PROVIDER*ALERT*

AmeriHealth Caritas Louisiana

To: **AmeriHealth Caritas Louisiana Providers**

Date: **July 23, 2026**

Subject: **Approved Clinical Guidelines**

Summary: Eight Approved Clinical Policies.

AmeriHealth Caritas Louisiana would like to inform you of eight updated clinical policies approved by the Louisiana Department of Health in accordance with La. R.S. 46:460.54. The guidelines are effective **August 23, 2026**, and will be located at the following link on our website under Clinical Policies: https://www.amerihealthcaritasla.com/provider/resources/index.aspx.

1. Air Ambulance Transport
2. Continuous Positive Airway Pressure
3. Hospice Prior Authorization
4. Hospital Services Prior Authorization
5. Microwave Thermotherapy for Lung and Kidney Tumors
6. Nonpharmacologic Treatments for Chronic Vertigo
7. Outpatient Therapy Licensed Practitioners
8. Three-Dimensional Imaging and Interpretation

Reminder: If your practice is not registered with our website portal, NaviNet, we highly recommend registering. To register, please visit www.navinet.net to sign up or contact your Provider Account Executive for details.

Questions:
Thank you for your continued support and commitment to the care of our members. If you have questions about this communication, please contact AmeriHealth Caritas Louisiana's Provider Services department at 1-888-922-0007 or your Provider Network Management Account Executive.

Missed an alert?
You can always find a complete listing of provider alerts on the Newsletters and Updates page of our website.

Need to update your provider information? Send full details to network@amerihealthcaritasla.com

Air ambulance transport

Clinical Policy ID: CCP.4051

Recent review date: 1/2026

Next review date: 5/2027

Policy contains: Air ambulance; medical helicopter; trauma care.

AmeriHealth Caritas Louisiana has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas Louisiana's clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered, on a case-by-case basis by AmeriHealth Caritas Louisiana when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas Louisiana's clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas Louisiana's clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas Louisiana will update its clinical policies as necessary. AmeriHealth Caritas Louisiana's clinical policies are not guarantees of payment.

Policy statement

Air ambulances may be used for emergency and non-emergency ambulance transportation (NEAT) when medically necessary. Licensure by the Louisiana Department of Health (LDH) Bureau of Emergency Medical Services (EMS) is required. Licensure for air ambulance services is governed by La. R.S. 40:1135.8. Rotor winged (helicopters) and fixed winged emergency aircraft must be certified by the Bureau of Health Services Financing (BHSF) in order to receive reimbursement.

All air ambulance services must comply with State laws and regulations governing the personnel certifications of the emergency medical technicians, registered nurses, respiratory care technicians, physicians, and pilots, as administered by the appropriate agency of competent jurisdiction.

Air ambulance transport is clinically proven and:

- Speedy admission of the member is essential and the point of pick-up of the member is inaccessible by a land vehicle; or
- Great distances or other obstacles are involved in getting the member to the nearest hospital with

appropriate services.

- If both land and air ambulance transport are necessary during the same trip, AmeriHealth Caritas shall reimburse each type of provider separately according to regulations for that type of provider. Prior approval shall not be required for emergency air ambulance transportation services, including mileage. Approval shall be done during a post payment review and shall not be completed prior to service delivery. Claims for payment of emergency air ambulance transportation services are received and reviewed retrospectively.

References

Louisiana Department of Health. Chapter 10. Medical transportation. Section 10.10. Air ambulance. Issued July 14, 2025.

Policy updates

2/2024: initial review date and clinical policy effective date: 3/2024

4/2015: Policy references updated.

4/2016: Policy references updated.

4/2017: Policy references updated.

4/2018: Policy references updated.

4/2019: Policy references updated. Policy number changed to CCP.1091.

4/2020: Policy references updated.

4/2021: Policy references updated.

4/2022: Policy references updated.

2/2024: Policy references updated. Coverage language modified.

1/2025: Policy references updated. Policy number changed to CCP.4051. Coverage language modified.

1/2026: Policy references updated. Coverage language modified. Code Table Added.

Related Codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy CCP.4051. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

Code	Code Description
A0430	Ambulance service, conventional air services, transport, one way (fixed wing)
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
A0435	Fixed wing air mileage, per statute mile
A0436	Rotary wing air mileage, per statute mile

Continuous Positive Airway Pressure

Plan: AmeriHealth Caritas Louisiana

Clinical Policy ID: CCP.4008

Recent review date: 1/2026

Next review date: 5/2027

Policy contains: Continuous Positive Airway Pressure; CPAP; obstructive sleep apnea; polysomnogram.

AmeriHealth Caritas Louisiana has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas Louisiana's clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of "medically necessary," and the specific facts of the particular situation are considered, on a case-by-case basis by AmeriHealth Caritas Louisiana when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas Louisiana's clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas Louisiana's clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas Louisiana will update its clinical policies as necessary. AmeriHealth Caritas Louisiana's clinical policies are not guarantees of payment.

Policy statement

Continuous positive airway pressure (CPAP) devices are clinically proven and, therefore, may be medically necessary for obstructive sleep apnea when the following criteria are met:

Criteria for Adults

A single level CPAP device is covered if the member has a diagnosis of obstructive sleep apnea (OSA), documented by an attended facility-based polysomnogram (PSG) or a home-based home sleep apnea test (HSAT), and meets either of the following criteria:

- The apnea-hypopnea index (AHI) is greater than or equal to 15 events per hour; or
- The AHI is from five to 14 events per hour with documented symptoms of:
    - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or
    - Hypertension, ischemic heart disease, or history of stroke.

AHI must be based on a minimum of two hours of sleep without the use of a positive airway pressure device. AHI must be reported using actual recorded hours of sleep and may not be extrapolated or projected.

For the purpose of this policy, polysomnographic studies may be performed in a facility-based sleep study laboratory, in the home, or in a mobile facility. These labs must be qualified providers of Medicare or Medicaid services and comply with all applicable state regulatory requirements.

For the purpose of this policy, polysomnographic studies may not be performed by a DME provider.

Pediatric Criteria (Under Age 21)

A single level CPAP device is covered if the member has a diagnosis of OSA documented by an attended, facility-based polysomnogram and there is:

- Documentation of physical exam (including airway) and of any other medical condition, which may be correctable (e.g., tonsillectomy and/or adenoidectomy) prior to the institution of assisted ventilation.
- Documentation of how sleep disturbance reduces the quality of life and affects the activities of daily living.
- Prescription by a physician with training and expertise in pediatric respiratory sleep disorders.
- Documentation of the medical diagnosis, which is known to cause respiratory/sleep disorders.
- Sleep or respiratory study documenting two or more of the following:
    - Oxygen saturation of less than 90% pulse oximetry or partial pressure of transcutaneous or arterial of less than 60 mm Hg;
    - Carbon dioxide greater than 55 mm Hg by end tidal, transcutaneous, arterial, or capillary blood measurement; and
    - Apnea of 10 to 20 seconds duration on the average of one per hour.
- A follow-up plan should be submitted identifying the responsible physician or facility, giving data collected to demonstrate the success or failure of intervention, and showing a visit within the first month of use and a second assessment within the first three months of use.
- Indication of a responsible, committed home environment and of caregivers properly trained in appropriate respiratory care.
- A written plan for home health follow-up care.

References

Louisiana Medicaid *Durable Medical Equipment Provider Manual.* 2010. Continuous Positive Airway Pressure. Chapter 18, Section 18.2. Issued 06/25/2025.

Policy updates

Initial review date: 3/2/2021

3/2023: Policy references updated.

1/2024: Policy references updated.

1/2025: Policy references updated.

1/2026: Policy references updated. Coverage criteria revised. Code table added.

Related Codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy CCP.4008. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

Code	Code Description
E0601	Continuous positive airway pressure (CPAP) device
E0470	Respiratory assist device, bi-level pressure capability, without backup rate feature, used with noninvasive interface
E0471	Respiratory assist device, bi-level pressure capability, with back-up rate feature, used with noninvasive interface
E0472	Respiratory assist device, bi-level pressure capability, with backup rate feature, used with invasive interface
E0561	Humidifier, non-heated, used with positive airway pressure device
E0562	Humidifier, heated, used with positive airway pressure device
A7030	Full face mask used with positive airway pressure device, each
A7031	Face mask interface, replacement for full face mask, each
A7032	Cushion for use on nasal mask interface, replacement only, each
A7033	Pillow for use on nasal cannula type interface, replacement only, pair
A7034	Nasal interface (mask or cannula type) used with positive airway pressure device, with or without head strap
A7035	Headgear used with positive airway pressure device
A7036	Chinstrap used with positive airway pressure device
A7037	Tubing used with positive airway pressure device
A7038	Filter, disposable, used with positive airway pressure device
A7039	Filter, non disposable, used with positive airway pressure device
A7046	Water chamber for humidifier, used with positive airway pressure device, replacement, each
A4604	Tubing with integrated heating element for use with positive airway pressure device
A7027	Combination oral/nasal mask, used with positive airway pressure device, each
A7028	Oral cushion for combination oral/nasal mask, replacement only, each
A7029	Nasal pillows for combination oral/nasal mask, replacement only, pair
A7044	Oral interface used with positive airway pressure device, each
A7045	Exhalation port with or without swivel used with positive airway pressure device, replacement only, each

Hospice Prior Authorization

Plan: AmeriHealth Caritas Louisiana

Clinical Policy ID: CCP.4014

Recent review date: 1/2026

Next review date: 5/2027

Policy contains: Hospice; prior authorization; documentation.

AmeriHealth Caritas has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas' clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of medically necessary, and the specific facts of the particular situation are considered, on a case by case basis, by AmeriHealth Caritas when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas' clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas' clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas will update its clinical policies as necessary. AmeriHealth Caritas' clinical policies are not guarantees of payment.

Policy statement

Prior authorization (PA) is required upon the initial request for hospice coverage. PA requests must be submitted within 10 calendar days of the hospice election date. If the PA is approved, it covers 90 days. If another 90-day election period is required, the PA request must be submitted at least 10 days prior to the end of the current election period. This will ensure that requests are received and approved/denied before the preceding period ends. If this requirement is not met and the period ends, reimbursement will not be available for the days prior to receipt of the new request. If approved, reimbursement will be effective the date the Prior Authorization Unit (PAU) receives the proper documentation.

The completed PA (see *Required Documentation* in this section,) which includes the updated and signed “Hospice Certification of Terminal Illness” (BHSF Form Hospice CTI) and all related documents, must be received before the period ends. Any PA request received after the period has ended will become effective on the date the request is received by the PAU if the request is approved. This policy also applies to PA packets received after eligibility has ended. It is the responsibility of the provider to verify eligibility on a monthly basis. The PA only approves the existence of medical necessity, not member eligibility.

All requests for hospice PA must be submitted to the AmeriHealth Caritas Louisiana Utilization Management department.

NOTE: PA is not required for dual eligible beneficiaries (Medicare primary) during the two 90-day election periods and the subsequent 60-day election periods. However, providers must submit through the e-PA system a copy of the Medicare Common Working File screen showing the hospice segment, along with the signed CTI and Notice of Election (NOE) forms.

Levels of hospice care, each with particular criteria and payment rates, include:

- Routine Home Care. Defined as when an individual who has elected to receive hospice care is at home and is not receiving continuous home care. The routine home care rate is paid without regard to the volume or intensity of routine home care services provided on any given day.

- Continuous Home Care. Defined as the individual receiving hospice care is not in an inpatient facility and receives care consisting predominantly of nursing care on a continuous basis at home. Continuous home care is only furnished during brief periods of medical crisis and only as necessary to maintain the terminally ill member at home.

- Inpatient Respite Care. Defined as when the individual receives care in an approved facility on a short-term basis to relieve the family members or other persons caring for the individual at home. Payment is made for respite care for a maximum of five continuous days at a time. Payment for the sixth day, and any subsequent days, is made at the routine home care rate.

- General Inpatient Care. Defined as when an individual receives general inpatient care in an inpatient facility for the purpose of pain control or acute or chronic symptom management, which cannot be managed in other settings. Payment is made for inpatient care for a maximum of five continuous days at a time, including the date of admission, but not counting the date of discharge. The hospice is the professional manager of the member's care.

Required Documentation

Documentation should paint a picture of the member's condition by illustrating the member's decline in detail (e.g., documentation should show last month's status compared to this month's status and should not merely summarize the member's condition for a month). In addition, documentation should show daily and weekly notes and illustrate why the member is considered to be terminal and not "chronic". Explanation should include the reason the member's diagnosis has created a terminal prognosis and show how the systems of the body are in a terminal condition. Telephone courtesy calls are not considered face-to-face encounters and will not be reviewed for prior authorization.

The following information will be required upon the initial request for hospice services.

First Benefit Period (90 days)

- Hospice Election Form (primary diagnosis code(s) using the International Classification of Disease, Tenth Revision (ICD-10) or its successor; other codes);
- Hospice Certification of Terminal Illness form (BHSF Form Hospice – CTI);
- Clinical/medical information;
- Hospice provider plan of care:
    - Progress notes (hospital, home health, physician's office, etc.);
    - Physician orders for plan of care; and
    - Include Minimum Data Set (MDS) or jRaven form (original and current) if member is in a facility; weight chart; laboratory tests; physician and nursing progress notes. The MDS or jRaven form is

not required if the member has been in a long-term care facility less than 30 days. The MDS or jRaven form must be provided upon the subsequent request for continuation of hospice services;

- Documentation to support member's hospice appropriateness, including the following:
  - Paint picture of member's condition;
  - Illustrate why member is considered terminal and not chronic;
  - Explain why his/her diagnosis has created a terminal prognosis; and
  - Show how the body systems are in a terminal condition.

Second and Subsequent Periods

Providers requesting PA for the second period, and each subsequent period, must send the following packet for prior authorization:

- MDS or jRaven forms (original and current) are required; weight chart; laboratory tests; physician and nursing progress notes if the member resides in a nursing facility;
- An updated Hospice Certification of Terminal Illness form (BHSF Form Hospice-CTI) and proof of a face-to-face encounter signed and dated by the hospice provider's medical director or physician member of the interdisciplinary group (IDG) for the third and subsequent requested PA periods;
- An updated plan of care;
- Updated physician's orders;
- List of current medications (within last 60 days);
- Current laboratory/test results (within last 60 days if available);
- Description of hospice diagnosis;
- Description of changes in diagnoses;
- Progress notes for all services rendered (daily/weekly physician, nursing, social worker, aide, volunteer and chaplain);
- A social evaluation;
- An updated scale such as: Karnofsky Performance Status Scale, Palliative Performance Scale or the Functional Assessment Tool (FAST);
- The member's current weight, vital sign ranges, lab tests and any other documentation supporting the continuation of hospice services. Documentation must illustrate the member's decline in detail. Compare last month's status to this month's status; and
- Original and current MDS or jRaven forms if member is a resident in a facility.

This information must be submitted for all subsequent benefit periods and must show a decline in the member's condition for the authorization to be approved.

For PA, the prognosis of terminal illness will be reviewed. A member must have a terminal prognosis in addition to a completed Hospice Certification of Terminal Illness form and proof of the face-to-face encounter. Authorization will be made on the basis that a member is terminally ill as defined in federal regulations. These regulations require certification of the prognosis, rather than diagnosis. Authorization will be based on objective clinical evidence in the clinical record about the member's condition and not simply on the member's diagnosis.

A cover letter attached to the required information will not suffice for supporting documentation.

The supporting information must be documented within the clinical record with appropriate dates and signatures.

Example: A member receives hospice care during an initial 90-day period and is discharged or revokes his/her election of hospice care during a subsequent 90-day period, thus losing any remaining days in that election period. If this member chooses to elect a subsequent period of hospice care, even after an extended period

without hospice care, prior authorization will be required. The Notice of Election (NOE), Hospice Certification of Terminal Illness form, and all prior authorization documentation are due within the 10 day time frame. Reimbursement will be effective the date the required information is received by the PAU if receipt is past 10 days.

A provider, who anticipates the possibility of providing hospice care for a member beyond the initial 90-day election period, must submit a prior authorization packet to the PAU. The required information and any supporting documentation must be sent.

Written Notice of Prior Authorization Decision

PA requests will be reviewed using the Medicare criteria found in local coverage determination hospice determining terminal status (L34538) and approved or denied within five working days. Once the review process has been completed and a decision has been made, the hospice provider will receive a written notification of the decision. A denial does not represent a determination that further hospice care would not be appropriate, but that based on the documentation provided, the member does not appear to be in the terminal stage of illness. Providers are encouraged to submit prior authorization packets for the next subsequent period within the set time frame when there is evidence of a decline in health if a prior period had been denied.

NOTE: It is the hospice provider's responsibility to inform the nursing facility of approval or denial.

Reconsideration

If a member does not agree with the denial of a period or subsequent period, reconsideration may be requested. Documentation must be recent and may not include information previously omitted or previously submitted. All reconsideration requests will be reviewed within five working days of receipt.

References

Louisiana Department of Health. 2012. Hospice Provider Manual. Chapter 24, Section 24.6. https://www.lamedicaid.com/provweb1/Providermanuals/manuals/Hospice/Hospice.pdf. Issued 5/19/2025.

Policy updates

Initial review date: 3/2/2021

1/2022: Coverage section updated.

1/2023: Coverage section updated.

1/2024: Coverage section updated.

1/2025: Coverage section updated.

1/2026: Coverage section updated. Coding section added.

Related Codes

Below are the most commonly submitted codes for the service(s)/item(s) subject to this policy CCP.4014. This is not an exhaustive list of codes. Providers are expected to consult the appropriate coding manuals and bill accordingly.

Code	Code Description
T2042	Hospice routine home care; per diem
T2043	Hospice continuous home care; per hour
T2044	Hospice inpatient respite care; per diem
T2045	Hospice general inpatient care; per diem
T2046	Hospice long term care, room and board only; per diem
G0299	Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting, each 15 minutes
Q5001	Hospice or home health care provided in patient's home/residence
Q5002	Hospice or home health care provided in assisted living facility
Q5003	Hospice care provided in nursing long term care facility (LTC) or non-skilled nursing facility (NF)
Q5004	Hospice care provided in skilled nursing facility (SNF)
G0300	Direct skilled nursing services of a licensed practical nurse (LPN) in the home health or hospice setting, each 15 minutes
Q5005	Hospice care provided in inpatient hospital
Q5006	Hospice care provided in inpatient hospice facility
Q5007	Hospice care provided in long term care facility
Q5008	Hospice care provided in inpatient psychiatric facility
Q5009	Hospice or home health care provided in place not otherwise specified (NOS)
Q5010	Hospice home care provided in a hospice facility

Hospital Services Prior Authorization

Plan: AmeriHealth Caritas Louisiana

Clinical Policy ID: CCP.4042

Recent review date: 7/2025

Next review date: 11/2026

Policy contains: Hospital services; prior authorization; therapy.

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Policy statement

Besides the services found below, AmeriHealth Caritas Louisiana has included a process for emergency authorization of certain equipment, which are considered life threatening should a delay in their receipt occur. These include Apnea monitors, breathing equipment, hyperalimentation therapy aids (parenteral and enteral) and suction machines. In addition to these items for life threatening situations, emergency requests may be made for the temporary rental of wheelchairs for post-operative needs after a hospital discharge. The providers of emergency items must contact the AmeriHealth Caritas Louisiana Utilization Management immediately by telephone and provide the following information:

- The recipient's name, age, and AmeriHealth Caritas Louisiana identification number;
- The treating physician's name;
- The diagnosis;
- The time period of need for the item(s);
- A complete description of the item(s) requested;
- The reason that the request is a medical emergency; and
- The cost of the item.

The decision will be made by AmeriHealth Caritas Louisiana within two working days of the date the completed request is received, and AmeriHealth Caritas Louisiana will contact the provider by telephone and follow up in writing.

Outpatient Rehabilitation Services

Outpatient rehabilitation is prior authorized and are reimbursed by the Healthcare Common Procedure Coding System (HCPCS) for outpatient rehabilitation services including:

- Physical therapy;
- Occupational therapy; and
- Speech and hearing therapy.

A licensed physician must make the referral. The referral must include the diagnosis, the date of the accident (or onset of illness), the address of the referring physician, his/her specialty (if known), and the date of the referral. The hospital must retain a copy of the physician's referral on file.

The rehabilitation services department must evaluate the recipient. Initial therapy and extended therapy plans require prior authorization. Evaluation codes do not require prior authorization, but are limited to one evaluation per 180 days.

Description	HCPC
Evaluation of Speech Fluency	92521
Evaluation of Speech Production	92522
Speech Sound Lang Comprehension	92523
Behavioral Quality Analysis Voice	92524
Speech/Lang/Hear Therapy – per 15 min	92507
Physical Therapy Evaluation: Low Comp	97161
Physical Therapy Evaluation: Mod Comp	97162
Physical Therapy Evaluation: High Comp	97163
Re-Evaluation of Physical Therapy	97164
Therapeutic Exercises – per 15 min	97110

Description	HCPC
Occupational Therapy Evaluation: Low Comp	97165
Occupational Therapy Evaluation: Mod Comp	97166
Occupational Therapy Evaluation: High Comp	97167
Re-Evaluation of Occupational Therapy	97168
Therapeutic Activities – per 15 min	97530

When requesting PA for outpatient rehabilitation services, the following information must be included, or the request could be delayed or be denied:

- A treatment request form Initial therapy and extended therapy plans;
- Number of services, visits being requested;
- Physician's referral;
- Evaluation results; and
- Revenue Code and the HCPCS code.

NOTE:CPT codes 97110 and 97530 may be billed with either Physical therapy revenue codes or Occupational therapy revenue codes to best reflect the specific scope of services provided. The request should be sent to AmeriHealth Caritas Louisiana.

Extension requests should be submitted at least 25 days prior to the end of the approved period. The requests should have at a minimum the following information attached:

- Therapy notes;
- Current evaluation results;
- Goals and objectives; and
- Copy of the physician's referral.

In cases where a delay in therapy would result in deterioration of the medical condition (e.g., burn cases, accidents, or surgery) the treatment may be instituted subject to later approval. The request for therapy should be submitted within the first week of therapy, with an explanation and a request for approval from the start of therapy.

To expedite the approval process, if it is known that outpatient rehabilitation services will be required upon discharge, a PA request can be submitted using anticipated discharge date as the beginning date of service.

Services may be provided by any enrolled AmeriHealth Caritas Louisiana provider even if furnished as part of an Individual Family Service Plan (IFSP) or Individual Service Plan or provided in a school setting. These services may be received at home from a provider of home services or home health agency.

Outpatient Surgery Performed On An Inpatient Basis

Certain surgical procedures are covered only when performed as outpatient unless otherwise authorized. These procedures are usually performed on an outpatient basis but can be performed inpatient if it is medically necessary and PA is obtained. A list of outpatient procedures requiring PA to be performed on an inpatient basis may be found on the AmeriHealth Caritas Louisiana website.

A prior authorization request form should be submitted prior to performance of the surgery. However, post authorization may be requested in emergency situations. See post authorization information below.

Approval for inpatient performance of these procedures will be granted only when one or more of the following exception criteria exists:

- Documented medical conditions exist that make prolonged pre-and/or postoperative observation by a nurse or skilled medical personnel a necessity.
- The procedure is likely to be time consuming or followed by complications.
- An unrelated procedure is being performed simultaneously that requires hospitalization.
- There is a lack of availability of proper post-operative care.
- Another major surgical procedure could likely follow the initial procedure (e.g., mastectomy).
- Technical difficulties as documented by admission or operative notes could exist.
- The procedure carries high recipient risk.

NOTE: Authorization is not required if the procedure is performed in a hospital based ambulatory surgery center.

Organ Transplants

Transplants must be prior authorized by AmeriHealth Caritas Louisiana. Transplants (other than bone marrow and stem cell) must be performed in a hospital that is a Medicare approved transplant center for the procedure. Hospitals seeking AmeriHealth Caritas Louisiana coverage for transplant procedures must submit documentation verifying that they are a Medicare approved center for each type of transplant other than bone marrow and stem cell transplants. A completed attestation form must be submitted to AmeriHealth Caritas Louisiana. AmeriHealth Caritas Louisiana may grant an exception to a transplant center for a specific procedure if the transplant surgeon can demonstrate experience with that specific procedure and a history of positive outcomes in another hospital. The other hospital must be a Medicare approved transplant center for that specific procedure.

In addition to the above criteria, transplant centers located in-state shall meet the following criteria for AmeriHealth Caritas Louisiana coverage of transplant services:

- Be a member of the Organ Procurement and Transplant Network (OPTN) or the National Marrow Donor Program (NMDP), if the hospital only performs bone marrow/stem cell transplants;
- Have an organ receiving and tissue typing facility (Centers for Medicare and Medicaid Services (CMS) approved for histocompatibility) or an agreement for such services;
- Maintain a written records tracking mechanism for all grafts and recipients including:
    - Patient and/or graft loss with the reason specified for failure;
    - Date of the procedure; and
    - Source of the graft.
- Have written policy for contacting recipients and appropriate governmental officials when an infectious agent is involved;
- Have a written criteria for acceptable donors for each type of organ for which transplants are performed;
- Have adequate ancillary departments and qualified staff necessary for pre-, intra-, and post-operative care including, but not limited to:
    - Assessment team;
    - Surgical suite;
    - Intensive care;
    - Radiology;
    - Laboratory pathology;
    - Infectious disease:
    - Dialysis; and
    - Therapy (rehabilitation).
- Have minimum designated transplant staff which includes:
    - Transplant surgeon- adopt standards as delineated and updated by the OPTN;
    - Transplant physician - same standards as above;
    - Clinical transplant coordinator:
        - Registered nurse licensed in Louisiana; and
        - Certified by NATCO or in training and certified within 18 months of hire date.
    - Transplant social worker;
    - Transplant dietician;
    - Transplant data coordinator; and
    - Transplant financial coordinator.

    NOTE: For individuals identified in the bullets immediately above this note, continuing education is required to maintain licensure and certification as applicable.
- Written recipient selection criteria and an implementation plan for application of criteria;
- Facility plan, commitment and resources for a program capable of performing the following minimum number of transplants per year/per organ:

- Heart: 12;
- Liver: 12;
- Kidney: 15;
- Pancreas: 6;
- Bone marrow: 10; and
- Other organs as established per Medicare and/or OPTN.

NOTE: If the level falls below the required volume, the hospital shall be evaluated by AmeriHealth Caritas Louisiana for continued recognition as a transplant center.

Facility must demonstrate survival rates per organ type per year, which meet or exceed the mean survival rates per organ type per year as published annually by the OPTN. (If rates fall below this level, the hospital shall supply adequate written documentation for evaluation and justification to AmeriHealth Caritas).

All organ transplants must be authorized by AmeriHealth Caritas Louisiana prior to the performance of the surgery via a prior authorization letter. The only exception is for recipients with retroactive eligibility.

Transplant charges are to be included in the inpatient hospital charges using the revenue codes 300 and 800 range. This includes donor search charges and all procedures involved in harvesting the organ from the donor. Costs associated with the search will not be covered on an outpatient basis. Costs are not covered when the AmeriHealth Caritas Louisiana recipient donates an organ to a non-AmeriHealth Caritas Louisiana recipient.

Required Documentation for Organ Transplant Authorization Requests

All transplants must be prior authorized. The only exception is for recipients with retroactive eligibility. All documentation supporting the performance of the transplant must be attached to the letter.

Standards for Coverage

Requests for transplants are reviewed on a case-by-case basis by applying the following criteria:

- Transplant procedure to be performed is compatible with the diagnosis.
- All alternative forms of treatment have been tried, and the only viable alternative is the transplant procedure.
- Death would be imminent if the procedure were not performed is a reasonable medical probability.
- The procedure has met with a reasonable degree of success in the past.
- The procedure may be performed out of the state, if the facilities in state are not available.
- Services to the organ donor and organ procurement costs are included in the reimbursement methodology.

Cochlear Implantation

Louisiana Medicaid covers unilateral or bilateral cochlear implants when deemed medically necessary for the treatment of severe-to-profound, bilateral sensorineural hearing loss in individuals under 21 years of age. All aspects of the cochlear implant (preoperative evaluation, implantation, device, repairs, supplies, therapy) must be prior authorized. For eligibility criteria and prior authorization instructions, please refer to Chapter 5, which is the Professional Services manual chapter. For information on coverage of cochlear implants, equipment, repairs and replacements, please refer to manual Chapter 18, Durable Medical Equipment.

Reimbursement

Reimbursement will be made to the hospital for both the implant and the per diem. The implant and the implantation surgery must be prior authorized by submitting the PA-01 form. After approval has been granted, the hospital shall bill for the implant(s) by submitting the appropriate HCPCS code on a CMS 1500 claim form. Write the letters DME in bold, black print on the top of the form and the PA number must be written in item 23.

Medical and Social Criteria

General Criteria

The following criteria apply to all candidates:

- Have a profound bilateral sensor-neural hearing loss with pure tone average of 90 dB HL or greater for frequencies of 1000, 2000, and 4000Hz;
- Have no response to Auditory Brainstem Response, Otoacoustic testing or any other special testing or any other special testing that would be required to determine if the hearing loss is valid and severe enough to qualify for cochlear implantation;
- Be a child age one year or older with a profound sensorineural hearing loss or be an adult through the age of twenty years; with a profound post lingual sensorineural hearing loss;
- Receive no significant benefit from hearing aids as validated by the implant team;
- Have a high motivation to be part of the hearing community as validated by the implant team;
- Have appropriate expectations;
- Had radiologic studies that demonstrate no intra cranial anomalies or malformations which contraindicate implanting the receiver-stimulator or the electrode array;
- Have no medical contraindication for undergoing implant surgery or post implant rehabilitation; and
- Show that the recipient and his/her family are well motivated, have appropriate expectations and are prepared and willing to participate and cooperate in the pre and post implant assessment and rehabilitation programs recommended by the implant team and in conjunction with the Food and Drug Administration (FDA) Guidelines.

Age-Specific Criteria

Children One through Nine Years

Children one through nine years must not receive any significant benefit from a hearing aid that was obtained in the best-aided condition as measured by age appropriate speech perception material.

Children 10-17 Years

Children in this age range must meet the following criteria:

- Receive no significant benefit from a hearing aid that was obtained in the best aided condition as measured by age and language appropriate speech perception material;
- Have received consistent exposure to effective auditory or phonological stimulation in conjunction with the oral method of education and auditory training;
- Utilizes spoken language as the primary mode of communication through one of the following: an oral/aural (re) habilitation program or total communications educational program with significant oral/aural; and

- Have at least six months' experience with a hearing aid or vibrotactile device in the case of meningitis (in which case the six-month period will be reduced to three months).

Adults - 18-20 Years

The following criteria must be met:

- Have a severe to profound post lingual bilateral sensorineural hearing loss;
- Receive no significant benefit from a hearing aid that was obtained in the best-aided condition for speech/sentence recognition material;
- Have received consistent exposure to effective auditory or phonological stimulation or auditory communication;
- Have no medical contraindication for the undergoing implant surgery or post-implant rehabilitation; and
- Show that the recipient and his/her family are well-motivated, have appropriate post-implant expectations and are prepared and willing to participate and cooperate in the pre and post implant assessment and rehabilitation programs recommended by the implant team and in conjunction with the Food and Drug Administration (FDA) guidelines.

The criteria utilized must be appropriate for the child's age.

Re-Performance of the Surgery

Prior Authorization is required for re-performance of the surgery because of infection, extrusion, or other reason. The request should be submitted to AmeriHealth Caritas Louisiana and contain sufficient documentation explaining the reason the surgery must be repeated.

Replacement of the External Speech Processor

Replacement of the external speech processor will be considered only if the processor is lost, stolen, or damaged beyond repair.

Upgrades due to cosmetic reasons or technological advances in the hardware do not qualify as reasons for a replacement.

When it is necessary to replace the external speech processor, the multidisciplinary team must initiate the required PA request by submitting a copy of PA's initial approval letter for the implant and documentation of the need for a new processor.

Non-Covered Expenses

Service contracts and/or extended warranties and insurance to protect against loss and theft are the responsibility of the family.

Vagus Nerve Stimulator

The vagus nerve stimulator (VNS) is an implantable device used to assist in the control of seizures related to epilepsy and must be prescribed by a physician.

Hospitals should confirm that the surgeon has received an authorization for the procedure prior to submitting their claim in order to prevent denials.

Intrathecal Baclofen Therapy

Intrathecal Baclofen Therapy (ITB) is for the treatment of severe spasticity of the spinal cord or cerebral origin and for the surgical implantation of the programmable infusion pump by which ITB is delivered. This treatment must be prior authorized before its administration. To obtain pre-certification for the stay, the pre-certification process must be followed.

Criteria for Recipient Selection

Consideration will be given for reimbursement for implanting an ITB infusion pump if the treatment is considered medically necessary, the recipient is four years of age or older with a body mass sufficient to support the implanted system, and any one or more of the following criteria is met:

- Inclusive criteria for candidates with spasticity of cerebral origin:
    - There is severe spasticity of cerebral origin with no more than mild athetosis;
    - The injury is older than one year;
    - There has been a drop in Ashworth scale of one or more;
    - Spasticity of cerebral origin is resistant to conservative management; or
    - The candidate has a positive response to the test dose of ITB.
- Inclusive criteria for candidates with spasticity of spinal cord origin:
    - Spasticity of spinal cord that is resistant to oral antispasmodics or side effects are unacceptable in effective doses;
    - There has been a drop in Ashworth scale of two or more; or
    - The candidate has a positive response to the test dose of ITB.

Caution should be exercised when considering ITB infusion pump implantation for candidates who:

- Have a history of autonomic dysreflexia;
- Suffer from psychotic disorders;
- Have other implanted devices; or
- Utilize spasticity to increase function such as posture, balance, and locomotion.

Exclusion Criteria for Recipients

- Fails to meet any of the inclusion criteria;
- Is pregnant, refuses or fails to use adequate methods of birth control;
- Has a severely impaired renal or hepatic function;
- Has a traumatic brain injury of less than one year pre-existent to the date of the screening dose;
- Has a history of hypersensitivity to oral baclofen;
- Has a systematic or localized infection which could infect the implanted pump; or
- Does not respond positively to a 50, 75, or 100 mcg intrathecal bolus of Lioresal during the screening trial procedure.

Prior Authorization for chronic infusion of ITB shall be requested after the screening trial procedure has been completed but prior to the pump implantation.

The request to initiate chronic infusion shall come from the multi-disciplinary team that evaluates the recipient. The multi-disciplinary team should consist of a neurosurgeon or an orthopedic surgeon, a physiatrist and/or neurologist, the recipient's attending physician, a nurse, a social worker and allied professionals (physical therapists, occupational therapist, etc.).

These professionals shall have expertise in the evaluation, management, and treatment of spasticity of cerebral and spinal cord origin and shall have undergone training in infusion therapy and pump implantation by Medtronic or an equally recognized product supplier with expertise in intrathecal baclofen.

A recent history with documentation of assessments in the following areas must be sent to AmeriHealth Caritas Louisiana:

- Medical and physical;
- Neurological;
- Functional;
- Psychosocial;
- Ashworth scores taken before and after the administration of the IBT test dose(s); and
- Documentation of any other findings about the recipient's condition which would be of interest to or would assist AmeriHealth Caritas Louisiana in making a decision regarding the recipient's need for chronic infusion, i.e., a videotape of the trial dosage.

Out-of-State Non-Emergency Hospitalizations

Out-of-state non-emergency hospitalizations require authorization, unless the request for hospitalization is for a dual Medicare/AmeriHealth Caritas Louisiana eligible recipient. Authorization is required for dual eligible recipients only if transportation services are being requested in addition to the hospitalization.

To obtain authorization for out-of-state non-emergency hospitalizations, send a facsimile (fax) of a "Letter of Referral" to the attention of AmeriHealth Caritas Louisiana. The referring physician should sign the "Letter of Referral" and answer the following questions:

- What is the recipient's name and AmeriHealth Caritas Louisiana identification number?
- What is the name and telephone number of the contact person representing the recipient?
- Is the recipient both Medicare and AmeriHealth Caritas Louisiana eligible?
- Does the recipient require transportation services as well?
- Is the facility where the recipient will be hospitalized a AmeriHealth Caritas Louisiana provider with a valid seven-digit provider number?
- Why is the situation so unique that it cannot be provided in Louisiana or in one of the Louisiana trade areas?
- What referrals were made in Louisiana before a referral was made to an out-of-state provider/hospital?

NOTE: Emergency out-of-state hospitalizations do not require PA.

Positron Emission Tomography Scans

Positron Emission Tomography Scans for Oncologic Conditions

Positron emission tomography (PET) scans are covered services, which require prior authorization, and must be consistent with AmeriHealth Caritas Louisiana's clinical guidelines and medical necessity criteria for oncologic indications. The medical necessity criteria can be found at PET Scan Medical Necessity Criteria. The procedure must be performed within 30 days of receiving prior authorization.

Combination Studies PET/Computed Tomography (CT)

The combination of PET and CT scans into a single system (PET/CT) may be considered for oncologic indications where a PET scan is considered medically necessary and specific anatomical identification is required to guide clinical management.

Prior Authorization

The following documentation is required for prior authorization of PET scans and PET/CT combination studies for oncologic conditions:

- Completed PA request form;
- Documentation of medical necessity includes all of the following;
- The primary diagnosis name and International Classification of Diseases (ICD) code(s) for the condition requiring PET imaging;
- All secondary diagnosis name(s) and ICD code(s) pertinent to comorbid condition(s);
- The most recent medical evaluation, including a summary of the medical history and the last physical exam (clinical information must be submitted by the recipient's treating oncologist);
- Laboratory and pathology reports pertinent to a diagnosis of malignant neoplasm or carcinoma;
- Risk factors or comorbid conditions;
- The patient's treatment plan, including a description of the type and dates of any anti-tumor therapy; and
- Any additional clinical information that supports the coverage criteria and that is requested by AmeriHealth Caritas Louisiana.

The payable revenue codes for positron emission tomography scans are 343 and 404. These revenue codes must be billed with the appropriate accompanying CPT codes for PET scans.

Reconsiderations

1. If a request for PA is denied, a provider may submit the request for reconsideration.

Instructions for Submitting a Reconsideration

2. Write the word "Reconsideration" across the top of the denial letter, and write the reason the request for reconsideration at the bottom of the page;

3. Attach all of the original documentation, as well as any additional documentation or information, which supports medical necessity, to the letter; and

4. Mail the letter and all documentation to AmeriHealth Caritas.

References

Louisiana Department of Health. 2011. Hospital Services Provider Manual. Prior Authorization. Chapter 25, Section 25.6. Issued 05/12/2025.

Policy updates

Initial review date: 3/2/2021

Policy references updated 7/2024

Policy references updated 7/2025

Microwave thermotherapy for lung and kidney tumors

Clinical Policy ID: CCP.1528

Recent review date: 7/2025

Next review date: 11/2026

Policy contains: Image-guided thermal ablation, microwave ablation, non-small cell lung cancer, percutaneous ablation, renal cell carcinoma

AmeriHealth Caritas Louisiana has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas Louisiana's clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of medically necessary, and the specific facts of the particular situation are considered by AmeriHealth Caritas Louisiana, on a case by case basis, when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas Louisiana's clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas Louisiana's clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas Louisiana will update its clinical policies as necessary. AmeriHealth Caritas Louisiana's clinical policies are not guarantees of payment.

Coverage policy

See also CCP.1397 Microwave thermotherapy for breast cancer.

Microwave thermotherapy (ablation) of a primary or metastatic lung tumor is clinically proven and, therefore, may be medically necessary when all of the following criteria are met (National Comprehensive Cancer Network, 2025b):

- The member is either:
- Is deemed medically inoperable due to the location or extent of the lesion or due to comorbid conditions.
- Will not receive stereotactic ablative radiotherapy or definitive radiation therapy.
- A single tumor is less than or equal to 3 centimeters in size.

Microwave ablation of malignant kidney tumors is clinically proven and, therefore, may be medically necessary when all of the following are met (National Comprehensive Cancer Network, 2025a):

- The member either is not a candidate for surgery due to other medical conditions or presents a significant risk of illness or death from the procedure.
- The tumor is a clinical stage one renal lesion that is 3 centimeters or less in diameter.

Limitations

No limitations were identified during the writing of this policy.

Alternative covered services

- Radiofrequency ablation.
- Cryoablation.
- Surgical resection.
- Stereotactic radiosurgery.
- Definitive radiation therapy.

Background

Tumor ablation is a minimally invasive technique that applies chemical or thermal methods under image guidance to induce cellular necrosis and destroy solid tumors while sparing adjacent tissue. Thermal ablation is accomplished by cooling or heating the targeted tissue to less than minus 40 degrees Celsius or more than 60 degrees Celsius, which will achieve cytotoxicity in most tissues. Depending on the technique, targeted tissues may be accessed percutaneously, laparoscopically, intraoperatively, endoscopically, or, in the case of high-intensity focused ultrasound, extracorporeally, to achieve locoregional tumor control (Gala, 2020).

Several minimally invasive thermal ablative modalities are available: radiofrequency, laser, cryoablation, high-intensity focused ultrasound, and microwave. Irreversible electroporation is a nonthermal option that applies short pulses of a strong electrical current to form permanent nanopores within the cell membrane to induce cell death. Radiofrequency is the most commonly used ablative modality for locoregional tumor eradication, but microwave ablation has emerged as an alternative (Gala, 2020).

Microwave systems comprise a microwave generator, a coaxial cable, and a 14 to 17-gauge antenna to transmit the waves to the tissue. Antenna (needle) placement is achieved using ultrasound, computed tomography, or fluoroscopic guidance, depending on lesion location. Total tumor necrosis can be achieved when temperature remains at 54 degrees Celsius for at least three minutes, or reaches 60 degrees Celsius instantly (Gala, 2020).

Both microwave and radiofrequency methods convert heat energy into coagulative necrosis of tumor cells. Unlike radiofrequency ablation, which uses electrical energy at a frequency of 3 hertz to 300 gigahertz, microwave ablation applies short-duration, high-voltage electromagnetic pulses with frequencies between 900 and 2,450 megahertz. Because of its larger electromagnetic field and rapid heating capabilities, microwave ablation creates a larger, homogenous ablative field and avoids the “heat sink” effect that commonly occurs with radiofrequency ablation of highly vascular solid organs. As a result, higher intratumoral temperatures and larger and predictable ablation zones can be created in a shorter time period. In addition, microwave ablation is not limited by the poor electrical conductivity and thermal conduction of charred or desiccated lung tissue, which can reduce the effectiveness of radiofrequency ablation (Gala, 2020).

For assessing response to locoregional treatment, computed tomography and magnetic resonance imaging are used at regular intervals. The optimal imaging modality for follow-up and imaging interpretation will depend on the therapy used and planned future treatments (American College of Radiology, 2018).

The U.S. Food and Drug Administration (2023) has issued 510(k) premarket approval to several microwave ablation devices as electrosurgical cutting and coagulation devices and accessories for soft tissue ablation.

Findings

Lung tumors

Overall efficacy and professional recommendations

Microwave ablation is a safe and effective treatment for malignant lung tumors in appropriately selected individuals, a conclusion supported by a substantial body of evidence and professional guidance. The National Comprehensive Cancer Network (2025b) recommends image-guided thermal ablation for primary or secondary lung tumors smaller than 3 centimeters in non-surgical candidates, with the choice of modality depending on tumor characteristics, complication risks, and operator expertise. Generally, microwave ablation is most effective for individuals with tumors smaller than 3 centimeters who are not ideal candidates for surgery. An expert consensus panel from the American Association for Thoracic Surgery identifies microwave ablation, as a form of image-guided thermal ablation, as a reasonable treatment option for high-risk patients with stage I non-small cell lung cancer who are not candidates for standard surgical resection. Surgical resection is generally favored when deemed safe, while stereotactic ablative radiotherapy is recommended as the preferred non-surgical modality. Image-guided thermal ablation techniques, including microwave ablation, are considered subsequent alternatives for patients who are ineligible for, or decline, both surgery and stereotactic ablative radiotherapy. The guideline emphasizes a tiered, individualized approach to treatment selection based on patient risk, tumor characteristics, and patient preferences (Pennathur, 2025).

Comparison with surgery and other ablative modalities

Compared to surgery, microwave ablation offers faster recovery and lower morbidity, and it demonstrates comparable or superior outcomes to other modalities in specific contexts. For stage 1 disease, one meta-analysis found no significant difference in overall survival between lobectomy and microwave ablation (Chan, 2021), while another large review found survival rates comparable to stereotactic body radiation therapy and superior to radiofrequency ablation (Laeseke, 2023). Direct comparisons with radiofrequency ablation highlight specific benefits, including less intraprocedural pain ($P = .0043$), greater tumor mass reduction ($P = .0215$), and a significantly shorter ablation duration (Macchi, 2017; Liu, 2025). Evidence on long-term survival is conflicting; while one meta-analysis found no difference in survival (Sun, 2019), another reported higher one- through five-year survival rates for radiofrequency ablation (all $P < .05$) (Yuan, 2019).

Combination therapy and specific patient populations

The role of microwave ablation has also been explored in combination with systemic treatments and for specific metastatic disease. For participants with stage 3B and 4 non-small cell lung cancer, adding microwave ablation ($n = 148$) to chemotherapy alone ($n = 145$) significantly improved both progression-free survival (10.3 vs. 4.9 months; $P < .0001$) and overall survival (median not reached vs. 12.6 months; $P < .0001$) (Wei, 2020). In participants with pulmonary metastases from colorectal cancer, a systematic review reported complete remission in 37.0%, local control in 44.8%, and a three-year disease-free survival of 43.2% following microwave ablation (Tan, 2023).

Complications, recurrence, and evidence gaps

While generally safe, microwave ablation is associated with known complications, and its effectiveness is limited by variable local recurrence rates and gaps in the evidence. The most common complication is pneumothorax requiring chest tube placement (10% to 52%), with other risks including pleural effusion (7% to 17.22%), pulmonary hemorrhage (10%), and pulmonary infection (7%) (Liu, 2025; Nelson, 2019; Tan, 2023; Wei, 2020). Furthermore, a key limitation is the highly variable local recurrence rate (9% to 37%), which likely reflects the retrospective nature and heterogeneity of existing studies (Nelson, 2019). The efficacy of ablation also

diminishes for tumors exceeding 3 centimeters, underscoring the need for prospective, comparative trials to clarify its role (Lanuti, 2025).

Kidney tumors

Evidence and guideline support

For small, localized kidney tumors, microwave ablation is a viable, tissue-sparing option for non-surgical candidates, supported by key professional guidelines and emerging evidence. While partial nephrectomy remains the standard of care for T1a renal cell carcinoma, guidelines from the National Comprehensive Cancer Network (2025a) and the Society of Interventional Radiology (Morris, 2020) now include microwave ablation as an appropriate technique for small renal masses, typically those 3 centimeters or smaller. This support exists even as the evidence base for microwave ablation remains less robust than for radiofrequency ablation or cryoablation, with no randomized controlled trials published to date. The American Urological Association recommends thermal ablation as an alternative to surgery for treatment of clinical T1a solid renal masses smaller than 3 centimeters in size. For patients who elect thermal ablation, the percutaneous technique is preferred over a surgical approach, whenever feasible, to minimize morbidity (Moderate Recommendation; Evidence Level: Grade C). Either radiofrequency ablation or cryoablation may be offered for thermal ablation (Conditional Recommendation; Evidence Level: Grade C). Microwave ablation was not mentioned specifically (Campbell, 2021).

Comparative efficacy and safety

Systematic reviews find that microwave ablation offers favorable oncologic outcomes. A 2025 meta-analysis reported a 5-year cancer-specific survival rate of 98% and a five-year local control rate of 92% for tumors smaller than 4 centimeters (Huang, 2025). Other reviews suggest microwave ablation provides comparable technical efficacy and survival to radiofrequency ablation and cryoablation, with a potentially lower rate of local recurrence (Castellana, 2023; McClure, 2023). When compared to partial nephrectomy, thermal ablation techniques generally show lower overall survival and local control but offer superior preservation of renal function and lower complication rates (Uhlig, 2019).

Complications and evidence limitations

Microwave ablation is a technical procedure with known risks. Major post-procedural complications occur in up to six percent of participants, with an overall complication rate of up to 21% (Gunn, 2020). Common complications include hemorrhage, abscess, and damage to adjacent structures (e.g., bowel, ureter). The primary limitation in the field remains the lack of high-quality, long-term data from prospective, randomized trials. Therefore, while microwave ablation is a recommended treatment option for appropriately selected individuals, further research is needed to solidify its long-term comparative effectiveness (Castellana, 2023; Huang, 2025).

In 2025, we updated the coverage policy to include microwave ablation for kidney tumors as a covered service for appropriately selected patients, reorganized the discussion section with clearer thematic headings, and updated references. We added four new 2025 publications: one systematic review/meta-analysis (Huang), one systematic review (Lanuti), one meta-analysis (Liu), and one expert consensus guideline (Pennathur). We also updated the National Comprehensive Cancer Network guidelines for kidney and lung cancers to their 2025 versions.

References

On June 6, 2025, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were “microwave ablation,” “lung neoplasm” (MeSH),

"lung cancer," and "renal cell carcinoma." We included the best available evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

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Policy updates

7/2023: initial review date and clinical policy effective date: 8/2023

7/2024: Policy references updated.

7/2025: Policy references updated. Coverage updated.

Nonpharmacologic treatments for chronic vertigo

Clinical Policy ID: CCP.1159

Recent review date: 9/2025

Next review date: 1/2027

Policy contains: Dynamic posturography; particle (canalith) repositioning maneuvers; transtympanic micropressure; vestibular rehabilitation.

AmeriHealth Caritas Louisiana has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas Louisiana's clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of medically necessary, and the specific facts of the particular situation are considered by AmeriHealth Caritas Louisiana, on a case by case basis, when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas Louisiana's clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas Louisiana's clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas Louisiana will update its clinical policies as necessary. AmeriHealth Caritas Louisiana's clinical policies are not guarantees of payment.

Coverage policy

Particle repositioning maneuvers (either the Epley maneuver or the Semont maneuver) for treatment of benign paroxysmal positioning vertigo is clinically proven and, therefore, and may be medically necessary when all of the following criteria are met (Bhattacharyya, 2017):

- Confirmed by a positive Dix-Hallpike maneuver, characterized by:
    - Vertigo is associated with a mixed torsional and vertical nystagmus.
    - Latency period between the completion of the maneuver and the onset of vertigo and nystagmus.
    - Limited duration of vertigo and nystagmus, typically less than 60 seconds.

For lateral (horizontal) canal BPPV: Confirmed by a positive supine roll test, characterized by:

- Horizontal nystagmus changing direction based on head position.
- Geotropic or apogeotropic nystagmus.

Patient History:

• Reports recurrent, brief episodes of vertigo triggered by changes in head position.

Vestibular rehabilitation may be clinically proven and, therefore, medically necessary when all of the following criteria are met (McDonnell, 2015; Porciuncula, 2012; Wegner 2014):

- Diagnosis of vestibular hypofunction has been confirmed by vestibular function tests.
- Symptoms of vestibular hypofunction have existed for at least one month.
- Rehabilitation is performed by a physical therapist or occupational therapist as part of a therapy plan of care.

Dynamic posturography and tympanic micropressure for treatment of vestibular disorders are investigational/not clinically proven and, therefore, not medically necessary (Ahsan, 2015; Syed 2014, 2015).

Limitations

All other uses of particle repositioning maneuvers (the Epley maneuver or the Semont maneuver) or vestibular rehabilitation are not medically necessary, including:

- For particle repositioning maneuvers, benign paroxysmal positioning vertigo is usually in remission within two visits. Beyond two visits, there should be justification in the medical record for continued treatment. Beyond four visits with no remission, there should be consideration of referral back to the attending physician.
- For vestibular rehabilitation:
    - Members with certain comorbidities may not be appropriate candidates or may need specialized, individually tailored vestibular rehabilitation protocols. Examples of such comorbidities include cervical stenosis, Down syndrome, severe rheumatoid arthritis, cervical radiculopathies, Paget's disease, morbid obesity, ankylosing spondylitis, low back dysfunction, and spinal cord injuries (Bhattacharyya, 2017).
    - One visit per week for six weeks is considered medically necessary. Six additional visits are considered medically necessary if, upon medical review, there is evidence of clinically significant improvement. If there is no evidence of improvement after 12 visits, additional visits are not considered medically necessary.

Alternative covered services

- Surgical treatment.
- Medical treatment such as antiepilepsy pharmacologics, antivertigo drugs, beta-receptor blockers, betahistine, ototoxic antibiotics, corticosteroids, calcium-channel blockers, carboanhydrase inhibitors and serotonin reuptake inhibitors.

Background

The vestibular system uses sensory input from the eyes, muscles and joints, and inner ear to maintain balance and stable vision (Vestibular Disorders Association, 2023). Vestibular disorders can result from disease or injury that damages the processing areas in the inner ear and brain. The most common causes of vestibular disorders in adults are head trauma and age-related degeneration of the otolithic membrane, but in many cases the cause is unknown (Vestibular Disorders Association, 2023). In children, the most common disorders known to cause dizziness and vertigo are benign paroxysmal vertigo of childhood, migraine, trauma, vestibular neuritis and otitis media (Gioacchini, 2014, McCaslin, 2011).

Common symptoms of vestibular disorders include imbalance or unsteadiness, dizziness, blurred or bouncing vision, nausea, hearing changes, problems with coordination, and vertigo (Vestibular Disorders Association,

2023). Symptoms of vestibular dysfunction may be mild, lasting perhaps only seconds or minutes, or they may be severe, resulting in total disability.

There is no consensus on the precise definition of vertigo, but it is generally recognized as a distinct type of dizziness with the sense of rotation, rocking, or of the world spinning, even when the person is perfectly still, also known as illusion of motion (Strupp, 2013). In the United States, 1.7% of ambulatory medical care visits recorded vertigo or dizziness among the chief complaints (Nguyen-Huynh, 2012).

The most common vestibular disorder is benign paroxysmal positioning vertigo (Vestibular Disorders Association, 2023). Subtypes of benign paroxysmal positioning vertigo are distinguished by the particular semicircular canal involved (anterior, posterior, or horizontal) and whether the detached otoconia are free-floating within the affected canal (canalithiasis) or attached to the cupula (cupulolithiasis). Benign paroxysmal positioning vertigo is typically unilateral, and the most common form is canalithiasis in the posterior semicircular canal.

In most cases, the symptoms diminish or disappear without treatment as the vestibular system heals or the nervous system learns to compensate for the disorder (Strupp, 2013). Watchful waiting may be preferred, but the time to resolution of symptoms varies considerably across diagnoses. Some patients or providers may wish to expedite recovery and avoid further risk of injury. When symptoms persist, treatment can provide a complete cure or only control the symptoms. Treatment for vestibular disorders varies according to the diagnosis and may consist of positional head maneuvers, dietary changes, vestibular rehabilitation therapy, prescribed drugs or equipment, or, in some cases, surgery.

Findings

An expanding body of clinical practice guidelines continues to affirm particle repositioning maneuvers as the primary treatment approach for benign paroxysmal positional vertigo, with strong support for the Epley maneuver and acknowledgement of the Semont maneuver as an alternative (Bhattacharyya, 2017). Recent systematic reviews and meta-analyses have reinforced the efficacy of repositioning maneuvers while also broadening the comparative evidence base to include additional techniques such as the Gans, Gufoni, and modified Epley maneuvers (Si, 2025; Valsted, 2024). Other analyses extend the scope of inquiry by evaluating outcomes related to gait, falls, and recurrence following treatment, underscoring the broader functional impact of these maneuvers (Pauwels, 2023; Alfarghal, 2023; Saishoji, 2023). Evidence has also begun to clarify the role of pharmacologic adjuncts, particularly betahistine, in addressing residual dizziness after repositioning maneuvers, suggesting potential benefit with longer use (Alsolamy, 2024). Finally, reviews of vestibular rehabilitation and other therapeutic options provide context for the selective use of adjunctive strategies and delineate interventions with insufficient or low-quality evidence, such as transtympanic micropressure therapy and microvascular decompression (McDonnell, 2015; Syed, 2015; van den Berge, 2017).

Guidelines

The Clinical Practice Guideline on Benign Paroxysmal Positional Vertigo from the American Academy of Otolaryngology—Head and Neck Surgery strongly recommends the use of particle repositioning maneuvers, such as the Epley maneuver or the Semont maneuver, for the treatment of benign paroxysmal positional vertigo. The guideline identifies the Epley maneuver as the first-line treatment for posterior semicircular canal benign paroxysmal positional vertigo based on high-quality evidence from randomized controlled trials and systematic reviews. The Epley maneuver has been shown to be significantly more effective than placebo or alternative treatments such as Brandt-Daroff exercises for resolving symptoms and converting the Dix-Hallpike test to negative. Multiple studies cited in the guideline demonstrate high success rates when repeated Epley maneuvers are performed for patients not fully cleared after the initial treatment. Serious adverse effects are rarely reported. The Semont maneuver is also considered effective, though the Epley maneuver is more consistently recommended as the primary repositioning procedure (Bhattacharyya, 2017).

Vestibular rehabilitation

There is sufficient evidence to support vestibular rehabilitation for the treatment of chronic vertigo. Moderate- to strong-quality evidence indicates that vestibular rehabilitation is safe and effective for individuals with unilateral peripheral vestibular dysfunction (McDonnell, 2015). Vestibular rehabilitation improves symptoms and functional outcomes in the medium term, with standardized mean difference −0.83, 95% CI −1.02 to −0.64. For benign paroxysmal positional vertigo specifically, however, the evidence is less conclusive, and rehabilitation is more appropriately used as an adjunctive therapy. Patients with additional balance deficits, central nervous system disorders, or increased fall risk may derive greater benefit than those with isolated benign paroxysmal positional vertigo (McDonnell, 2015; Porciuncula, 2012; Wegner, 2014; Bhattacharyya, 2017).

Systematic Reviews and Meta Analysis

Particle pepositioning maneuvers

Systematic reviews and meta-analyses consistently support particle repositioning maneuvers as the first-line treatment for benign paroxysmal positional vertigo. A meta-analysis of 22 studies (n=5,196) reported that 58.9% of patients achieved symptom resolution after a single maneuver, 18.3% required two sessions, and 4.4% required three (Alfarghal, 2023). A review of 20 studies (n=2,597) found significant improvements in gait velocity, reduced fall rates, and decreased fear of falling after repositioning maneuvers (Pauwels, 2023). Another systematic review of 27 randomized controlled trials (n=1,629) confirmed that the Epley maneuver consistently reduces vertigo symptoms and yields negative Dix-Hallpike tests in both primary and specialty care settings (Saishoji, 2023).

Newer comparative evidence expands on these findings. A Bayesian network meta-analysis of 22 randomized controlled trials (n=2,507) showed that the Epley maneuver (odds ratio 7.9, 95% CI 3.21 to 23.31) and the Semont maneuver (odds ratio 6.1, 95% CI 1.97 to 18.46) were significantly more effective than usual treatment. Other maneuvers also demonstrated benefit, with the Gans maneuver (odds ratio 11, 95% CI 1.65 to 83.85) showing the highest ranking probability (Si, 2025). A separate review of 9 randomized controlled trials (n=413) reported no significant difference between Epley and Semont (relative risk 1.13, 95% CI 0.89 to 1.44), transient superiority of Epley over Gans at 24 hours (relative risk 1.44, 95% CI 1.04 to 2.00), and comparable results for the Li maneuver (Valsted, 2024). Together, these findings indicate that while the Epley maneuver remains the most strongly endorsed, other maneuvers can achieve similar outcomes and may be preferable in patients with limited cervical mobility or specific canal variants.

Pharmacologic adjuncts

Beyond maneuvers, there is emerging evidence on the use of medication for residual dizziness. A systematic review and meta-analysis of 8 randomized controlled trials (n=516) compared the Epley maneuver plus betahistine with the Epley maneuver alone. No clinically significant difference was observed in Dizziness Handicap Inventory scores or visual analog scale for vertigo at 1 week. However, pooled data with 4 weeks of follow-up demonstrated a statistically significant reduction in visual analog scale scores, standardized mean difference −0.89, 95% CI −1.30 to −0.49, suggesting that adjunct betahistine may provide a time-dependent benefit in managing persistent symptoms (Alsolamy, 2024).

Other evidence

Randomized controlled trials provide additional support for alternative maneuvers. A trial comparing the Epley and Gans maneuvers (n=234) found both effective, with negative Dix-Hallpike tests in 82.2% of the Epley group and 78.4% of the Gans group at 24 hours. At one month, 95% of both groups maintained remission, confirming that the Gans maneuver is a viable option, particularly for patients with cervical spine disorders (Dhiman, 2023).

Evidence for other interventions remains limited. For Ménière’s disease, systematic reviews have not

demonstrated a significant benefit of transtympanic micropressure therapy compared with placebo, and the evidence for microvascular decompression of the cochleovestibular nerve remains low in quality with only modest benefit (Syed, 2015; van den Berge, 2017).

In 2025, we expanded the Findings section by integrating three new systematic reviews and meta-analyses on pharmacologic adjuncts and comparative repositioning maneuvers (Alsolamy, 2024; Valsted, 2024; Si, 2025), reorganized the evidence into clearer subsections for vestibular rehabilitation, particle repositioning maneuvers, pharmacologic adjuncts, and other therapies, and streamlined older reviews to reduce redundancy while maintaining coverage-relevant detail. No policy changes warranted.

References

On August 16, 2025, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and the Centers for Medicare & Medicaid Services. Search terms were “transtympanic micropressure treatment” (MeSH), “physical therapy modalities” (MeSH), “vestibular diseases” (MeSH), “Dizziness” (MeSH). We included the best available evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

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Policy updates

2/2015: initial review date and clinical policy effective date: 7/2015

3/2016: Policy references updated.

3/2017: Policy references updated.

3/2018: Policy references updated.

3/2019: Policy references updated. Policy ID changed.

4/2020: Policy references updated.

4/2021: Policy references updated.

4/2022: Policy references updated.

4/2023: Policy references updated.

8/2024: Policy references updated.

8/2025: Policy references updated.

Outpatient Therapy by Licensed Practitioners

Plan: AmeriHealth Caritas Louisiana

Clinical Policy ID: CCP.4036

Recent review date: 12/2025

Next review date: 4/2027

Policy contains: Outpatient therapy; licensed practitioner; telehealth.

AmeriHealth Caritas has developed clinical policies to assist with making coverage determinations. AmeriHealth Caritas' clinical policies are based on guidelines from established industry sources, such as the Centers for Medicare & Medicaid Services (CMS), state regulatory agencies, the American Medical Association (AMA), medical specialty professional societies, and peer-reviewed professional literature. These clinical policies along with other sources, such as plan benefits and state and federal laws and regulatory requirements, including any state- or plan-specific definition of medically necessary, and the specific facts of the particular situation are considered, on a case by case basis, by AmeriHealth Caritas when making coverage determinations. In the event of conflict between this clinical policy and plan benefits and/or state or federal laws and/or regulatory requirements, the plan benefits and/or state and federal laws and/or regulatory requirements shall control. AmeriHealth Caritas' clinical policies are for informational purposes only and not intended as medical advice or to direct treatment. Physicians and other health care providers are solely responsible for the treatment decisions for their patients. AmeriHealth Caritas' clinical policies are reflective of evidence-based medicine at the time of review. As medical science evolves, AmeriHealth Caritas will update its clinical policies as necessary. AmeriHealth Caritas' clinical policies are not guarantees of payment.

Policy statement

Licensed Practitioner Outpatient Therapy includes:

- Outpatient psychotherapy (individual, family, and group);
- Psychotherapy for crisis;
- Psychoanalysis;
- Electroconvulsive therapy;
- Biofeedback;
- Hypnotherapy;
- Screening, assessment, examination, and testing;
- Diagnostic evaluation;
- Medication management.

Provider Qualifications

Licensed mental health practitioners are licensed individuals who are in good standing in the state of Louisiana to practice within the scope of all applicable state laws, practice acts, and the practitioner’s professional license. Licensed mental health practitioners include the following individuals:

- A licensed mental health professional (LMHP) is an individual who is licensed in the State of Louisiana to diagnose and treat mental illness or substance use, acting within the scope of all applicable State laws and their professional license. An LMHP includes the following individuals who are licensed to practice independently:
    - Medical psychologists;
    - Licensed psychologists;
    - Licensed clinical social workers (LCSWs);
    - Licensed professional counselors (LPCs);
    - Licensed marriage and family therapists (LMFTs);
    - Licensed addiction counselors (LACs); and
    - Advanced practice registered nurses (APRNs).

The following provisionally licensed professionals may render outpatient therapy:

- Provisionally licensed professional counselors (PLPCs);
- Provisionally licensed marriage and family therapists (PLMFTs);
- Licensed master social workers (LMSWs).

LPCs may render or offer prevention, assessment, diagnosis, and treatment, which includes psychotherapy of mental, emotional, behavioral, and/or addiction disorders to individuals, groups, organizations, or the general public by a licensed professional counselor, which is consistent with their professional training as prescribed by La. R.S. 37:1101 et seq. LPCs shall not engage in the practice of psychology or prescribe, either orally or in writing, distribute, dispense, or administer any medications. If intellectual, personality, developmental, or neuropsychological tests are deemed necessary, the licensed professional counselor shall make an appropriate referral.

PLPCs shall have a valid, current and unrestricted license issued by the Louisiana Board of Professional Counselors. PLPCs shall deliver services in accordance with the current, applicable scope of practice and must be actively engaged in supervision as required by their respective licensing board. (Reference: Louisiana Mental Health Counselor Licensing Act, La R.S. 37:1101 et seq.)

LMFTs may render professional marriage and family therapy and psychotherapy services limited to prevention, assessment, diagnosis, and treatment of mental, emotional, behavioral, relational, and addiction disorders to individuals, couples and families, singly or in groups that is consistent with their professional training as prescribed by La. R.S. 37:1101 et seq. LMFTs shall not engage in the practice of psychology or prescribe, either orally or in writing, distribute, dispense, or administer any medications. If intellectual, personality, developmental, or neuropsychological tests are deemed necessary, the licensed marriage and family therapist shall make an appropriate referral. (Reference: Louisiana Mental Health Counselor Licensing Act; Section 1103). All treatment is restricted to marriage and family therapy issues.

PLMFTs shall have a valid, current and unrestricted license issued by the Louisiana Board of Professional Counselors. PLMFTs shall deliver services in accordance with the current, applicable scope of practice and must be actively engaged in supervision as required by their respective licensing board. (Reference: Louisiana Mental Health Counselor Licensing Act, La R.S. 37:1101 et seq.)

LMSWs shall have a valid, current and unrestricted license issued by the Louisiana Board of Social Worker Examiners. LMSWs shall deliver services in accordance with the current, applicable scope of practice and must be actively engaged in supervision as required by their respective licensing board. (Reference: Louisiana Social Work Practice Act, La R.S. 37:2701 et seq.)

LACs, who provide addiction services, must demonstrate competency, as defined by LDH, State law, Addictive Disorders Practice Act, and regulations. LACs are not permitted to diagnose under their scope of practice under State law. LACs providing addiction and/or behavioral health services must adhere to their scope of practice license.

APRNs shall have a valid, current, and unrestricted advanced practice registered nurse license, as a nurse practitioner or clinical nurse specialist, issued by the Louisiana State Board of Nursing. APRNs must be nurse practitioner specialists in adult psychiatric and mental health, and family psychiatric and mental health, or certified nurse specialists in psychosocial, gerontological psychiatric mental health, adult psychiatric and mental health and child-adolescent mental health and may practice to the extent that services are within the APRN's scope of practice.

Physician must be a psychiatrist or physician's assistant working under protocol of a psychiatrist.

NOTE: Psychiatrists are covered under the physician section of the Louisiana Medicaid State Plan. However, psychiatrists often are employed by agencies that employ other licensed practitioners. For ease of reference, psychiatrist codes often billed under agencies are included in this section of the provider manual. However, psychiatrists may bill any codes under the physician section of the Louisiana Medicaid State Plan for which they may be qualified. Note that prior authorization or authorization beyond an initial authorization level of benefit is not a required CMS element for psychiatrist services under the Louisiana Medicaid State Plan; however, AmeriHealth Caritas may choose to require prior authorization for psychiatrist services or may prior authorize psychiatrist services beyond an initial authorization level of benefit at their option.

In general, the following provider types and specialties may bill these codes according to the scope of practice outlined under State Law. The specific provider types and specialties are permitted to bill each code as noted in the Specialized Behavioral Health Fee Schedule.

Allowed Provider Types and Specialties

- PT 77 Mental Health Rehab PS 78 MHR
- PT 74 Mental Health Clinic PS 70 Clinic / Group
- PT 68 Substance Use and Alcohol Use Center PS 70 Clinic/Group
- PT 38 School Based Health Center PS 70 Clinic/Group
- PT 31 Psychologist PS
    - 6A Psychologist - Clinical
    - 6B Psychologist – Counseling
    - 6C Psychologist - School
    - 6D Psychologist - Developmental
    - 6E Psychologist - Non-declared
    - 6F Psychologist – Other
    - 6G Psychologist – Medical
- PT 73 Social Worker (Licensed/Clinical) PS 73 Social Worker
    - 73 Licensed Clinical Social Worker (LCSW); and
    - LL Lower Level – Licensed Master Social Worker (LMSW).
- PT AK Licensed Professional Counselor (LPC) PS 8E LPC
    - 8E CSoC/Behavioral Health – LPC; and
    - LL Lower Level – Provisionally Licensed Professional Counselor (PLPC).

- PT AH Licensed Marriage & Family Therapists (LMFT) PS 8E
    - 8E CSoC/Behavioral Health – LMFT; and
    - LL Lower Level – Provisionally Licensed Marriage and Family Therapist (PLMFT).
- PT AJ Licensed Addiction Counselor PS 8E CSoC/Behavioral Health
- PT 20 Psychiatrist PS
    - 26 Psychiatry
    - 2W Addiction Specialist
- PT 78 Nurse Practitioner (APRN) PS 26
- PT 93 Clinical Nurse Specialist (APRN) PS 26
- PT 94 Physician Assistant PS 26

Eligibility Criteria

All Medicaid-eligible children and adults who meet medical necessity criteria.

Limitations/Exclusions

Providers cannot provide services or supervision under this section if they are a provider who is excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act. In addition, they may not be debarred, suspended, or otherwise excluded from participating in procurement activities under the State and federal laws, regulations, and policies, including the federal Acquisition Regulation, Executive Order No.12549 and Executive Order No. 12549. In addition, providers who are an affiliate, as defined in the federal Acquisition Regulation, of a person excluded, debarred, suspended, or otherwise excluded under State and federal laws, regulations and policies may not participate.

All services must be authorized. Services which exceed the limitation of the initial authorization must be approved for re-authorization prior to service delivery.

Service providers that offer addiction services must demonstrate competency, as defined by LDH, State law (RS 37:3386 et seq.) and regulations. Anyone providing addiction or behavioral health services must be adhering to their scope of practice license.

Individuals who reside in an institution (inpatient hospital setting) or secure settings (jails and prisons) are not permitted to receive rehabilitation services. Visits to intermediate care facilities for the intellectually disabled are not covered. All LMHP services provided while a person is a resident of an institute for mental disease (IMD), such as a free-standing psychiatric hospital or psychiatric residential treatment facility, are the content of the institutional service and not otherwise separately reimbursable by Medicaid.

Billing

LMSWs, PLPCs and PLMFTs may not directly bill for services provided to an AmeriHealth Caritas member. LMSWs, PLPCs and PLMFTs may be the rendering provider on a claim when in accordance with Title 46 and their individual practice acts.

Allowed Mode(s) of Delivery

- Individual;

- Family;
- Group;
- On-site;
- Off-site; and
- Tele-video.

Additional Service Criteria

Services provided to children and youth must include communication and coordination with the family and/or legal guardian, as well as the primary care physician (PCP). Coordination with other child-serving systems should occur, as needed, to achieve the treatment goals. All coordination must be documented in the youth's treatment record.

Psychological testing must be prior authorized by AmeriHealth Caritas Louisiana.

Telehealth

Telemedicine/telehealth is the use of a telecommunications system to render healthcare services when a physician or licensed practitioner and a member are not in the same location. Telehealth does NOT include the use of text, e-mail, or facsimile (fax) for the delivery of healthcare services.

The originating site means the location of the member at the time the telehealth services are provided. There is no restriction on the originating site and it can include, but is not limited to, a healthcare facility, school, or the member's home. Distant site means the site at which the physician or other licensed practitioner is located at the time the telehealth services are provided. Assessments, evaluations, individual psychotherapy, family psychotherapy, and medication management services may be provided via telecommunication technology when the following criteria are met:

- The telecommunication system must be secure, ensure member confidentiality, and be compliant with the requirements of the Health Insurance Portability and Accountability Act (HIPAA);
- The services provided are within the practitioner's telehealth scope of practice as dictated by the respective professional licensing board and accepted standards of clinical practice;
- The member's record includes informed consent for services provided through the use of telehealth;
- Services provided using telehealth must be identified on claims submission by appending the modifier "95" to the applicable procedure code and indicating the correct place of service, either POS 02 (other than home) or 10 (home). Both the correct POS and the 95 modifier must be present on the claim to receive reimbursement;
- Assessments and evaluations conducted through telehealth should include synchronous, interactive, real-time electronic communication comprising both audio and visual elements unless clinically appropriate and based on member consent;
- Providers must deliver in-person services when telehealth is not clinically appropriate or when the member requests in-person services;
- Group psychotherapy is only allowed via telehealth when utilized for Dialectical Behavioral Therapy (DBT) and must include synchronous, interactive, real-time electronic communication comprising both audio and visual elements.

References

Louisiana Department of Health. Behavioral Health Services Provider Manual. Outpatient Therapy by a Licensed Practitioner. Chapter 2, Section 2.3. Originally published 2017. Issued 10/1/2024.

Policy updates

Initial review date: 3/1/2021

11/1/2022: Policy updated.

12/2024: Policy references. Coverage updated.

12/2025: Policy references reviewed. Additional language added to Provider Qualifications

Three-dimensional imaging and interpretation

Clinical Policy ID: CCP.1389

Recent review date: 11/2025

Next review date: 3/2027

Policy contains: Endoscopy; three-dimensional rendering or reconstruction; tomography; ultrasonography.

Coverage policy

Three-dimensional imaging (also called three-dimensional reconstruction or rendering), interpretation, and reporting are clinically proven and, therefore, may be medically necessary when all of the following criteria are met (American Association of Endodontists/American Academy of Oral and Maxillofacial Radiology, 2015; Dong, 2025; Plana, 2014; Simpson, 2017; Tang, 2025; Virani, 2016):

- The additional imaging detail will impact the diagnosis or clinical course of the member.
- The service is consistent with accepted standards of medical practice.
- Sufficient clinical expertise is available to perform the procedure and interpret the results.
- A written order or referral documents the medical necessity for the additional three-dimensional imaging.
- The interpreting physician’s report addresses the medical necessity identified by the ordering or referring health care provider.

Limitations

The interpreting physician shall maintain a copy of the test results and interpretation along with a copy of the ordering or referring health care provider's order for the study.

The use of three-dimensional imaging, interpretation, and reporting is investigational/not clinically proven and, therefore, not medically necessary when any of the following conditions are present:

- Equivalent information obtained from the test has already been provided by another procedure (such as ultrasound, magnetic resonance imaging, or angiography).
- Equivalent information obtained from the test could be provided by a standard (two-dimensional) imaging study without reconstruction.
- The procedure is performed routinely based on the internal protocols of the testing facility.
- The procedure is not consistent with accepted standards of medical practice.
- Documentation of medical necessity is lacking.

Alternative covered services

Standard of care patient evaluation and management by a network health care provider.

Background

The majority of medical imaging is presented as two-dimensional information. Advances in multi-detector computed tomographic imaging capture large volumes of information in digital form, which, in turn, allows data to be manipulated into other planes that were not acquired directly during the acquisition (~~Fenster, 2011~~). Multidetector tomographic modalities (e.g., computed tomography, magnetic resonance tomography, and positron-emission tomography) and ultrasonography can create three-dimensional depictions of morphologic and physiological attributes characteristic of health and disease (Sarmah, 2023).

Many techniques may be used to produce and store three-dimensional imaging and improve the understanding of a pathological process. Pre-image processing is essential for clearing extraneous data and accurately depicting tissues and organs. It may require specialized algorithms for processing. Three-dimensional reconstruction is expensive, and its use is confined to specially designed medical devices that can accommodate higher-resolution images (Sarma, 2023).

Findings

Guidelines

A number of guidelines support three-dimensional imaging, when the additional information will impact diagnosis or treatment planning and when sufficient expertise is available to perform the procedure and interpret the results. Three-dimensional rendering and reconstruction represent important technological advancements that capture more anatomically accurate data sets and, in turn, provide additional detail and a dimension of depth of anatomy and pathology not found with standard two-dimensional modalities. Three-dimensional imaging can be justified on an individual basis based on clinical presentation taking into account specific use, optimization protocols, radiation dose, risk-assessment strategies, and current standards of practice (American Association of Endodontists/American Academy of Oral and Maxillofacial Radiology, 2015; Dong, 2025; Plana, 2014; Simpson, 2017; Tang, 2025; U.S. Preventive Services Task Force, 2024; Virani, 2016).

Evidence review

Low- to moderate-quality evidence from systematic reviews and meta-analyses demonstrates comparable to superior aspects of diagnostic accuracy of three-dimensional imaging versus two-dimensional imaging for many clinical applications. However, the impact of these technological advancements on diagnostic certainty, treatment planning, and clinical outcomes has not been quantified, and the clinical or cost effectiveness compared to less expensive and more readily available alternatives has not been established, lending ambiguity to the optimal choice of imaging. The intended clinical application will determine the degree of accuracy and precision required, along with the desire to reduce radiation exposure. The incremental value of three-dimensional imaging over current imaging standards for many indications has not been determined, and justification for the additional information would be needed.

Several systematic reviews and meta-analyses have examined a range of clinical uses for three-dimensional imaging methods. Clinical applications include, but are not limited to:

- Assessment and treatment planning in craniofacial surgery (Werathammo, 2025).
- Assessment and treatment planning in dentistry and oral surgery (Awarun, 2019; Chen, 2021; Erum, 2025; Hartmann, 2019; Saini, 2025; Thierens, 2018; Wismeijer, 2018).
- Assessment and treatment planning in liver surgery (Banchini, 2024).
- Assessment and treatment planning in orthopedic surgery (Boudissa, 2024; Kosy, 2018; Kwan, 2025; Liu, 2025; Nevalainen, 2025; Suri, 2025).
- Breast cancer detection (specifically ultrasonography) (Bin, 2019).
- Detection of soft tissue defects of the knee (Shakoor, 2018) and rotator cuff (Teng, 2018).
- Diagnosis and classification of uterine abnormalities (Spagnol, 2022; Xydias, 2025).
- Facilitation of laparoscopic and thoracoscopic surgeries (Fergo, 2017; Liang, 2018; Sánchez-Margallo, 2021; Vettoretto, 2018).
- Guiding brachytherapy for cervical cancer (Kim, 2020).
- Guiding tubal sterilization microinsert positioning (Carretti, 2019).

In 2019, we updated the references and added several new systematic reviews and meta-analyses with no policy changes warranted.

In 2020, we updated the reference list. No policy changes are warranted.

In 2021, we updated the references with no policy changes warranted.

In 2022, we updated the reference list. No policy changes are warranted.

In 2023, we identified no newly published, relevant literature to add to the policy.

In 2024, we updated the references with no policy changes warranted.

In 2025, we reorganized the findings and updated the references with no policy changes.

References

On September 16, 2025, we searched PubMed and the databases of the Cochrane Library, the U.K. National Health Services Centre for Reviews and Dissemination, the Agency for Healthcare Research and Quality, and

the Centers for Medicare & Medicaid Services. Search terms were “Imaging, Three-Dimensional” (MeSH), “three-dimensional imaging,” “three-dimensional rendering,” and “three-dimensional reconstruction.” We included the best available evidence according to established evidence hierarchies (typically systematic reviews, meta-analyses, and full economic analyses, where available) and professional guidelines based on such evidence and clinical expertise.

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Policy updates

6/2018: initial review date and clinical policy effective date: 10/2018

10/2019: Policy references updated.

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10/2021: Policy references updated.

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11/2023: Policy references updated.

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