

Title: Kymriah (tisagenlecleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP219
Review Date: 05/27/2025	Cross Reference Number:
Retired Date:	Page 1 of 12

I. POLICY DESCRIPTION:

Medical Oncology- Anti- CD19 CAR-T Immunotherapy, Kymriah (tisagenlecleucel)

II. RESPONSIBLE PARTIES:

Medical Management Administration, Utilization Management, Integrated CareManagement, Pharmacy, Claims Department, Provider Contracting.

III. DEFINITIONS:

Kymriah (tisagenlecleucel) is a chimeric antigen receptor T-cell (CAR-T) which reprograms a patient's own T-cells to identify and eliminate CD19 expressing malignant and normal cells. Upon binding to CD-19 expressing cells, the CAR promotes T-cell expansion, activation and target cell elimination.

Kymriah is indicated for the treatment of:

Patients up to 25 years of age with B-cell precursor acute lymphoblastic leukemia (ALL) that is refractory or in second or later relapse.

Adult patients with relapsed or refractory (r/r) large B-cell lymphoma after two or more lines of systemic therapy, including diffuse large B-cell lymphoma (DLBCL) not otherwise specified, high grade B-cell lymphoma and DLBCL arising from follicular lymphoma.

Adult patients with relapsed or refractory follicular lymphoma (FL) after two or more lines of systemic therapy.

All other uses for Kymriah are considered experimental and investigational.

IV. POLICY:

For the Medicare and UltraCare lines of business, MetroPlusHealth determines medical necessity based on applicable Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD).

<https://www.cms.gov/medicare-coverage-database/search.aspx>

For all non-Medicare LOBs:

Kymriah will be considered medically necessary once the following coverage criteria is met.

Title: Kymriah (tisagenlecleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP219
Review Date: 05/27/2025	Cross Reference Number:
Retired Date:	Page 2 of 12

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

INITIAL REQUEST:**1. Pediatric and Young Adult Relapsed or Refractory (r/r) B-cell precursor Acute Lymphoblastic Leukemia (B-ALL)**

A. Member is up to 25 years of age;

AND

B. Member has a diagnosis confirmed by submitted documentation including chart notes of B-cell precursor Acute Lymphoblastic Leukemia (B-ALL) that is refractory or in second or later relapse as defined by one of the following:

a. Member has experienced disease relapse after hematopoietic stem cell transplantation (HSCT) and member is ≥ 6 months or more from HSCT at the time of Kymriah infusion;

OR

b. Member has relapse or refractory Philadelphia chromosome-negative B-ALL with ONE of the following:

i. Disease progressed after 2 cycles of a standard chemotherapy regimen for initial diagnosis;

OR

ii. Disease progressed after 1 cycle of standard chemotherapy for relapsed leukemia;

OR

c. Member has Philadelphia chromosome-positive B-ALL that progressed after trial and failure, intolerance or contraindication to 2 prior regimens, including a tyrosine kinase inhibitor therapy (TKI) containing regimen (Gleevec (imatinib), Bosulif (bosutinib), Sprycel (dasatinib), Tassigna (nilotinib), or Iclusig (ponatinib));

AND

C. Member has a performance score on Karnofsky or Lansky Scale is $\geq 50\%$;

AND

D. Member does not have primary central nervous system lymphoma;

AND

E. Member is screened for HBV, HCV, and HIV in accordance with clinical guidelines prior to collection of cells for manufacturing;

Title: Kymriah (tisagenlecleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP219
Review Date: 05/27/2025	Cross Reference Number:
Retired Date:	Page 3 of 12

AND

F. Member has not received any live vaccines within the past 6 weeks;

AND

G. Member does not have an active systemic infection or inflammatory disorder;

AND

H. If member has a history of an allogeneic stem cell transplant, there are no current signs of active graft versus host disease (GVHD);

AND

I. Member has not previously been treated with Kymriah or any other CAR-T therapy;

AND

J. The requesting provider belongs to a healthcare facility that has enrolled in the Kymriah REMS (Risk Evaluation and Mitigation Strategy) program and training has been given to providers on the management of cytokine release syndrome (CRS) and neurological toxicities (treatment centers can be found [here](#));

AND

K. Authorization is for no more than one dose

2. Adult Relapsed or Refractory (r/r) Diffuse Large B-cell Lymphoma (DLBCL)

A. Member is 18 years of age or older;

AND

B. Member has a diagnosis confirmed by submitted documentation including chart notes of relapsed/refractory B-cell lymphoma including any ONE of the following:

a. Diffuse large B-cell lymphoma (DLBCL) not otherwise specified;

OR

b. Diffuse large B-cell lymphoma (DLBCL) arising from follicular lymphoma;

OR

c. High grade B-cell lymphoma;

AND

C. Member has relapsed or refractory disease after trial and failure or contraindication to at least TWO lines of therapy

(Examples of systemic therapy include:

RCHOP (rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone);

DA-EPOCH (dose adjusted etoposide, prednisone, vincristine, cyclophosphamide, doxorubicin) + Rituximab;

RCDOP (rituximab, cyclophosphamide, liposomal doxorubicin, vincristine,

Title: Kymriah (tisagenlecleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP219
Review Date: 05/27/2025	Cross Reference Number:
Retired Date:	Page 4 of 12

prednisone);

RGCVP (rituximab, gemcitabine, cyclophosphamide, vincristine, prednisone);

RCEPP (rituximab, cyclophosphamide, etoposide, prednisone, procarbazine);

RCEOP (rituximab, cyclophosphamide, etoposide, vincristine, prednisone);

GDP ± rituximab (gemcitabine, dexamethasone, cisplatin ± rituximab);

GemOx ± rituximab (Gemcitabine, Oxaliplatin + Rituximab)

AND

D. Member does not have primary central nervous system lymphoma;

AND

E. Member is screened for HBV, HCV, and HIV in accordance with clinical guidelines prior to collection of cells for manufacturing;

AND

F. Member has not received any live vaccines within the past 6 weeks;

AND

G. Member does not have an active systemic infection or inflammatory disorder;

AND

H. If member has had a prior allogeneic HSCT, the member does not currently have active GVHD;

AND

I. Member has not previously been treated with Kymriah or any other CAR-T therapy;

AND

J. The requesting provider belongs to a healthcare facility that has enrolled in the Kymriah REMS (Risk Evaluation and Mitigation Strategy) program and training has been given to providers on the management of cytokine release syndrome (CRS) and neurological toxicities (treatment centers can be found [here](#));

AND

K. Authorization is for no more than one dose

3. Adult Relapsed or Refractory (r/r) Follicular lymphoma (FL)

A. Member is 18 years of age or older;

AND

B. Member has a diagnosis confirmed by submitted documentation including chart notes of relapsed or refractory Follicular Lymphoma;

AND

Title: Kymriah (tisagenlecleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP219
Review Date: 05/27/2025	Cross Reference Number:
Retired Date:	Page 5 of 12

- C. Member has relapsed or refractory disease after trial and failure or contraindication to at least TWO lines of therapy
(Examples of system therapy include:
Bendamustine + obinutuzumab or rituximab;
CHOP (cyclophosphamide, doxorubicin, vincristine, prednisone) + obinutuzumab or rituximab;
CVP (cyclophosphamide, vincristine, prednisone) + binutuzumab or rituximab;
Lenalidomide + rituximab;
Chlorambucil ± rituximab;
Cyclophosphamide ± rituximab

AND

- D. Member is screened for HBV, HCV, and HIV in accordance with clinical guidelines prior to collection of cells for manufacturing;

AND

- E. Member has not received any live vaccines within the past 6 weeks;

AND

- F. Member does not have an active systemic infection or inflammatory disorder;

AND

- G. If member has had a prior allogeneic HSCT, the member does not currently have active GVHD;

AND

- H. Member has not previously been treated with Kymriah or any other CAR-T therapy;

AND

- I. The requesting provider belongs to a healthcare facility that has enrolled in the Kymriah REMS (Risk Evaluation and Mitigation Strategy) program and training has been given to providers on the management of cytokine release syndrome (CRS) and neurological toxicities (treatment centers can be found [here](#));

AND

- J. Authorization is for no more than one dose

RENEWAL REQUEST:

Repeat administration of Kymriah is investigational and will not be covered.

V. LIMITATIONS/EXCLUSIONS

- Repeat administration of Kymriah is considered experimental and investigational

Title: Kymriah (tisagenlecleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP219
Review Date: 05/27/2025	Cross Reference Number:
Retired Date:	Page 6 of 12

because there have been no established studies to demonstrate effectiveness

- Kymriah is not indicated for the treatment of patients with primary central nervous system lymphoma.
- History of prior CAR-T cell therapy or other genetically modified T cell therapy
- Ejection fraction < 50% or evidence of pericardial effusion
- History or presence of CNS disorder such as seizure disorder, cerebrovascular ischemia/hemorrhage, dementia, cerebellar disease, or any autoimmune disease with CNS involvement

VI. APPLICABLE PROCEDURE CODES:

CPT	Description
Q2042	Tisagenlecleucel, up to 600 millioncar-positive viable T cells, including leukapheresis and dose preparation procedures, per therapeutic dose

VII. APPLICABLE DIAGNOSIS CODES:

Code	Description
C82.00	Follicular lymphoma grade I, unspecified site
C82.01	Follicular lymphoma grade I, lymph nodes of head, face, and neck
C82.02	Follicular lymphoma grade I, intrathoracic lymph nodes
C82.03	Follicular lymphoma grade I, intra-abdominal lymph nodes
C82.04	Follicular lymphoma grade I, lymph nodes of axilla and upper limb
C82.05	Follicular lymphoma grade I, lymph nodes of inguinal region and lower limb
C82.06	Follicular lymphoma grade I, intrapelvic lymph nodes
C82.07	Follicular lymphoma grade I, spleen
C82.08	Follicular lymphoma grade I, lymph nodes of multiple sites
C82.09	Follicular lymphoma grade I, extranodal and solid organ sites
C82.10	Follicular lymphoma grade II, unspecified site
C82.11	Follicular lymphoma grade II, lymph nodes of head, face, and neck
C82.12	Follicular lymphoma grade II, intrathoracic lymph nodes
C82.13	Follicular lymphoma grade II, intra-abdominal lymph nodes
C82.14	Follicular lymphoma grade II, lymph nodes of axilla and upper limb
C82.15	Follicular lymphoma grade II, lymph nodes of inguinal region and lower limb
C82.16	Follicular lymphoma grade II, intrapelvic lymph nodes

Title: Kymriah (tisagenlecleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP219
Review Date: 05/27/2025	Cross Reference Number:
Retired Date:	Page 7 of 12

C82.17	Follicular lymphoma grade II, spleen
C82.18	Follicular lymphoma grade II, lymph nodes of multiple sites
C82.19	Follicular lymphoma grade II, extranodal and solid organ sites
C82.20	Follicular lymphoma grade III, unspecified, unspecified site
C82.21	Follicular lymphoma grade III, unspecified, lymph nodes of head, face, and neck
C82.22	Follicular lymphoma grade III, unspecified, intrathoracic lymph nodes
C82.23	Follicular lymphoma grade III, unspecified, intra-abdominal lymph nodes
C82.24	Follicular lymphoma grade III, unspecified, lymph nodes of axilla and upper limb
C82.25	Follicular lymphoma grade III, unspecified, lymph nodes of inguinal region and lower limb
C82.26	Follicular lymphoma grade III, unspecified, intrapelvic lymph nodes
C82.27	Follicular lymphoma grade III, unspecified, spleen
C82.28	Follicular lymphoma grade III, unspecified, lymph nodes of multiple sites
C82.29	Follicular lymphoma grade III, unspecified, extranodal and solid organ sites
C82.30	Follicular lymphoma grade IIIa, unspecified site
C82.31	Follicular lymphoma grade IIIa, lymph nodes of head, face, and neck
C82.32	Follicular lymphoma grade IIIa, intrathoracic lymph nodes
C82.33	Follicular lymphoma grade IIIa, intra-abdominal lymph nodes
C82.34	Follicular lymphoma grade IIIa, lymph nodes of axilla and upper limb
C82.35	Follicular lymphoma grade IIIa, lymph nodes of inguinal region and lower limb
C82.36	Follicular lymphoma grade IIIa, intrapelvic lymph nodes
C82.37	Follicular lymphoma grade IIIa, spleen
C82.38	Follicular lymphoma grade IIIa, lymph nodes of multiple sites
C82.39	Follicular lymphoma grade IIIa, extranodal and solid organ sites
C82.40	Follicular lymphoma grade IIIb, unspecified site
C82.41	Follicular lymphoma grade IIIb, lymph nodes of head, face, and neck
C82.42	Follicular lymphoma grade IIIb, intrathoracic lymph nodes
C82.43	Follicular lymphoma grade IIIb, intra-abdominal lymph nodes
C82.44	Follicular lymphoma grade IIIb, lymph nodes of axilla and upper limb
C82.45	Follicular lymphoma grade IIIb, lymph nodes of inguinal region and lower limb
C82.46	Follicular lymphoma grade IIIb, intrapelvic lymph nodes

Title: Kymriah (tisagenlecleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP219
Review Date: 05/27/2025	Cross Reference Number:
Retired Date:	Page 8 of 12

C82.47	Follicular lymphoma grade IIIb, spleen
C82.48	Follicular lymphoma grade IIIb, lymph nodes of multiple sites
C82.49	Follicular lymphoma grade IIIb, extranodal and solid organ sites
C82.50	Diffuse follicle center lymphoma, unspecified site
C82.51	Diffuse follicle center lymphoma, lymph nodes of head, face, and neck
C82.52	Diffuse follicle center lymphoma, intrathoracic lymph nodes
C82.53	Diffuse follicle center lymphoma, intra-abdominal lymph nodes
C82.54	Diffuse follicle center lymphoma, lymph nodes of axilla and upper limb
C82.55	Diffuse follicle center lymphoma, lymph nodes of inguinal region and lower limb
C82.56	Diffuse follicle center lymphoma, intrapelvic lymph nodes
C82.57	Diffuse follicle center lymphoma, spleen
C82.58	Diffuse follicle center lymphoma, lymph nodes of multiple sites
C82.59	Diffuse follicle center lymphoma, extranodal and solid organ sites
C82.60	Cutaneous follicle center lymphoma, unspecified site
C82.61	Cutaneous follicle center lymphoma, lymph nodes of head, face, and neck
C82.62	Cutaneous follicle center lymphoma, intrathoracic lymph nodes
C82.63	Cutaneous follicle center lymphoma, intra-abdominal lymph nodes
C82.64	Cutaneous follicle center lymphoma, lymph nodes of axilla and upper limb
C82.65	Cutaneous follicle center lymphoma, lymph nodes of inguinal region and lower limb
C82.66	Cutaneous follicle center lymphoma, intrapelvic lymph nodes
C82.67	Cutaneous follicle center lymphoma, spleen
C82.68	Cutaneous follicle center lymphoma, lymph nodes of multiple sites
C82.69	Cutaneous follicle center lymphoma, extranodal and solid organ sites
C82.80	Other types of follicular lymphoma, unspecified site
C82.81	Other types of follicular lymphoma, lymph nodes of head, face, and neck
C82.82	Other types of follicular lymphoma, intrathoracic lymph nodes
C82.83	Other types of follicular lymphoma, intra-abdominal lymph nodes
C82.84	Other types of follicular lymphoma, lymph nodes of axilla and upper limb
C82.85	Other types of follicular lymphoma, lymph nodes of inguinal region and lower limb
C82.86	Other types of follicular lymphoma, intrapelvic lymph nodes
C82.87	Other types of follicular lymphoma, spleen

Title: Kymriah (tisagenlecleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP219
Review Date: 05/27/2025	Cross Reference Number:
Retired Date:	Page 9 of 12

C82.88	Other types of follicular lymphoma, lymph nodes of multiple sites
C82.89	Other types of follicular lymphoma, extranodal and solid organ sites
C82.90	Follicular lymphoma, unspecified, unspecified site
C82.91	Follicular lymphoma, unspecified, lymph nodes of head, face, and neck
C82.92	Follicular lymphoma, unspecified, intrathoracic lymph nodes
C82.93	Follicular lymphoma, unspecified, intra-abdominal lymph nodes
C82.94	Follicular lymphoma, unspecified, lymph nodes of axilla and upper limb
C82.95	Follicular lymphoma, unspecified, lymph nodes of inguinal region and lower limb
C82.96	Follicular lymphoma, unspecified, intrapelvic lymph nodes
C82.97	Follicular lymphoma, unspecified, spleen
C82.98	Follicular lymphoma, unspecified, lymph nodes of multiple sites
C82.99	Follicular lymphoma, unspecified, extranodal and solid organ sites
C83.30	Diffuse large B-cell lymphoma, unspecified site
C83.31	Diffuse large B-cell lymphoma, lymph nodes of head, face, and neck
C83.32	Diffuse large B-cell lymphoma, intrathoracic lymph nodes
C83.33	Diffuse large B-cell lymphoma, intra-abdominal lymph nodes
C83.34	Diffuse large B-cell lymphoma, lymph nodes of axilla and upper limb
C83.35	Diffuse large B-cell lymphoma, lymph nodes of inguinal region and lower limb
C83.36	Diffuse large B-cell lymphoma, intrapelvic lymph nodes
C83.37	Diffuse large B-cell lymphoma, spleen
C83.38	Diffuse large B-cell lymphoma, lymph nodes of multiple sites
C83.39	Diffuse large B-cell lymphoma, extranodal and solid organ sites
C91.00	Acute lymphoblastic leukemia not having achieved remission
C91.02	Acute lymphoblastic leukemia, in relapse
Z51.12	Encounter for antineoplastic immunotherapy

Title: Kymriah (tisagenlecleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP219
Review Date: 05/27/2025	Cross Reference Number:
Retired Date:	Page 10 of 12

VIII. REFERENCES:

1. Kymriah [Product Information], Novartis Pharmaceuticals Corporation, East Hanover, NJ; December 2024.
2. Porter DL, Hwang WT, Frey NV, et al. Chimeric antigen receptor T cells persist and induce sustained remissions in relapsed refractory chronic lymphocytic leukemia. Sci Transl Med. 2015 Sep 2;7(303):303ra139. doi: 10.1126/scitranslmed.aac5415
3. ClinicalTrials.gov. Identifier NCT02228096. Study of Efficacy and Safety of CTL019 in Pediatric ALL Patients. Available at <https://clinicaltrials.gov/ct2/show/NCT02228096?term=tisagenlecleucel&rank=1>.
4. The Leukemia & Lymphoma Society (LLS). Ph-Positive ALL Therapy. Available at <https://www.lls.org/leukemia/acute-lymphoblastic-leukemia/treatment/ph-positive-all-therapy>
5. Kymriah [Product Information], Novartis Pharmaceuticals Corporation, East Hanover, NJ; May 2022.
6. IPD Analytics Client Log In - Pharma Market Insights. secure.ipdanalytics.com. Accessed April 17, 2023. <https://secure.ipdanalytics.com/User/Pharma/RxStrategy/Page/389b4581-4323-4e36-b9df-9305d9bb0f7b#section-group-410419>
7. The NCCN Clinical Practice Guidelines in Oncology® B-Cell Lymphomas (Version 4.2024; January 18, 2024). © 2021 National Comprehensive Cancer Network, Inc. <https://www.nccn.org>.
8. The NCCN Clinical Practice Guidelines in Oncology® Acute Lymphoblastic Leukemia (Version 4.2023; February 5, 2024). © 2021 National Comprehensive Cancer Network, Inc. <https://www.nccn.org>



Policy and Procedure

Title: Kymriah (tisagenlecleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP219
Review Date: 05/27/2025	Cross Reference Number:
Retired Date:	Page 11 of 12

REVISION LOG:

REVISIONS	DATE
Creation date	3/30/2018
Annual Review	3/15/2019
CPT Code Change	6/21/2019
Annual Review	6/23/2020
Pharmacy update	10/29/2020
Annual Review	4/30/2021
Annual Review	4/30/2022
Annual Review and Update	4/25/2023
Annual Review	4/23/2024
Update LOBs to remove Medicare and Ultracare	8/9/2024
Annual Review	05/27/2025

Approved:

Date:

Approved:

Date:

David Ackman, MD
VP of Medical Directors

Sanjiv Shah, MD
Chief Medical Officer



Policy and Procedure

Title: Kymriah (tisagenlecleucel)	Division: Medical Management Department: Utilization Management
Approval Date: 3/30/2018	LOB: Medicaid, HIV SNP, HARP, CHP, MetroPlus Gold, GoldCare, Marketplace, Essential
Effective Date: 3/30/2018	Policy Number: UM-MP219
Review Date: 05/27/2025	Cross Reference Number:
Retired Date:	Page 12 of 12

Medical Guideline Disclaimer:

Property of Metro Plus Health Plan. All rights reserved. The treating physician or primary care provider must submit MetroPlus Health Plan clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, MetroPlus Health Plan will not be able to properly review the request for prior authorization. The clinical review criteria expressed in this policy reflects how MetroPlus Health Plan determines whether certain services or supplies are medically necessary. MetroPlus Health Plan established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). MetroPlus Health Plan expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Each benefit program defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by MetroPlus Health Plan, as some programs exclude coverage for services or supplies that MetroPlus Health Plan considers medically necessary. If there is a discrepancy between this guidelines and a member's benefits program, the benefits program will govern. In addition, coverage may be mandated by applicable legal requirements of a state, the Federal Government or the Centers for Medicare & Medicaid Services (CMS) for Medicare and Medicaid members. All coding and website links are accurate at time of publication.