
Subject: Stereotactic Radiofrequency Pallidotomy**Guideline #:** CG-SURG-108**Status:** New**Publish Date:** 04/15/2020**Last Review Date:** 02/20/2020

Description

This document addresses the use of stereotactic radiofrequency pallidotomy for the treatment of Parkinson's disease and other conditions. Stereotactic radiofrequency pallidotomy is a surgical procedure that uses stereotactic (3-D) imaging procedures to identify the target globus pallidus followed by surgical placement of radiofrequency emitting needles to create thermal lesions designed-proposed to relieve the symptoms of Parkinson's disease and other conditions.

Note: Please see the following for related topics:

- SURG.00026 Deep Brain, Cortical, and Cerebellar Stimulation

Clinical Indications

Medically Necessary:

Unilateral stereotactic radiofrequency pallidotomy with microelectrode mapping is considered medically necessary for individuals with Parkinson's disease who meet all of the following criteria:

- Accurate diagnosis of idiopathic Parkinson's disease (striatonigral degeneration has been ruled out as a cause for symptoms); and
- Severe levodopa-induced dyskinesia or disease characterized by severe bradykinesia, dystonia, or akinesia/rigidity, or by marked 'on-off' fluctuations; and
- No evidence of dementia.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

Stereotactic Radiofrequency Pallidotomy

Not Medically Necessary:

Unilateral stereotactic radiofrequency pallidotomy with microelectrode mapping is considered not medically necessary when any of the following contraindications are present:

- A. **History of encephalitis or neuroleptic treatment; or**
- B. **Evidence of dementia or focal brain abnormality on magnetic resonance imaging (MRI); or**
- C. **Medical conditions that might increase risk of hemorrhage (for example, poorly controlled hypertension); or**
- D. **A medical, neurological, or orthopedic disorder that might compromise assessment (cerebrovascular disease, metabolic disorders, spinal stenosis).**

Unilateral stereotactic radiofrequency pallidotomy with microelectrode mapping is considered not medically necessary when the criteria above are not met.

Investigational and Not Medically Necessary:

Bilateral stereotactic radiofrequency pallidotomy is considered ~~investigational and~~ not medically necessary for all indications.

The use of unilateral stereotactic radiofrequency pallidotomy is considered ~~investigational and~~ not medically necessary for all indications not addressed above.

Coding

The following codes for treatments and procedures applicable to this guideline are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

Stereotactic Radiofrequency Pallidotomy

When services may be Medically Necessary when criteria are met:

CPT

61720

Creation of lesion by stereotactic method, including burr hole(s) and localizing and recording techniques, single or multiple stages; globus pallidus or thalamus [stereotactic pallidotomy]

ICD-10 Procedure

00580ZZ

For the following codes when specified as stereotactic radiofrequency pallidotomy:

00583ZZ

Destruction of basal ganglia, open approach

00584ZZ

Destruction of basal ganglia, percutaneous approach

Destruction of basal ganglia, percutaneous endoscopic approach

ICD-10 Diagnosis

G20

Parkinson’s disease (primary and idiopathic)

G21.0-G21.9

Secondary parkinsonism

G24.01

Drug induced subacute dyskinesia

T42.8X5S

Adverse effect of antiparkinsonism drugs and other central muscle-tone depressants, sequela

When services are Not Medically Necessary:

For the procedure and diagnosis codes listed above when criteria are not met or a contraindication exists.

When services are Investigational and Not Medically Necessary:

For procedure codes listed above for all other diagnoses not listed; or when the code describes a procedure indicated in the Position Statement section as investigational and not medically necessary.

Discussion/General Information

Description of Parkinson’s Disease

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue’s standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue’s Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member’s card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan’s or line of business’s members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

Stereotactic Radiofrequency Pallidotomy

Parkinson's disease (PD) is a progressive, incurable disease caused by the slow continuous loss of nerve cells in a part of the brain that controls muscle movement. Common symptoms of the disease include tremors or involuntary movement in the jaw and extremities, slowed movement, muscle stiffness, gradual loss of voluntary movement, gradual loss of automatic movement, postural instability and depression. It is estimated that over a half million people in the U.S. are affected, and approximately 50,000 new cases are diagnosed annually. PD is primarily an age-related disease, with average age of onset being about 60 years of age, but development of PD in people as young as 20 has been reported. The exact cause of PD is not known, but there is some evidence that there may be an inheritable component to the disease.

There is no known cure for PD. Primary management of the disease is through pharmacological therapy with one or several drugs to relieve the symptoms of the disease. No drug has been shown to effectively slow the progression of the disease. As PD progresses pharmacotherapy becomes less and less effective in managing the symptoms of the disease. When an individual's symptoms are inadequately controlled for a period of 3 months, the individual's disease may be considered medically unresponsive and surgical therapy may be considered.

Description of Stereotactic Radiofrequency Pallidotomy

Stereotactic radiofrequency pallidotomy involves placing thermal lesions in the globus pallidus, a part of the brain that is responsible for the symptoms of PD. For this procedure the individual's head is placed into a stereotactic frame, which is anchored to the individual's skull through the skin with four pins. This frame ensures accurate location of the target internal brain structures with magnetic resonance imaging (MRI) and special computerized mapping techniques. These computer programs also assist in planning the surgical approach. During the surgery, a small hole is made in the individual's skull through which the surgeon uses a special electrode to precisely map the location of the globus pallidus. When mapping is complete, the electrode is removed and replaced with a needle that produces the radiofrequency thermal lesions.

Scientific evidence

Results of small randomized trials and cohort studies have reported that unilateral stereotactic radiofrequency pallidotomy with microelectrode mapping is a relatively safe and effective method of

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

Stereotactic Radiofrequency Pallidotomy

managing symptoms of advanced Parkinson's disease (PD) refractory to pharmacological management (deBie, 1999, 2001; Green, 2002; Masterman, 1998; Vitek, 2003). In these studies, unilateral stereotactic radiofrequency pallidotomy has resulted in significant improvements in dyskinesia, bradykinesia, and other symptoms of PD. It must be noted that this procedure is considered inappropriate in individuals with several comorbidities, including specific central nervous system disorders and coagulopathies, which may compromise the proper assessment of the individual or the success of the surgical procedure.

A 1999 technology assessment issued by the American Academy of Neurology (AAN) offered the following recommendation (Hallett, 1999): "Unilateral pallidotomy is indicated for advanced PD with motor fluctuations and drug-induced involuntary movements (dyskinesias) along with significant bradykinesia and rigidity, with or without tremor."

Although there was initial interest in bilateral stereotactic radiofrequency pallidotomy, this procedure has been abandoned due to severe motor and psychiatric complications (Merello, 2001). The AAN assessment also noted that bilateral pallidotomy is associated with a higher incidence of neurologic adverse effects, particularly speech complications.

Deep brain stimulation using implanted electrodes is another treatment of advanced PD. This treatment may be preferred by physicians and individuals due to its reversible nature and the ability to provide bilateral stimulation. One small randomized trial comparing unilateral pallidotomy with bilateral deep brain stimulation suggests that the latter treatment is more effective in reducing symptoms compared to pallidotomy (Esselink, 2004). For these reasons, the use of unilateral pallidotomy has declined over the past several years in favor of deep brain stimulation. The declining role of pallidotomy is reflected in 2006 practice parameters issued by the American Academy of Neurology regarding the treatment of Parkinson's disease (Pahwa, 2006). These guidelines do not address pallidotomy.

Definitions

Akinesia: Difficulty *beginning* or *maintaining* a body motion.

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

Stereotactic Radiofrequency Pallidotomy

Bradykinesia: An abnormal slowness of movement, sluggishness of physical and mental responses.

Dementia: A mental disorder characterized by a general loss of intellectual abilities, involving impairment of memory, judgment, and abstract thinking, as well as changes in personality.

Dyskinesia: Impairment of voluntary movement, resulting in fragmentary or incomplete movements.

Dystonia: A neurological movement disorder characterized by involuntary muscle contractions, which force certain parts of the body into abnormal, sometimes painful, movements or postures.

Encephalitis: Inflammation of the brain that may be due to a wide variety of causes.

Levodopa: A drug commonly used to treat the symptoms of Parkinson's disease.

References

Peer Reviewed Publications:

1. **deBie RM, de Haan RJ, Nijssen PC, et al. Unilateral pallidotomy in Parkinson's disease: a randomised, single-blind, multicentre trial. Lancet. 1999; 354(9191):1665-1669.**
2. **deBie RM, Schuurman PR, Bosch DA, et al. Outcome of unilateral pallidotomy in advanced Parkinson's disease: cohort study of 32 patients. J Neurol Neurosurg Psychiatry. 2001; 71(3):375-382.**
3. **Esselink RA, de Bie RM, de Haan RJ, et al. Long-term superiority of subthalamic nucleus stimulation over pallidotomy in Parkinson disease. Neurology. 2009; 73(2):151-153.**
4. **Esselink RA, de Bie RM, de Haan RJ, et al. Unilateral pallidotomy versus bilateral subthalamic nucleus stimulation in PD: a randomized trial. Neurology. 2004; 62(2):201-207.**
5. **Green J, McDonald WM, Vitek JL, et al. Neuropsychological and psychiatric sequelae of pallidotomy for PD: clinical trial findings. Neurology. 2002; 58(6):858-865.**
6. **Hallett M, Litvan I. Task Force on Surgery for Parkinson's Disease. Evaluation of surgery for Parkinson's disease: a report of the Therapeutics and Technology Assessment Subcommittee of the American Academy of Neurology. Neurology. 1999; 53(9):1910-1921.**

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

Stereotactic Radiofrequency Pallidotomy

7. Masterman D, DeSalles A, Baloh RW, et al. Motor, cognitive, and behavioral performance following unilateral ventroposterior pallidotomy for Parkinson disease. Arch Neurol. 1998; 55(9):1201-1208.
8. Merello M, Starkstein S, Nouzeilles MI, et al. Bilateral pallidotomy for treatment of Parkinson's disease induced corticobulbar syndrome and psychic akinesia avoidable by globus pallidus lesion combined with contralateral stimulation. J Neurol Neurosurg Psychiatry. 2001; 71(5):611-614.
9. Vitek JL, Bakay RA, Freeman A, et al. Randomized trial of pallidotomy versus medical therapy for Parkinson's disease. Ann Neurol. 2003; 53(5):558-569.

Websites for Additional Information

1. National Library of Medicine: Medical Encyclopedia. Parkinson's disease. Available at: <https://medlineplus.gov/ency/article /000755.htm>. Accessed on February 13, 2020.

Index

Pallidotomy

The use of specific product names is illustrative only. It is not intended to be a recommendation of one product over another, and is not intended to represent a complete listing of all products available.

History

<u>Status</u>	<u>Date</u>	<u>Action</u>
<u>New</u>	<u>02/20/2020</u>	<u>Medical Policy & Technology Assessment Committee (MPTAC) review. Initial document development. Moved content of SURG.00016 Stereotactic Radiofrequency Pallidotomy to new clinical utilization management guideline document with the same title.</u>

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.

DRAFT

This Clinical UM Guideline is intended to provide assistance in interpreting Healthy Blue's standard Medicaid benefit plan. When evaluating insurance coverage for the provision of medical care, federal, state and/or contractual requirements must be referenced, since these may limit or differ from the standard benefit plan. In the event of a conflict, the federal, state and/or contractual requirements for the applicable benefit plan coverage will govern. Healthy Blue reserves the right to modify its Policies and Guidelines as necessary and in accordance with legal and contractual requirements. This Clinical UM Guideline is provided for informational purposes. It does not constitute medical advice. Healthy Blue may also use tools and criteria developed by third parties, to assist us in administering health benefits. Healthy Blue's Policies and Guidelines are intended to be used in accordance with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Federal and State law, as well as contract language, and Medical Policy take precedence over Clinical UM Guidelines. We reserve the right to review and update Clinical UM Guidelines periodically. Clinical guidelines approved by the Medical Policy & Technology Assessment Committee are available for general adoption by plans or lines of business for consistent review of the medical necessity of services related to the clinical guideline when the plan performs utilization review for the subject. Due to variances in utilization patterns, each plan may choose whether to implement a particular Clinical UM Guideline. To determine if review is required for this Clinical UM Guideline, please contact the customer service number on the member's card.

Alternatively, commercial or FEP plans or lines of business which determine there is not a need to adopt the guideline to review services generally across all providers delivering services to Plan's or line of business's members may instead use the clinical guideline for provider education and/or to review the medical necessity of services for any provider who has been notified that his/her/its claims will be reviewed for medical necessity due to billing practices or claims that are not consistent with other providers, in terms of frequency or in some other manner.

No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.