IEHP’s Utilization Management Subcommittee has approved the following authorization guideline updates/changes, **effective August 12, 2020**:

<table>
<thead>
<tr>
<th>Guideline #</th>
<th>Guideline Title</th>
<th>Degree of Change</th>
<th>Updates/Changes</th>
</tr>
</thead>
</table>
| UM_DIA 05   | Dexa Scan       | Retired          | • Medicare does not have a California guideline.  
• MCG A-0093 Bone Density Study, Central, Dual Energy X-Ray Absorptiometry (DXA) provides criteria for men and women.  
• Apollo RAD 102 Bone Mass/Bone Mineral Density Studies (BMDS)-- Osteoporosis criteria mirrors IEHP UM Subcommittee Guidelines.  
• **Retire the current UM Subcommittee Guideline and replace with:**  
  o MCG A-0093 for Medicare  
  o Medi-Cal Provider Manual--Preventive Services  
  o Apollo RAD 102 for the cases that are not covered by MCG |
| UM_DIA 08   | Elastography    | Moderate         | • Medicare: No mention of use of elastography.  
• Medi-Cal: Medi-Cal Provider Manual provides billing codes, but no clinical guideline.  
• MCG: Provides no specific policies addressing the use of elastography.  
• Apollo addresses evaluation, but not monitoring.  
• Updated DHCS Treatment Policy for Management of Chronic Hepatitis C eliminates the requirement for elastography. |
| UM_OTH 13  | Transitional Care Medicine (TCM) | Moderate | • Elimination of exclusion of Landmark cohort Members.  
• Landmark Healthcare is no longer a contracted provider.  
• Continue using current UM Subcommittee Guideline on TCM. |
| UM_OTH 01  | Complementary and Alternative Medicine or Holistic Therapies | Moderate | • CAM is not covered because there is inadequate evidence of efficacy.  
• Many more CAM and Holistic therapies have been added since the guideline was created and are included in the Guideline references.  
• The Veterans Health Administration established a policy regarding integrating complementary and integrative health (CIH) approaches but does not specify therapies.  
• Continue using the UM Subcommittee Guideline |
| UM_PA1 01  | Pain Management Interventional Treatment/Diagnostic Procedures | Retired | This guideline has been retired for the following procedures:  
• Epidural steroid injections: laminar or transforaminal  
• Facet joint injection/medial branch nerve block  
• Nerve block  
• Trigger point injection  
• Sacroiliac joint injection  
• Replacement guidelines are on the following slides for each procedure. |
| Epidural steroid injections: laminar or transforaminal | | | • UM Subcommittee Guidelines list indication and frequency.  
• Medicare Local Coverage Determination (LCD) has detailed criteria that also indicates frequency.  
• Medi-Cal Provider Manual only mentions codes.  
• MCG does not list frequency limits, only addresses indications.  
• Apollo is similar to UM Subcommittee Guidelines in indications and frequency.  
• Retire the current UM Subcommittee Guideline and replace with:  
  o Medicare: LCD 34982 Lumbar Epidural Injections  
  o Medi-Cal: Apollo POS21-050 Transforaminal Epidural Injections, Diagnostic, Therapeutic |
| Facet joint injections/medial branch nerve block | | | • UM Subcommittee Guideline lists indication and frequency.  
• Medicare LCD has detailed criteria that also indicates.  
• Medi-Cal Provider Manual only mentions codes. |
| Nerve block | - MCG A-0695 Facet Joint Injection does not provide guidance with sufficient detail.  
- Apollo is similar to UM Subcommittee Guideline.  
- **Retire the current UM Subcommittee Guideline and replace with:**  
  - Medicare: LCD L34993 Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy  
  - Medi-Cal: Apollo AN 116 Facet Joint Injections, Median Branch Nerve Blocks |
| Trigger point injection | - UM Subcommittee Guideline lists indication and frequency.  
- Medicare has detailed major and minor criteria for trigger point injections.  
- Medi-Cal Provider Manual lists codes only.  
- MCG is silent on trigger point injections.  
- Apollo also lists indications and frequency.  
- **Retire the current UM Subcommittee Guideline and replace with:**  
  - Medicare: LCD L34211 Trigger Point Injections  
  - Medi-Cal: Apollo POS20-180 Trigger Point Injections |
| Sacroiliac joint injection | - UM Subcommittee Guideline lists indications and frequency.  
- Medicare has no specific guideline. |
- Medi-Cal only provides coding information.
- MCG is silent on sacroiliac joint injections.
- Apollo lists indications and frequency.
- **Retire the current UM Subcommittee Guideline and replace for both lines of business (Medicare and Medi-Cal) with:**
  - Apollo SM 150 Sacroiliac Joint Arthrography, Fusion, Injection, Sacroplasty

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<thead>
<tr>
<th>UM_DME 04</th>
<th>Durable Medical Equipment</th>
<th>Retired</th>
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<tbody>
<tr>
<td></td>
<td>Information and guidelines outlined in Medicare, Medi-Cal Provider Manual and Apollo are similar to that of UM Subcommittee Guideline.</td>
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<td>MCG addresses specific devices but not DME in general.</td>
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<td><strong>Retire the current UM Subcommittee Guideline and replace with:</strong></td>
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<td></td>
<td>- <strong>Medicare:</strong></td>
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<tr>
<td></td>
<td>- NCD for Durable Medical Equipment Reference List (280.1)</td>
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<tr>
<td></td>
<td>- Medicare Benefit Policy Manual – Chapter 15: Covered Medical and Other Health Services – Section 110.2 – Repairs, Maintenance, Replacement, and Delivery</td>
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<tr>
<td></td>
<td>- <strong>Medi-Cal:</strong></td>
<td></td>
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<tr>
<td></td>
<td>- Medi-Cal Provider Manual - Durable Medical Equipment (DME): An Overview</td>
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<tr>
<td></td>
<td>- Apollo DM 110 Disposable Medical Supplies (DM) / Durable Medical Equipment (DME) – Overview</td>
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<tr>
<th>UM_DME 10</th>
<th>Power Wheelchairs and Power Operated</th>
<th>Retired</th>
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<tbody>
<tr>
<td></td>
<td>Medicare covers Mobility Assistive Equipment (MAE) only for needs within the home when criteria is met.</td>
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<td></td>
<td>Medi-Cal covers Wheelchairs in or out of the home, including access to the community when criteria is met.</td>
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<td></td>
<td><strong>Retire the current UM Subcommittee Guideline and replace with:</strong></td>
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<td></td>
<td>- <strong>Medicare:</strong></td>
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<td></td>
<td>- Local Coverage Determination (LCD): Power Mobility Devices (L33789)</td>
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<tr>
<td></td>
<td>- National Coverage Determination (NCD) for Mobility Assistive Equipment (MAE) (280.3)</td>
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<td></td>
<td>- Medicare Benefit Policy Manual, Chapter 15, Section 110.2-Repairs, Maintenance, Replacement and Delivery</td>
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<td>- <strong>Medi-Cal:</strong></td>
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<td></td>
<td>- Medi-Cal Provider Manual - Durable Medical Equip (DME): Wheelchair and Wheelchair Accessories Guidelines</td>
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You may access these and all other authorization guidelines through the Provider portal.

**Location:** [www.iehp.org](http://www.iehp.org) > For Providers > Provider Resources > Utilization Management Criteria

As a reminder, all communications sent by IEHP can also be found on the Provider portal:

**Location:** [www.iehp.org](http://www.iehp.org) > For Providers > Plan Updates > Correspondence

If you have any questions, please do not hesitate to contact the IEHP Provider Relations Team at (909) 890-2054.

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<tr>
<th>UM_ONC 03</th>
<th>Selective Internal Radiation Therapy</th>
<th>Retired</th>
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|           | - UM Subcommittee Guideline states that SIRT is considered investigational and not medically necessary.  
- Medicare: No Local or National Coverage Determinations pertaining to SIRT.  
- Medi-Cal: No criteria or guidelines found for SIRT.  
- MCG: No criteria or guidelines found for SIRT.  
- Apollo: States that SIRT is considered medically necessary as palliative treatment for certain conditions.  
- **Retire the current UM Subcommittee Guideline and replace for both lines of business (Medicare and Medi-Cal) with:**  
  o Apollo RT 114 Selective Internal Radiation Therapy (SIRT) |

➢ Apollo DM185 Wheelchairs (Manual and Power), Power Operated Vehicles (POV)