MetroPlus Health

**Policy and Procedure**

| | |
|---|---|
| **Title: High Tech Radiology Studies (CT, MRI, PET)** | **Division: Medical Management**<br>**Department: Utilization Management** |
| **Approval Date: 6/27/2022** | **LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&II, Market Plus, Essential, HARP, UltraCare** |
| **Effective Date: 6/27/2022** | **Policy Number: UM-MP337** |
| **Review Date: 7/22/2025** | **Cross Reference Number:** |
| **Retired Date:** | **Page 1 of 14** |

1) **POLICY DESCRIPTION:** This policy will outline the criteria for review of requests for Computed Tomography (CT) of the spine, Magnetic Resonance Imaging (MRI) of the spine, and Positron Emission Tomography (PET) for both oncologic and cardiac indications.

   PET Scan and MRI: - 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

2) **RESPONSIBLE PARTIES:** Medical Management Administration, Utilization Management, Integrated Care Management, Pharmacy, Claim Department, Providers Contracting.

3) **DEFINITIONS: (All of these imaging methods are non-invasive)**

   **Ionizing radiation**: high energy particles (photons) that can penetrate through the body; these particles have some risk of cancer or birth defects. CT and PET use ionizing radiation, MRI does not.

   **Computed Tomography (CT scan or CAT scan):** X-rays are sent through the body from many angles. X-ray detectors send information to a computer that creates images of internal body parts.

   **Magnetic Resonance Imaging (MRI):** A powerful magnet temporarily "magnetizes" some atoms. Sensors detect the spin of magnetized atoms. A computer turns that information into images of internal body parts.

   **Positron Emission Tomography (PET) Scan:** A patient is given a radioactive tracer which produces a tiny amount of antimatter (a positron). A positron that comes in contact with matter (an electron) produces radiation, which the PET scanner detects. Body parts with low tracer levels are "cold spots". High tracer levels are "hot spots". A stroke or heart attack may show up as a cold spot; hot spots may show cancer.

4) **POLICY:**

   **I. Computed Tomography (CT or CAT) Scan and Magnetic Resonance Imaging (MRI)**

a) MetroPlusHealth requires prior authorization for computed tomography (CT) and magnetic resonance imaging (MRI) of the spine. CT or MRI of the spine is considered medically necessary when ***any*** of the following criteria are met:
   1) Clinical evidence of spinal stenosis
      a) CT with myelography may be preferable to an MRI for imaging of bony anatomy with neural elements. However, this procedure is invasive with an inherent risk of complications so therefore, MRI without contrast is preferred unless contraindicated.
      b) If an MRI is performed and a CT with myelography is subsequently ordered, the ordering physician must present an evidence-based indication for performing the second imaging.
   2) Clinical suspicion of a spinal cord or cauda equina compression syndrome.
   3) Congenital anomalies or deformities of the spine.
   4) Evaluation of recurrent symptoms after spinal surgery(1).
   5) Evaluation prior to epidural injection to rule out tumor of infection and to delineate the optimal location for performing the injection.
   6) Follow-up evaluation for spinal malignancy or spinal infection.
   7) Known or suspected myelopathy for initial diagnosis when MRI of the brain is negative or symptoms mimic those of other spinal or brainstem lesions.
   8) Known or suspected primary spinal cord tumors (malignant or non-malignant).
   9) Persistent back or neck pain with radiculopathy as evidenced by pain *and* objective findings of motor or reflex changes in the specific nerve root distribution *and* no improvement after 6 weeks of conservative management(2).
   10) Primary spinal bone tumors or suspected vertebral, paraspinal, or intraspinal metastases.
   11) Progressively severe symptoms despite conservative management(2).
   12) Rapidly progressing neurological deficit or major motor weakness.
   13) Severe back pain including:
      a) Subacute or chronic low back pain with or without radiculopathy.
      b) Initial imaging for persistent or progressive symptoms during or following 6 weeks of optimal conservative treatment in surgery or intervention candidates.
      c) Initial imaging for low back pain with suspected cauda equina syndrome.
   14) Spondylolisthesis and degenerative disease of the spine that has not responded to 4 weeks of conservative management**.
   15) Suspected infectious processes such as osteomyelitis, or epidural abscess of the spine or soft tissue.
   16) Suspected spinal fracture and/or dislocation secondary to trauma when x-rays are not conclusive within six (6) weeks of the trauma.

17) Suspected transverse myelitis.
18) Suspected fracture and/or dislocation secondary to trauma when x-rays are not conclusive.

b) MetroPlusHealth considers the following CT or MRI testing not medically necessary:
   1) MRI for further evaluation of an unstable injury in neurologically intact patients with blunt trauma after a negative cervical spine CT result.
   2) MRI or CT for evaluation of chronic mechanical low back pain without radiculopathy, neurologic deficit, trauma, or clinical suspicion of systemic disorders (e.g., infectious process, metastatic disease) unless the back pain is severe (e.g., requiring hospitalization) or where symptoms are progressing despite conservative management.
   3) MRI or CT for evaluation of non-specific low back pain that cannot be attributed to a specific disease or spinal abnormality.
   4) MRI or CT for evaluation of non-specific low back pain within the first 6 weeks of symptoms appearing.

c) MetroPlusHealth considers MRI and CT of the spine for all other indications other than those listed above experimental/investigational because their clinical value has not been established.

e) Requests for repeat CT or MRI of the same section of the spine within a 12-month span require Medical Director review for final determination.

*(1) MRI with and without gadolinium enhancement is the preferred method of imaging for evaluation of recurrent symptoms after spinal surgery.*

*(2) Conservative management includes moderate activity, analgesics, non-steroidal anti-inflammatory drugs, muscle relaxants.*

### II. Positron Emission Tomography (PET) Scans for Oncologic Indications

a) MetroPlusHealth considers FDG-6 PET scans medically necessary for the list below of oncologic indications for any of the following indications:
   1) To avoid an invasive diagnostic procedure or to assist in determining the optimal anatomic location to perform an invasive diagnostic procedure when other diagnostic imaging has been performed and has yielded inconclusive results.
   2) To determine staging following a tissue diagnosis (biopsy) of a solid tumor when one of the following are met:
      a) The stage of the cancer remains in doubt after completion of a standard diagnostic work-up including CT scan, MRI, or ultrasound.

   b) The use of PET would potentially replace one or more conventional imaging studies when it is expected that conventional study results will be insufficient for the clinical management of the member.
3) For characterization of newly discovered Solitary Pulmonary Nodules (SPNs) in persons without known malignancy when both of the following conditions are met:
   a) A concurrent thoracic CT scan has been performed.
   b) A single indeterminate or possibly malignant lesion, more than 0.8cm and not exceeding 4cm in diameter, has been detected (usually by CT).
4) When the study is used for Radiotherapy Planning (RT), contouring and planning the radiation fields.

b) MetroPlusHealth considers repeat PET scans medically necessary for any of the following indications:
1) For re-staging after completion of treatment for the purpose of any of the following:
   a) Detecting residual disease.
   b) Detecting suspected recurrence in persons with signs or symptoms of recurrence.
   c) To determine the extent of recurrence.
   d) The use of PET would potentially replace one or more conventional imaging studies when it is expected that conventional study results will be insufficient for the clinical management of the patient.
2) To assess response to treatment during or after therapy.
3) For follow-up or surveillance; for assessment of disease in the absence of critical evidence of recurrence. Follow-up PET scan intervals should be at least 12 weeks.

**List of Oncologic Indications**

- Acute Myeloid Leukemia
- Alveolar rhabdomyosarcoma
- Ampullary cancer
- Anal cancer: all requests for this diagnosis require Medical Director review.
- Appendiceal cancer
- Brain tumors
- Breast cancer
- Burkitt's lymphoma
- Castleman disease
- Cervical cancer
- Chordoma
- Chronic lymphocytic leukemia/small lymphocytic lymphoma with suspected Richter's transformation

- Colorectal cancer
- Diffuse large B-cell lymphoma
- Esophageal cancer
- Ewing sarcoma and osteosarcoma
- Follicular lymphoma
- Gastric cancer
- Gastrointestinal stromal tumors
- Head and neck cancers (excluding cancers of the central nervous system)
- Hodgkin lymphoma
- Malignant Melanoma
- Mantle cell lymphoma
- Marginal Zone and MALT lymphoma
- Merkel cell carcinoma: all requests for this diagnosis require Medical Director review
- Mesothelioma
- Multiple Myeloma
- Non-Hodgkin's lymphoma
- Non-small cell lung carcinoma
- Occult primary cancers
- Ovarian cancer
- Pancreatic cancer
- Post-transplant lymphoproliferative disorder: all requests for this diagnosis require secondary review
- Primary cutaneous B-cell lymphoma
- Primary peritoneal cancer
- Prostate cancer (Ga-68 PSMA-11 PET,Piflufolastat F-18 (Pylarify) PET, and 18F-Flotufolastat (Posluma) PET)
- Small cell lung carcinoma (SCLC)
- Small bowel adenocarcinoma
- Soft tissue sarcoma
- Solitary pulmonary nodules for diagnosis only, Medical Director review is required for any other reason
- T-cell lymphoma
- Testicular cancer
- Thymic malignancies
- Thyroid cancer
- Uterine sarcoma

- Vaginal cancer
- Vulvar squamous cell cancer

Requests for approval of a PET scan for any other indication not listed above require Medical Director review for final determination.

### III. Positron Emission Tomography (PET) Scans for Cardiac Indications

a) MetroPlusHealth considers PET scans medically necessary for the following cardiac indications:

b) Ruling out CAD-Stress PET scanning, with or without concomitant CT or MRI will be covered to identify possible coronary artery disease if the diagnosis remains in question after a standard evaluation which included
   1) serial EKGs
   2) troponin
   3) Prior, inconclusive cardiac imaging. M+ considers a stress cardiac echocardiogram (93350, 93351) to be the routine initial imaging modality. It is 75-80% sensitive at detecting cardiac ischemia, including cardiac ischemia without large vessel coronary disease. Echocardiography is also an excellent technique to identify structural abnormality which may require treatment. It is cost effective and involves no ionizing radiation. (Sicari) We will cover cardiac PET to rule out ischemia in the absence of a stress echocardiograph if the diagnosis of CAD remains questionable after Cardiac CTA, stress SPECT, or stress MRI)

c) To identify hibernating myocardium (chronic ischemia that may recover after revascularization in patients with known ischemic heart disease)
   1) Indications
      a) Known or suspected angina
      b) Assessment of the physiologic significance of known CAD
   2) Contraindications
      a) Unstable angina or acute MI
      b) Decompensated CHF

c) Acute illness including pulmonary embolism, acute myocarditis/pericarditis, aortic dissection or CVA
d) Severe systemic hypertension (>200/110)
e) Severe pulmonary hypertension (mean PAP>70)

d) To evaluate for areas of poor perfusion in patients with previously diagnosed myocarditis and dysrhythmia
e) For diagnosis of sarcoidosis in a patient with previously biopsy diagnosed sarcoidosis and one of the following:
   1) Initial Diagnosis
      a) Bundle branch block
      b) New onset heart block
      c) sustained idiopathic ventricular tachycardia
   2) Repeat PET scan following prior PET scan for sarcoidosis: to assess effect of treatment (which must be documented)
f) To diagnose possible endocarditis for patients with implanted cardiac devices (prosthetic heart valves, pacemaker wires…). PET scanning is not the preferred method (less sensitive and specific than ultrasound) to identify endocarditis in native valves.
g) For cardiac oncology evaluation

1) To differentiate benign cardiac lesions from malignant lesions.
2) To monitor the cardiac effect of chemotherapy on known malignancies.

PET measurement of quantitative blood flow is considered appropriate when the indications for cardiac PET are a,b and c above

Requests for repeat Cardiac PET scans within a 12-month span require Medical Director review for final determination.

IV. **Positron Emission Tomography (PET) Scans for Neurological Indications**
   a. MetroPlusHealth considers PET scans medically necessary for the following neurological indications:
      i. Pre-surgical evaluation for the purpose of localization of a focus of refractory seizure activity

**V.** Amyloid PET scan (including florbetapir F18 [Amyvid],florbetaben F18 [Neuraceq] flortaucipir F 18 injection [Tauvid],flutemetamol F18 [Vizamyl]) for persons with mild cognitive impairment due to Alzheimer disease who are being considered for aducanumab (Aduhelm), lecanemab-irmb (Leqembi), ordonanemab-azbt (Kisunla) therapy.

**VI. Other Indications**

a. Diagnosis, staging and re-staging of Langerhans cell histiocytosis;
b. Evaluation of Erdheim-Chester disease;
c. Evaluation of hemangiopericytoma;
d. Evaluation of large-vessel vasculitis (including giant cell arteritis and Takayasu arteritis) when diagnosis is uncertain following negative temporal artery biopsy results;
e. Workup of monoclonal gammopathy of undefined significance (MGUS) if computed tomography/magnetic resonance imaging (CT/MRI) are negative.
f. Whole-body PET/CT medically necessary for Rosai-Dorfman disease (RDD) to provide information for treatment decision-making that cannot be obtained by conventional imaging or biopsy. 1.

**5) LIMITATIONS/ EXCLUSIONS:** One (1) CT/MRI of the spine within a 12-month period; one (1) Cardiac PET scan within a 12-month period.

**6) APPLICABLE PROCEDURE CODES:**

| CPT | Description |
|---|---|
| 72125 | Computed tomography, cervical spine; without contrast material |
| 72126 | Computed tomography, cervical spine; with contrast material |
| 72127 | Computed tomography without contrast material, followed by contrast material(s) and further sections |
| 72128 | Computed tomography, thoracic spine; without contrast material |
| 72129 | Computed tomography, thoracic spine; with contrast material |
| 72130 | Computed tomography, thoracic spine without contrast material, followed by contrast material(s) and further sections |
| 72131 | Computed tomography, lumbar spine; without contrast material |

| | |
|---|---|
| **72132** | Computed tomography, lumbar spine; with contrast material |
| **72133** | Computed tomography, lumbar spine without contrast material, followed by contrast material(s) and further sections |
| **72141** | Magnetic resonance imaging, spinal canal, and contents, cervical; without contrast material |
| **72142** | Magnetic resonance imaging, spinal canal, and contents, cervical; with contrast material |
| **72146** | Magnetic resonance imaging, spinal canal, and contents, thoracic; without contrast material |
| **72147** | Magnetic resonance imaging, spinal canal, and contents, thoracic; with contrast material |
| **72148** | Magnetic resonance imaging, spinal canal, and contents, lumbar; without contrast material |
| **72149** | Magnetic resonance imaging, spinal canal, and contents, lumbar; with contrast material |
| **72156** | Magnetic resonance imaging, spinal canal, and contents, without contrast material followed by contrast material(s) and further sequences; cervical |
| **72157** | Magnetic resonance imaging, spinal canal, and contents, without contrast material followed by contrast material(s) and further sequences; thoracic |
| **72158** | Magnetic resonance imaging, spinal canal, and contents, without contrast material followed by contrast material(s) and further sequences; lumbar |
| **78429** | Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study; with concurrently acquired computed tomography transmission scan |
| **78430** | Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), single study, at rest or stress (exercise of pharmacologic), with concurrently acquired computed tomography transmission scan |
| **78431** | Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), multiple studies, at rest or stress (exercise of pharmacologic), with concurrently acquired computed tomography transmission scan |

| | |
|---|---|
| **78432** | Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (e.g., myocardial viability) |
| **78433** | Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer (e.g., myocardial viability) with concurrently acquired computed tomography transmission scan |
| **78434** | Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure) |
| **78459** | Myocardial imaging, positron emission tomography (PET), metabolic evaluation |
| **78491** | Myocardial imaging, positron emission tomography (PET), metabolic evaluation |
| **78492** | Myocardial imaging, positron emission tomography (PET), metabolic evaluation, multiple studies at rest or stress |

## 7) REFERENCES:

Agency for Healthcare Research and Quality (AHRQ). Comparative Effectiveness Review. Noninvasive testing for coronary artery disease. http://www.ahrq.gov. Published March 2016.

Ahmed, I and Devulapally, P. (2021). Nuclear Medicine PET Scan Cardiovascular Assessment, Protocols, and Interpretation. https://www.ncbi.nlm.nih.gov/books/NBK570631/

Al-Oweidi AS, Albabtain H, Kharabsheh SM, et al. Prevalence and predictors of myocardial ischemia by preoperative myocardial perfusion single photon emission computed tomography in patients undergoing noncardiac surgery. Ann Saudi Med. 2017;37(6):461-468.

Alster P, Madetko NK, Koziorowski DM, et al. Accumulation of tau protein, metabolism and perfusion-application and efficacy of positron emission tomography (PET) and single photon emission computed tomography (SPECT) imaging in the examination of progressive supranuclear palsy (PSP) and corticobasal syndrome (CBS). Front Neurol. 2019;10:101.

American College of Cardiology (ACC). 2014 AHA/ACC guideline for the management of patients with non-ST-elevation acute coronary syndromes. http://www.acc.org. Published December 23, 2014.

American College of Cardiology (ACC). 2018 ACC/AHA/HRS guideline on the evaluation and management of patients with bradycardia and cardiac conduction delay. http://www.acc.org. Published August 20, 2019.

American College of Radiology. (2017). Practice Parameter: Cardiac PET/CT.

Ben Bouallègue F, Mariano-Goulart D, Agostini D, Manrique A.EJNMMI Res. 2018 Sep 17;8(1):92. doi: 10.1186/s13550-018-0445-x.PMID: 30225682 Free PMC article
Brusko GD, Perez-Roman RJ, Tapamo H, et al. Preoperative SPECT imaging as a tool for surgical planning in patients with axial neck and back pain. Neurosurg Focus. 2019;47(6):E19.

Chen EQ, MacIntyre WJ, Fouad FM, Brunken RC, Go RT, Wong CO, Saha GB, Dorosti K, Razavi M, Armstrong R.Eur J Nucl Med. 1996 Aug;23(8):993-6. doi: 10.1007/BF01084378.PMID: 8753693

European Journal of Nuclear Medicine and Molecular Imaging. (2021) 48:1016-1039. Procedural recommendations of cardiac PET/CT imaging: standardization in inflammatory-, infective-, infiltrative-, and innervation (4ls)-related cardiovascular diseases: a joint collaboration of the EACVI and the EANM

Fujita S, Nagamachi S, Wakamatsu H, et al. Usefulness of triple-phase thallium-201 SPECT in non-small-cell lung cancer (NSCLC): Association with proliferative activity. Ann Nucl Med. 2008;22(10):833-839.

Hage FG, AlJaroudi WA.J Nucl Cardiol. 2018 Aug;25(4):1390-1399. doi: 10.1007/s12350-018-1266-z. Epub 2018 Apr 16.PMID: 29663117 Review of cardiovascular imaging in the journal of nuclear cardiology in 2016: Part 2 of 2-myocardial perfusion imaging.

Hage FG, AlJaroudi WA.J Nucl Cardiol. 2017 Aug;24(4):1190-1199. doi: 10.1007/s12350-017-0875-2. Epub 2017 Apr 6.PMID: 28386817

Johns Hopkins Medicine. (2022). Computed Tomography (CT or CAT) Scan of the Spine. https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/ct-scan-of-the-spine

Johns Hopkins Medicine. (2022). Magnetic Resonance Imaging (MRI) of the Spine and Brain.

https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/magnetic-resonance-imaging-mri-of-the-spine-and-brain

Journal of Nuclear Cardiology. Review of cardiovascular imaging. 2019: Positron emission tomography, computed tomography and magnetic resonance.

Journal of Nuclear Cardiology. Review of cardiovascular imaging. 2019: myocardial perfusion imaging.

Knaapen P, Lubberink M, Rijzewijk LJ, van der Meer RW, Unger M, Germans T, Bax JJ, Smit JW, Lamb HJ, van Rossum AC, Diamant M, Visser FC, Lammertsma AA.J Nucl Cardiol. 2008 Mar-Apr;15(2):218-24. doi: 10.1016/j.nuclcard.2007.11.016.PMID: 18371593
Mullani NA, Herbst RS, O'Neil RG, Gould KL, Barron BJ, Abbruzzese JL.J Nucl Med. 2008 Apr;49(4):517-23. doi: 10.2967/jnumed.107.048504. Epub 2008 Mar 14.PMID: 18344436

RadiologyInfo.org. (2019). Computed Tomography (CT) Spine.
https://www.radiologyinfo.org/en/info/spinect

Slomka PJ, Berman DS, Germano G.Semin Nucl Med. 2014 Jul;44(4):232-51. doi: 10.1053/j.semnuclmed.2014.04.003

The American College of Cardiology Foundation. JACC: Cardiovascular Imaging. Vol. 3, No. 6, 2010. Cardiac PET Imaging for the Detection and Monitoring of Coronary Artery Disease and Microvascular Health.

Characterizing and predicting pathologic spine fractures in myeloma patients with FDG PET/CT and MR imaging. AU Mulligan M, Chirindel A, Karchevsky M

Cancer Invest. 2011 Jun;29(5):370-6.
https://www.uptodate.com/contents/clinical-presentation-and-evaluation-of-complete-and-impending-pathologic-fractures-in-patients-with-metastatic-bone-disease-multiple-myeloma-and-lymphoma/abstract/31

Use of FDG-PET in differentiating benign from malignant compression fractures.
Bredella MA, Essary B, Torriani M, Ouellette HA, Palmer WE Skeletal Radiol. 2008 May;37(5):405-13. Epub 2008 Feb 16.

https://www.uptodate.com/contents/clinical-presentation-and-evaluation-of-complete-and-impending-pathologic-fractures-in-patients-with-metastatic-bone-disease-multiple-myeloma-and-lymphoma/abstract/30

The role of magnetic resonance imaging and positron emission tomography-computed tomography combined in differentiating benign from malignant lesions contributing to vertebral compression fractures. Aggarwal A, Salunke P, Shekhar BR, Chhabra R, Singh P, Bhattacharya A, Garg R Surg Neurol Int. 2013;4(Suppl 5): S323-6. Epub 2013 May 28.

https://www.uptodate.com/contents/clinical-presentation-and-evaluation-of-complete-and-impending-pathologic-fractures-in-patients-with-metastatic-bone-disease-multiple-myeloma-and-lymphoma/abstract/17,27,29,30

**REVISION LOG:**

| REVISIONS | DATE |
|---|---|
| Creation | 04/05/2022 |
| Revision made to definitions | 7/25/2022 |
| Annual Review | 4/23/2024 |
| Update to the policy | 10/28/2024 |
| Annual Review | 12/18/2024 |
| Update to the policy | 4/22/2025 |
| Annual Review and update to policy | 7/22/2025 |
| | |
| | |

**Approved:**

David Ackman — Digitally signed by David Ackman Date: 2026.01.09 12:00:34 -05'00'

**Dr. David Ackman**
**VP of Medical Directors**

Sanjiv Shah MD — Digitally signed by Sanjiv Shah MD Date: 2026.01.12 14:45:26 -05'00'

**Dr. Sanjiv Shah**
**Chief Medical Officer**

| Title: High Tech Radiology Studies (CT, MRI, PET) | Division: Medical Management<br>Department: Utilization Management |
|---|---|
| Approval Date: 6/27/2022 | LOB: Medicaid, Medicare, HIV SNP, CHP, MetroPlus Gold, Goldcare I&II, Market Plus, Essential, HARP, UltraCare |
| Effective Date: 6/27/2022 | Policy Number: UM-MP337 |
| Review Date: 7/22/2025 | Cross Reference Number: |
| Retired Date: | Page 14 of 14 |

**Medical Guideline Disclaimer:**

 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 guideline 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 the time of publication. MetroPlus Health Plan has adopted the policy herein providing management, administrative and other services to our members, related to health benefit plans offered by our organization.