New and Emerging Technology - Coverage Status

LOB(s): ☒ *Commercial* ☒ *Medicare*	*State(s):* ☒ *Idaho* ☒ *Montana* ☒ *Oregon* ☒ *Washington* ☐ *Other:*
☒ *Medicaid*	☒ *Oregon*

Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

New and emerging medical and behavioral healthcare procedures, pharmaceuticals, and devices (collectively "technologies") are often prescribed by physicians and/or marketed to the public before FDA or other government agency approval, or research is available in peer-reviewed literature documenting efficacy, safety, and long-term positive outcomes.

New and emerging technologies are reviewed by the New Technologies and Operational Criteria (NTOC) Committee which is chaired by a PacificSource Medical Director. The PacificSource Behavioral Health Medical Director or behavioral healthcare professional designee is involved in the decision-making process for behavioral healthcare services. Pharmaceuticals are reviewed by the PacificSource Pharmacy and Therapeutics (P&T) Committee.

The NTOC Committee bases its recommendation of coverage on review and evaluation of the following resources:

- Available peer-reviewed and evidenced-based literature
- Survey of standards of care and coverage
- Consultation with specialists and expert professionals
- PacificSource group and individual contracts

- Medicare and Medicaid requirements

This “New and Emerging Technologies – Coverage Status” policy outlines the evaluation process of new and emerging technology as well as coverage status of items considered experimental, investigational, or unproven.

Procedure

Commercial

Evaluation Process

The NTOC Committee reviews and evaluates new technology and new application of existing technology of medical and behavioral healthcare procedures and devices. NTOC Committee members represent key departments and stakeholders who have operational insight or responsibility for applying the criteria developed by the Committee. A PacificSource Medical Director chairs the NTOC Committee and ensures the Behavioral Health Medical Director or behavioral healthcare professional designee is involved in the decision-making process for behavioral healthcare services.

Agenda items for the NTOC Committee to review for coverage status are collected from multiple sources, which include, but are not limited to:

- New CPT or HCPCS codes
- New FDA approvals
- Provider inquiries
- Reports of new technology acquired by a community provider or anticipated to have widespread acceptance
- Utilization reviews and trends
- Vendor requests – vendor requests for reassessment of coverage position are limited to an annual review unless there is a change in FDA status or Hayes, Inc. rating

To inform its decision-making, the NTOC Committee reviews peer-reviewed and evidence-based information, which indicates if the technology is in general use or a community standard, is under continued scientific review (testing/research), is shown to have a demonstratable benefit, or is shown to be safe and efficacious). The reviews may consist of the following:

- Technology assessment consisting of:
    - Information from appropriate government regulatory bodies such as Food and Drug Administration (FDA) and Centers for Medicare & Medicaid Services (CMS)
        - FDA approval alone is not a basis for coverage
    - Assessment of peer-reviewed literature and their conclusions concerning:
        - Effect of the technology on health outcomes, with emphasis on random controlled clinical trial outcomes
        - Evidence comparing new technology to established alternatives
        - Results attained outside of investigational settings, with emphasis on studies that were not underwritten by the manufacturer or other sponsor with financial interest in the service or technology

    - Reports on long-term studies indicating improved health outcomes and/or clinical trials in process or recruiting
- Information available from evidence-based resources may vary depending on treatment procedure or device. The evidenced-based resources, which rely on the judgment of experts, include the following resources (additional resources may be reviewed as necessary based on the technology being reviewed):
    - Agency for Healthcare Research and Quality (AHRQ)
    - Carelon Medical Benefits Management Clinical Guidelines, formerly AIM (AIM Specialty Health) Clinical Guidelines
    - Alliance of Community Health Plans (ACHP)
    - American College of Radiology® (ACR)
    - American Hospital Formulary Service Drug Information (AHFS® DI™)
    - Bree Collaborative – Foundation for Health Care Quality
    - Centers for Disease Control and Prevention (CDC)
    - Cochrane Collaboration
    - Facts and Comparison®
    - symplr (Hayes, Inc., and Hayes Genetic Testing Evaluation Service)
    - MCG Health
    - MEDLINE® (component of PubMed®
    - Micromedex®
    - National Comprehensive Cancer Network® (NCCN)
    - National Institute for Health and Care Excellence (NICE)
    - Oregon Health Evidence Review Commission (HERC)
    - Professional Societies Recommendations and Practice Guidelines
    - UpToDate®
    - U.S. Pharmacopeia Dispensing Information
    - Washington Health Technology Assessment (HTA)
    - Washington Health Technology Clinical Committee (HTCC)
- Survey of similar market carriers and their published coverage position and/or medical policy concerning the service of technology under review
- PacificSource utilization and authorization data, as available and applicable

The PacificSource Medical Director may seek input or consult with specialists and professionals who have expertise in a specific technology when additional information is needed.

The NTOC committee, which includes a Medical Director, makes a determination based on the review of the technology that results in either:

- A covered service, which may include developing specific clinical guidelines criteria

- Experimental, Investigational, or Unproven (E/I/U) determination, which is added to the "New and Emerging Technologies – Coverage Status" policy or as an E/I/U item to an existing policy related to the technology reviewed
    - A technology may remain unproven and will not be reviewed annually (unless there is a request or increased utilization) when the following conditions are met:
        - The scientific evidence does not support clinical efficacy of the technology demonstrated by **ONE** of the following:
            - There is no general use within the medical community, i.e., the technology does not meet community standards
            - There have not been clinical studies for five or more years, indicating the technology is no longer under scientific review
            - The technology has not been proven to have a demonstrate able benefit or been shown to be safe and efficacious
        - Claims utilization indicates PacificSource has not received a request for a period of at least two years
    - The unproven technology which is not reviewed annually, will be moved to an excel sheet (NTOC Items Not Annually Reviewed on the Special Function SharePoint site and the NTOC Decision Tracker on the NTOC Teams channel) and noted as "Removed From Annual Review" in the modification history of the NTOC policy, along with associated codes

Quality Oversight

The "New and Emerging Technologies – Coverage Status" policy will be reviewed at least annually.

In addition, an annual report summarizing the NTOC review activity is presented to our Clinical Quality and Utilization Management (CQUM) committee, which consists of external providers and PacificSource Medical Directors, for review.

Medicaid

PacificSource Community Solutions (PCS) follows Excluded Services Guidelines E1 and E2 of the OHP Prioritized List of Health Services for guidance on New and Emerging Technology.

In the absence of coverage guidance on the OHA Prioritized List, Oregon Administrative Rules (OARs), or CMS guidelines and criteria, PCS will follow commercial criteria within a specific PacificSource policy, as applicable, or external criteria for determination of coverage and medical necessity coverage.

Medicare

PacificSource Medicare follows CMS guidelines and criteria. In the absence of CMS guidelines and criteria, PacificSource Medicare will follow commercial criteria within a specific PacificSource policy, as applicable, or external criteria for determination of coverage and medical necessity coverage.

Experimental/Investigational/Unproven Determinations for Coverage Status

The new and emerging medical technologies in the following list have been determined by the NTOC Committee to be experimental, investigational, or unproven (E/I/U) and therefore are not covered. The

impact of these technologies on health outcomes has not been established as the current scientific evidence is either not yet sufficient or does not support clinical efficacy.

The NTOC Committee has the authority to add new technologies or revise the determinations listed below based on additional review of current scientific evidence, advice, and recommendations by the NTOC Committee.

Experimental/Investigational/Unproven Determinations for Coverage Status

The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

PROCEDURE	CPT HCPCS	COVERAGE STATUS
AcuDetox (Auricular Acupuncture) treatment Addiction/substance abuse disorder or any other indication.	No Specific Code 97810, 97811	Not Covered (Experimental/Investigational/Unproven) (Review Contract for coverage)
Allogeneic haemopoietic stem cell transplantation (HSCT) and Autologous stem cell transplant (AHSCT) for Crohn's Disease	No Specific Code 38240	Not Covered (Experimental/Investigational/Unproven)
Bone Marrow Aspirate Concentrate (BMAC) therapy & Hematopoietic progenitor cell (HPC) used alone or in combination with other bone graft materials for all orthopedic applications including adjunct to spinal surgery	38230, 38241, 38232	Not Covered (Experimental/Investigational/Unproven) Exception: Bone Marrow Aspiration for transplant members
Botox injections for Cricopharyngeal (CP) dysfunction	No Specific Code 31571, 43499, 43236	Not Covered (Experimental/Investigational/Unproven)
CardioMEMS Sensor (implantable pulmonary artery pressure sensor) for Heart Failure	33289, 93264, C2624	Not Covered (Experimental/Investigational/Unproven)
Ceramics/Calcium Bone Void Fillers (also known as synthetic bone void fillers); (e.g., PRO-DENSE Regenerative Graft) used alone or in combination with other bone graft materials or bone marrow aspirate for all indications	No Specific Code 20900, 20902;	Not Covered (Experimental/Investigational/Unproven)
Clinicom" software platform for all indications	No Specific Code	Not Covered (Experimental/Investigational/Unproven)

PROCEDURE	CPT HCPCS	COVERAGE STATUS
	96146, 96127, 96130, 96136, 96138	
Coil embolization of hemorrhoids (Emborrhoid technique) embolization of the hemorrhoidal arteries.	No Specific Code 37241, 37244	Not Covered (Experimental/Investigational/Unproven)
Continuous Passive Motion (CPM) for Knees and all other indications	No Specific Code E0935, E0936	Not Covered (Experimental/Investigational/Unproven) (Legacy Employee Health Plan covers for knees)
Cryoablation for chronic rhinitis (allergic or nonallergic) (e.g., ClariFix device)	No Specific Code 31243	Not Covered (Experimental/Investigational/Unproven)
Deep Brain Stimulation (e.g., Reclaim DBS) for Obsessive-compulsive disorder and comorbid psychiatric disorders.	No specific Code **CPT Codes:** 61863, 61864, 61867, 61868, 61880, 61850, 61860 **HCPC Codes:** L8680, L8685, L8686, L8687, L8688	Not Covered (Experimental/Investigational/Unproven)
EarliPoint™ Evaluation - for diagnosing and assessing autism in children 16 to 30 months old	No specific Code 97110, 97112	Not Covered (Experimental/Investigational/Unproven)
Erector Spinae Pain block (ESP block) (paraspinal fascial plane block) for all indications	No Specific Code 64999	Not Covered (Experimental/Investigational/Unproven)
External Trigeminal Nerve Stimulation (eTNS) System (e.g., Monarch) indication ADHD in children aged 7 to 12 years	E0733, A4541	Not Covered (Experimental/Investigational/Unproven)
External upper limb tremor stimulator (e.g., Cala One; Cala Trio) for essential tremors or Parkinson's Disease	E0734, A4542	Not Covered (Experimental/Investigational/Unproven)
Gait Analysis (computerized) (Motion Analysis) for all indications.	No Specific Code 96000, 96001, 96004	Not Covered (Experimental/Investigational/Unproven)

PROCEDURE	CPT HCPCS	COVERAGE STATUS
gammaCore Sapphire handheld device (non-invasive Vagus nerve stimulation (nVNS)) for migraines; cluster headaches and Paroxysmal Hemicrania	E0735	Not Covered (Experimental/Investigational/Unproven)
Ganglion Impar block for Coccydynia, pelvic pain, and all other indications	No Specific Code 64999	Not Covered (Experimental/Investigational/Unproven)
Genicular artery embolization (GAE) (embolization of the knee) – treatment of osteoarthritis (OA) or other degenerative conditions	No Specific Code 37242	Not Covered (Experimental/Investigational/Unproven) **Approved** for coverage of knee hemarthrosis
Implantable intracardiac pressure monitors (e.g., CardioMEMS™ Heart Failure (HF) System) all indications	No Specific Code 93264, 33289, C2624	Not Covered (Experimental/investigational/Unproven)
Ingestible "Vibrant Capsule Devices," also known as an Ingestible vibrating capsules or Vibrant Gastro System for chronic idiopathic constipation and all other indications	A9268, A9269	Not Covered (Experimental/investigational/Unproven)
Intense Pulse Light Therapy for the treatment of dry eyes from meibomian gland dysfunction	No Specific Code 17999	Not Covered (Experimental/investigational/Unproven)
Interactive Metronome Training (e.g., attention deficit hyperactivity disorder or any other indication)	No Specific Code 97039, 97139, 97799 **Therapy codes:** 97110, 97112	Not Covered (Experimental/Investigational/Unproven)
Interferential Current Stimulation Therapy (IFS/ICT) (electrical stimulation) for all indications.	No Specific Code S8130, S8131	Not Covered (Experimental/Investigational/Unproven)
Intravascular Lithotripsy (IVL) – (Shockwave intravascular lithotripsy system (IVL)) Coronary for all indications	92972	Not Covered (Experimental/Investigational/Unproven)
iovera System ("cryoneurolysis,"- cold) for Knee Osteoarthritis	No Specific Code 64640, 64624, C9809	Not Covered (Experimental/Investigational/Unproven)
Jaw Motion Rehab System (e.g., TheraBite Jaw Motion	No Specific Code	Not Covered (Experimental/Investigational/Unproven)

PROCEDURE	CPT HCPCS	COVERAGE STATUS
Rehabilitation System, OraStretch press, and Dynasplint Trismus System) – all indications	E1700, E1701, E1702	
LimFlow System for Transcatheter Arterialization of Deep Veins (TADV) for all indications	C1889	Not Covered (Experimental/Investigational/Unproven)
LipiView II and LipiScan Ocular Surface Interferometer images Technique (diagnose and monitor meibomian gland dysfunction (MGD) and dry eye syndrome)	92285, 0330T, 0507T	Not Covered (Experimental/Investigational/Unproven)
Lymphaticovenous Anastomosis (LVA) (Lymphovenous bypass or shunt) for lymphedema	No Specific Code 38999, 38308	Not Covered (Experimental/Investigational/Unproven)
Magnetic Resonance Neurography (MRN), (also known as Magnetic Resonance Neurogram or MR Imaging of the Peripheral Nerves (PNI)) for all indications	No Specific Code 76498	Not Covered (Experimental/Investigation/Unproven)
Mesenchymal Stem Cell Therapy - considers the use of mesenchymal stem cell therapy (e.g., AlloStem, Osteocel, Trinity Evolution) for all orthopedic applications including repair or regeneration of musculoskeletal tissue, osteochondritis dissecans, spinal fusion, and bone nonunions.	No Specific Code 20999	Not Covered (Experimental/Investigational/Unproven)
Metatarsophalangeal Joint Replacement Implants: Ceramic prosthesis (e.g., Moje); or Modular implant (e.g., Metis); or Molded cylindrical implant (e.g., Cartiva SCI) for all indications and second Metatarsophalangeal joint replacement	No Specific Code L8641, L8642, L8658; L8699, 28899	Not Covered (Experimental/Investigational/Unproven)
MiraDry System aka Microwave or electromagnetic energy (microwave thermolysis) for all indications of hyperhidrosis	No Specific Code 17999	Not Covered (Experimental/Investigational/Unproven)
Nd: YAG laser vitreolysis (YAG Reflex Laser Systems, Ellex) -	No Specific Code 67031, 67299	Not covered (Experimental/Investigational/Unproven)

PROCEDURE	CPT HCPCS	COVERAGE STATUS
treatment of vitreous floaters or any other indication		
Nerve Hydrodissection procedure (e.g., Tarsal Tunnel tibial nerve compression) for all indications	No Specific Code 28899, 28035, 64999, 64722, 76942	Not covered (Experimental/Investigational/Unproven)
Non-Pneumatic Active Dynamic Compression (NPCD) or Garment to treat conditions like lymphedema; venous insufficiency or wound healing	No Specific Code E0677, E0678, E0679, E0680, E0681, E0682	Not covered (Experimental/Investigational/Unproven)
Occipital Nerve Stimulation (ONS) - intended to prevent migraines headaches and all other headaches	No Specific Code 64553, 61885, 61886	Not Covered (Experimental/Investigational/Unproven)
Oscillation and lung expansion device (e.g., BiWave Clear System) for all indications	No Specific Code E1399, E0469, A7021	Not Covered (Experimental/Investigation/Unproven)
OSSIOfiber Trimmable Nail System/Compression Screws - Orthopedic Surgeries fixation devices for all indications.	No Specific Code L8699	Not Covered (Experimental/Investigation/Unproven) **(May be included in surgical procedure)**
Ovarian or Internal Iliac Vein Embolization for Treatment of Pelvic Congestion Syndrome	No Specific Code 37241	Not Covered (Experimental/Investigational/unproven)
Platelet Rich Plasma for all indications (e.g., platelet-enriched plasma, platelet-rich concentrate) for all indications	P9020, G0460, G0465	Not Covered (Experimental/Investigational/unproven)
Patency Capsule Testing (e.g., PillCam Patency System, Agile Patency System/Capsule) for all indications	No specific code, 91299	Not Covered (Experimental/Investigational/Unproven)
Percutaneous Needled Tenotomy (PNT) for all indications	No Specific Code 27599, 20599	Not Covered (Experimental/Investigational/Unproven)
Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)	92972	Not Covered (Experimental/Investigational/Unproven)

PROCEDURE	CPT HCPCS	COVERAGE STATUS
Pleximmune a specialized qualitative prognostic test (age group pediatrics less than 21 y/o) for acute cellular rejection in children with liver or intestine transplantation and all other indications	81560	Not Covered (Experimental/Investigational/Unproven)
PortableConnect/ROMTech (ROMTech Portable Connect Rehab Adaptive Device) (e.g., postsurgical rehabilitative exercises) for all indications	No Specific Code E1399	Not Covered (Experimental/Investigational/Unproven)
Prescription Digital Therapeutics (PDT) (prescription-only software to manage medical disorders or diseases)	No Specific Code T1505, A9291, A9292	Not Covered (Experimental/Investigational/Unproven)
Pudendal Nerve Blocks (Injections) (e.g., Chronic Pelvic Pain, Pudendal neuralgia (PN))	No Specific Code 64430	Not Covered (Experimental/Investigation/Unproven) **Note:** Does not apply to the use of pudendal nerve blocks in obstetrics and other operative pelvic procedures; considered bundle charges
Pulsed radiofrequency Denervation (for the treatment of various chronic pain syndromes) for all indications	No Specific Code 64999	Not Covered (Experimental/Investigation/Unproven)
Radiofrequency Ablation (RFA) For Treatment Of Cervicogenic Headache	No Specific Code 64640	Not Covered (Experimental/Investigational/Unproven)
Radiofrequency Ablation (RFA) of Cluneal Nerve for all indications	No Specific Code 64640	Not Covered (Experimental/Investigational/Unproven)
Radiofrequency Ablation (RFA) of the femoral and obturator nerves for all indications	No Specific Code 64640	Not Covered (Experimental/Investigational/Unproven)
Radiofrequency Ablation – Genicular nerve ablation (knee pain) for all indications	64624	Not Covered (Experimental/Investigational/Unproven)
Radiofrequency Neurotomy for Morton's Neuroma	64632, 64632	Not Covered (Experimental/Investigational/Unproven)

PROCEDURE	CPT HCPCS	COVERAGE STATUS
Radiofrequency Neurotomy for planter nerve pain (also known as plantar neuropathy, (e.g., Baxter's Neuritis)	64632	Not Covered (Experimental/Investigational/Unproven)
Radiofrequency Ablation (RFA) for Plantar fasciitis (plantar fasciosis) (heel pain syndrome)	64632	Not Covered (Experimental/Investigational/Unproven)
Relivion MG device for headaches and all other indications	E0733, A4541, E1399	Not Covered (Experimental/Investigational/Unproven)
Renal sympathetic denervation for all indications	No Specific Code 0338T, 0339T, 0935T	Not Covered (Experimental/Investigational/Unproven)
Reverse Axillary Lymphatic Mapping - all indications	No Specific Code 38999, 38900	Not Covered (Experimental/Investigational/Unproven)
RhinAer Procedure non-invasive treatment for chronic rhinitis (allergic or nonallergic)	No Specific Code 31242	Not Covered (Experimental/Investigational/Unproven
Robotic Assisted In-Home Therapy Device/ Systems (e.g., Motus Hand/Foot Robotic System, IpsilHand) for all indications	E0739, E0738	Not Covered (Experimental/Investigational/Unproven)
Sphenopalatine Ganglion Nerve Block for any indication including, but may not be limited to, headaches and facial pain	64505	Not Covered (Experimental/Investigational/Unproven)
Supraorbital Nerve Block Injection w/Ultrasound (SON) - for all indications (e.g., Migraine Headaches; Cluster Headache suboccipital neuralgia)	No Specific Code 64400	Not Covered (Experimental/Investigational/Unproven)
TenoTac® Soft Tissue Fixation System for all indications	No Specific Code 28285	Not Covered (Experimental/Investigational/Unproven)
Topaz Coblation Therapy, (also known as Topaz Surgery, Radiofrequency coblation tenotomy) for all indications	No Specific Code 28899, 20999	Not Covered (Experimental/Investigational/Unproven)
Trabecular Bone Score (TBS) Bone Mineral Density Measurement) to Predict Fracture Risk (e.g., Osteoporosis) in Postmenopausal Patients	77089, 77090, 77091, 77092	Not Covered (Experimental/Investigational/Unproven)

PROCEDURE	CPT HCPCS	COVERAGE STATUS
Transcutaneous Vagal Nerve Stimulator (t-VNS) (e.g., noninvasive VNS (nVNS) treatment resistive depression, Bipolar or psychological disorders and all other indications	E0735	Not Covered (Experimental/Investigational/Unproven)
Trigeminal nerve blocks for Trigeminal Neuralgia; Cluster Headaches, Migraines and other facial pain	No Specific Code 64400	Not Covered (Experimental/Investigational/Unproven)
Vascular Lymph Node Transfer (VLNT) also called lymph node transfer (LNT); Lymphatic By-pass Procedure) for all indications	No Specific Code 38999, 38308	Not Covered (Experimental/Investigational/Unproven)
Vertebral axial decompression (non-surgical, noninvasive spinal traction therapy) for any indication	S9090	Not Covered (Experimental/Investigational/Unproven)
Virtual Reality Cognitive Behavioral Health therapy device for all indications	E1905	Not Covered (Experimental/Investigational/Unproven)
VivAer procedure (type of radiofrequency volumetric tissue reduction (RFVTR)) treat nasal airway obstruction (NAO)	30469, 30801	Not Covered (Experimental/Investigational/Unproven)
Whole body vibration (WBV) therapy (e.g.; Galileo Plate Device) for all indications	No Specific Code 97110, 97112, 97139, 97530, E1399	Not Covered (Experimental/Investigational/Unproven)

* HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).
* CPT® codes, descriptions and materials are copyrighted by the American Medical Association (AMA).

Definitions

Experimental, Investigational, or Unproven - medical and behavioral healthcare procedures, pharmaceuticals, and devices (collectively “technologies”) where peer-reviewed and evidence-based literature indicates the technology remains under scientific review, is not in general use or a community standard, has not been found to be safe and efficacious, and has not been shown to have a demonstratable benefit.

Related Policies

Category III Current Procedural Terminology (CPT) Codes

Medical Necessity Reviews

Proprietary Laboratory Codes (PLA)

Appendix

Policy Number:

Effective: 1/1/2021 **Next review:** 3/1/2026

Policy type: Enterprise

Author(s):

Depts.: Health Services

Applicable regulation(s): Social Security Act Section §1862(a), 42 CFR 411.15(o), NCQA UM 10(A)(B) – Evaluation of New Technology; Excluded Services Guideline E1 and E2 of the OHP Prioritized List of Health Services for guidance on New and Emerging Technology; OAR 410-120-1200; WAC 284-44-043, WAC 284-46-507, IDS 41-3930, 41-5903, MCA 33-32-103, ARM 37.82.102(c).

OPs Approval: 12/2025