Review
MVP VT HMO	Potential for Retrospective Review
MVP VT HDHP HMO	Potential for Retrospective Review
MVP VT Plus HMO	Potential for Retrospective Review
MVP VT Plus HDHP HMO	Potential for Retrospective Review
MVP Secure	Potential for Retrospective Review
ASO	See SPD
♦ Note: Prior authorization requirements for HDHP products are the same as the base product (e.g. HDHP HMO auth requirements are the same as listed for HMO).	

***Medical Management Requirements**

Prior Auth	Prior Authorization Required
Potential for Retrospective Review	No Prior Authorization Required. May be subject to Retrospective Review
Retro Review	Retrospective Review Required
Not Covered	Service is not a covered benefit.
See SPD	See Specific Plan Design

MVP Health Care Medical Policy

Revision History:

02/01/2022 – Annual review with no changes to the indications or criteria.

04/01/2024 – Annual review with no changes to indications or criteria.

04/01/2026 – Annual review with no changes to indications or criteria