Magnetoencephalography (MEG) is a noninvasive functional imaging technique in which weak magnetic forces are recorded externally. When this information is superimposed on an anatomic image of the brain, typically a magnetic resonance imaging (MRI) scan, the image is referred to as magnetic source imaging (MSI). This technique has been studied for identifying “eloquent” areas of the brain for neurosurgical planning and for use in localization of epileptic foci.

Magnetoencephalography/magnetic source imaging for the purpose of determining the laterality of language function, when used as a substitute for the Wada test, may be considered medically necessary in patients being prepared for surgery for any of the following indications:

- Brain Tumors
- Epilepsy
- Other indications requiring brain resection

Magnetoencephalography/magnetic source imaging as part of the preoperative evaluation of patients with intractable epilepsy (seizures refractory to at least 2 first-line anticonvulsants) may be considered medically necessary when standard techniques, (i.e., MRI and EEG), do not provide satisfactory localization of epileptic lesion(s).

Magnetoencephalography/magnetic source imaging is considered investigational for all other indications.

The following CPT codes specifically describe magnetoencephalography:

- **95965**: Magnetoencephalography (MEG), recording and analysis for spontaneous brain magnetic activity (e.g., epileptic cerebral cortex localization);
- **95966**: For evoked magnetic fields, single modality (e.g., sensory, motor, language, or visual cortex localization).
• **95967**: For evoked magnetic fields, each additional modality (e.g., sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)

### Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program (FEP)) prohibit Plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

### Rationale

#### Background

MEG is a noninvasive functional imaging technique in which weak magnetic forces associated with brain electrical activity are recorded externally. Using mathematical modeling, recorded data are then analyzed to provide an estimated location of electrical activity. This information can be superimposed on an anatomic image of the brain, typically a magnetic resonance imaging (MRI) scan, to produce a functional/anatomic image of the brain, referred to as magnetic source imaging or MSI. The primary advantage of MSI is that, while conductivity and thus measurement of electrical activity as recorded by electroencephalogram (EEG) is altered by surrounding brain structures, magnetic fields are not. Therefore, MSI permits a high-resolution image.

The technique is sophisticated. Detection of weak magnetic fields requires gradiometer detection coils coupled to a superconducting quantum interference device, which requires a specialized room shielded from other magnetic sources. Mathematical modeling programs based on idealized assumptions are then used to translate detected signals into functional images. In its early evolution, clinical applications were limited by the use of only 1 detection coil requiring lengthy imaging times, which, because of body movement, also were difficult to match with the MRI. However, more recently, the technique has evolved to multiple detection coils in an array that can provide data more efficiently over a wide extracranial region.

One clinical application is localization of the pre- and postcentral gyri as a guide to surgical planning in patients scheduled to undergo neurosurgery for epilepsy, brain neoplasms, arteriovenous malformations, or other brain disorders. These gyri contain the "eloquent" sensorimotor areas of the brain, the preservation of which is considered critical during any type of brain surgery. In normal situations, these areas can be identified anatomically by MRI, but frequently, anatomy is distorted by underlying disease processes. In addition, location of eloquent functions varies, even among healthy people. Therefore, localization of the eloquent cortex often requires such intraoperative invasive functional techniques as cortical stimulation with the patient under local anesthesia or somatosensory-evoked responses on electrocorticography (ECoG). Although these techniques can be done at the same time as the planned resection,
they are cumbersome and can add up to 45 minutes of anesthesia time. Furthermore, these techniques can sometimes be limited by the small surgical field. A preoperative test, which is often used to localize the eloquent hemisphere, is the Wada test. MEG/MSI has been proposed as a substitute for the Wada test.

Another related clinical application is localization of epileptic foci, particularly for screening of surgical candidates and surgical planning. Alternative techniques include MRI, positron emission tomography (PET), or single photon emission computed tomography (SPECT) scanning. Anatomic imaging (ie, MRI) is effective when epilepsy is associated with a mass lesion, such as a tumor, vascular malformation, or hippocampal atrophy. If an anatomic abnormality is not detected, patients may undergo a PET scan. In a small subset of patients, extended ECoG or stereotactic electroencephalography EEG (SEEG) with implanted electrodes is considered the criterion standard for localizing epileptogenic foci. MEG/MSI has principally been investigated as a supplement to or an alternative to invasive monitoring.

**Regulatory Status**

FDA-cleared magnetoencephalography devices include the 700 Series Biomagnetometer (Biomagnetic Technologies; San Diego, CA) cleared in 1990 and subsequent devices (K901215, K941553, K962317, K993708); the CTF Whole-Cortex MEG System (CTF Systems; British Columbia, Canada) cleared in 1997 and subsequent devices (K971329, K030737); and the Elekta Oy (Elekta Neuromag; Helsinki, Finland) cleared in 2004 and subsequent devices (K041264, K050035, K081430, K091393).

Intended use of these devices is to “non-invasively detect and display biomagnetic signals produced by electrically active nerve tissue in the brain. When interpreted by a trained clinician, the data enhance the diagnostic capability by providing useful information about the location relative to brain anatomy of active nerve tissue responsible for critical brain functions.” More recent approval summaries add, “MEG is routinely used to identify the locations of visual, auditory, somatosensory, and motor cortex in the brain when used in conjunction with evoked response averaging devices. MEG is also used to noninvasively locate regions of epileptic activity within the brain. The localization information provided by MEG may be used, in conjunction with other diagnostic data, in neurosurgical planning.”

**Literature Review**

**Localization of Seizure Focus**

This section is based on a 2008 TEC Special Report reviewing the evidence regarding MEG for localization of epileptic lesions. MEG has been proposed as a method for localizing seizure foci for patients with normal or equivocal magnetic resonance imaging (MRI) and negative video-electroencephalogram (EEG) examinations, so-called “nonlesional” epilepsy. Such patients often undergo MEG, positron emission tomography (PET), or ictal-single photon emission computed tomography (SPECT) tests to attempt to localize the seizure focus. They then often undergo invasive intra-cranial EEG, a surgical procedure in which electrodes are inserted next to the brain. MEG would be considered useful if, when compared with not using MEG, it improved patient outcomes. Such improvement in outcomes would include more patients being rendered seizure-free, use of a less invasive and morbid diagnostic workup, and increased surgical success rates. This is a complicated array of outcomes that has not been thoroughly evaluated in a comprehensive manner.

Ideally, a randomized trial comparing the outcomes of patients who receive MEG as part of their diagnostic workup compared with patients who do not receive MEG could
determine whether MEG improves patient outcomes. However, almost all of the studies evaluating MEG have been retrospective, where MEG, other tests, and surgery have been selectively applied to patients. Because patients often drop out of the diagnostic process before having intracranial EEG (IC-EEG), and many patients ultimately do not undergo surgery, most studies of associations between diagnostic tests and between diagnostic tests and outcomes are biased by selection and ascertainment biases. For example, studies that evaluate the correlation between MEG and IC-EEG invariably do not account for the fact that MEG information was sometimes used to deselect a patient from undergoing IC-EEG. In addition, IC-EEG findings only imperfectly correlate with surgical outcomes, meaning that it is an imperfect reference standard.

Numerous studies have shown associations between MEG findings and other noninvasive and invasive diagnostic tests, including IC-EEG, and between MEG findings and surgical outcomes. However, such studies do not allow any conclusions regarding whether MEG added incremental information to aid the management of such patients and whether patients' outcomes were improved as a result of the additional diagnostic information.

A representative study of MEG by Knowlton et al (2008) demonstrates many of the problematic issues of evaluating MEG.4 In this study of 160 patients with nonlesional epilepsy, all had MEG, but only 72 proceeded to IC-EEG. The calculations of diagnostic characteristics of MEG are biased by incomplete ascertainment of the reference standard. However, even examining the diagnostic characteristics of MEG using the 72 patients who underwent IC-EEG, sensitivities and specificities were well below 90%, indicating the likelihood of both false positive and false negative studies. Predictive values based on these sensitivities and specificities mean that MEG can neither rule in nor rule out a positive IC-EEG, and that MEG cannot be used as a triage test before IC-EEG to avoid potential morbidity in a subset of patients.

One study more specifically addressed the concept that MEG may improve the yield of IC-EEG, thus, allowing more patients to ultimately receive surgery. In a 2009 study by Knowlton et al, MEG results modified the placement of electrodes in 18 (23%) of 77 patients who were recommended to have IC-EEG.5 Seven (39%) of 18 patients had positive intracranial seizure recordings involving additional electrode placement because of MEG results. It was concluded that 4 patients (5%) were presumed to have had surgery modified as a result of the effect of MEG electrode placement.

Several studies correlated MEG findings with surgical outcomes. Lau et al (2008) performed a meta-analysis of 17 such studies.6 In this meta-analysis, sensitivity and specificity had unorthodox definitions. Sensitivity was the proportion of patients cured with surgery in whom the MEG-defined epileptic region was resected, and specificity was the proportion of patients not cured with surgery in whom the MEG-defined epileptic region was not resected. Pooled sensitivity was 0.84, meaning that among the total number of cured patients, 16% occurred despite the MEG-defined region not being resected. Pooled specificity was 0.52, meaning that among 48% of patients not cured, the MEG-localized region was resected. These results are consistent with an association between resection of the MEG-defined region and surgical cure, but that it is an imperfect predictor of surgical success. However, it does not address the question as to whether MEG contributed original information to improve the probability of cure. In a retrospective review of 22 children with medically intractable focal epilepsy (median age at epilepsy surgery, 11 years), Kim et al (2013) used a cutoff of 70% or more for the number of MEG-identified spike dipole sources located within the resection margin to define a positive study.7 Sensitivity, specificity, and positive and negative predictive values for seizure-free status postoperatively was 67%, 14%, 63%, and 17%, respectively.
Other studies implied a value of MEG, but it is difficult to make firm conclusions regarding its value. In a 2013 study by Schneider et al, 14 patients with various findings on MEG, IC-EEG, and interictal SPECT underwent surgery for nonlesional neocortical focal epilepsy. Concordance of IC-EEG and MEG occurred in 5 patients, 4 of whom became seizure-free. This concordance of the 2 tests was the best predictor of becoming seizure-free. Although this was prognostic for success, whether this would actually change surgical decision making, such as declining to operate where there is not such concordance, is uncertain. A similar study by Widjaja et al (2013) showed that concordance of MEG findings with the location of surgical resection was correlated with better seizure outcomes. However, the authors acknowledged that MEG was entrenched in clinical practice, and the decision to proceed further in diagnostic and therapeutic endeavors was based on results of MEG and other tests.

In 2009, the American Clinical MEG Society released a position statement that supported routine clinical use of MEG/MSI for presurgical evaluation of patients with medically intractable seizures. In this statement, a 2008 study by Sutherling et al is cited as being a “milestone class I study.” Class I evidence usually refers to randomized comparisons of treatment. However, the study by Sutherling et al is called by its authors a “prospective, blinded crossover-controlled, single-treatment, observational case series.” The study attempted to determine the proportion of patients in whom diagnostic or treatment strategy was changed as a consequence of MEG. They concluded that the test provided nonredundant information in 33% of patients, changed treatment in 9% of surgical patients, and benefited 21% of patients who had surgery. There was no control group in this study. Benefit of MEG was inferred by assumptions of what might have occurred in the absence of MEG results. Less than half of 69 enrolled patients went on to receive IC-EEG; thus, there appeared to be incomplete accounting for outcomes of all patients in the study. A similar study by De Tiege et al (2012) also attempted to determine the number of patients in whom management decisions were altered based on MEG results. The authors concluded that clinical management was altered in 13% of patients.

Section Summary

There are no clinical trials demonstrating clinical utility of MEG in determining location of seizure focus and no high-quality studies of diagnostic accuracy. Available evidence on diagnostic accuracy is limited by ascertainment and selection biases because MEG findings were used to select and deselect patients in the diagnostic pathway, thus making it difficult to determine the role of MEG for the purpose of seizure localization. Evidence supporting the effect of MEG on patient outcomes is indirect and incomplete. Surgical management may be altered in a minority of patients based on MEG, but there is insufficient evidence to conclude that outcomes are improved as a result of these management changes. Trials with a control group are needed to determine whether good outcomes can be attributed to the change in management induced by knowledge of MEG findings.

Localization of Eloquent and Sensorimotor Areas

A 2003 TEC Assessment of MEG concluded that evidence for this particular indication was insufficient to demonstrate efficacy. At that time, studies reviewed had relatively weak designs and small sample sizes. There are 2 ways to analyze the potential utility of MEG for this indication: MEG could potentially be a noninvasive substitute for the Wada test, which is a standard method of determining hemispheric dominance for language. The Wada test requires catheterization of the internal carotid arteries, which carries the risk of complications. The determination of language laterality is important to know to determine the suitability of a patient for surgery and what types of additional functional
testing might be needed before or during surgery. If MEG provided concordant information with the Wada test, then such information would be obtained in a safe, noninvasive manner.

Several studies have shown high concordance between the Wada test and MEG. In the largest study, by Papanicolaou et al (2004), among 85 patients, there was concordance between the MEG and Wada tests in 74 (87%). In no cases were the tests discordant in a way that the findings were completely opposite. Discordant cases occurred mostly when the Wada test indicated left dominance and MEG indicated bilateral language function. In an alternative type of analysis, when the test is being used to evaluate the absence or presence of language function in the side in which surgical treatment is being planned, using the Wada procedure as the criterion standard, MEG was 98% sensitive and 83% specific. Thus, if the presence of language function in the surgical site requires intraoperative mapping and/or a tailored surgical approach, use of MEG rather than Wada would have “missed” 1 case where such an approach would be needed (false negative MEG), and resulted in 5 cases where such an approach was unnecessary (false positive MEG). However, it should be noted that the Wada test is not a perfect reference standard, and some discordance may reflect inaccuracy of the reference standard. In another study by Hirata et al (2004), MEG and the Wada test agreed in 19 (95%) of 20 cases.

The other potential use (utility) of MEG would be to map the sensorimotor area of the brain, again to avoid such areas in the surgical resection area. Intraoperative mapping just before resection is generally done as the reference standard. Preoperative mapping as potentially done by MEG might aid in determining the suitability of the patient for surgery or for assisting in the planning of other invasive testing. Similar to the situation for localization of epilepsy focus, the literature is problematic in terms of evaluating the comprehensive outcomes of patients due to ascertainment and selection biases. Studies tend to be limited to correlations between MEG and intraoperative mapping. Intraoperative mapping would be performed anyway in most resection patients. Several studies evaluated in the 2003 TEC Assessment showed good to high concordance between MEG findings and intraoperative mapping. A 2006 technology assessment of functional brain imaging prepared by the Ontario Ministry of Health reviewed 10 studies of MEG and invasive functional mapping and showed good to high correspondence between the 2 tests. However, these studies do not demonstrate that MEG would replace intraoperative mapping or reduce the morbidity of such mapping by allowing a more focused procedure.

Recent studies of the use of MEG in localizing the sensorimotor area provide only indirect evidence of utility. A 2013 study by Niranjan et al reviewed results of 45 patients in whom MEG was used for localizing somatosensory function. In 32 patients who underwent surgery, surgical access routes were planned to avoid regions identified as somatosensory by MEG. All patients retained somatosensory function. It is unknown to what extent MEG provided unique information not provided by other tests. In a 2012 study by Tarapore et al, 24 patients underwent MEG, transcranial magnetic stimulation, and intraoperative direct cortical stimulation to identify the motor cortex. MEG and navigated transcranial magnetic stimulation were both able to identify several areas of motor function, and the median distance between corresponding motor areas was 4.71 mm. When comparing MEG with direct cortical stimulation, median distance between corresponding motor sites (12.1 mm) was greater than the distance between navigated transcranial magnetic stimulation and direct cortical stimulation (2.13 mm). This study cannot determine whether MEG provided unique information that contributed to better patient outcomes.
Section Summary

There are no clinical trials that demonstrate the clinical utility of using MEG for localization and lateralization of eloquent and sensorimotor regions of the brain. Available evidence comprises studies that correlate results of MEG with the Wada test, which is an alternative method for localization. Evidence generally shows that concordance between MEG and the Wada test is high. Because MEG is a less invasive alternative to the Wada test, this evidence indicates that it is a reasonable alternative. There is also some evidence that the correlation of MEG with intraoperative mapping of eloquent and sensorimotor regions is high, but the test has not demonstrated sufficient accuracy to replace intraoperative mapping.

Ongoing and Unpublished Clinical Trials

A search of online site ClinicalTrials.gov identified several studies of MEG/MSI for various indications (see Table 1). None are randomized. Additional ongoing studies with no completion date identified evaluate MEG/MSI in mood and anxiety disorders (NCT00024635, NCT00047853) and autism spectrum disorders (NCT01031407).

Table 1. Active Studies of MEG/MSI Listed at ClinicalTrials.gov

<table>
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<tr>
<th>NCT Number</th>
<th>Title</th>
<th>Enrollment</th>
<th>Completion Date</th>
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<tr>
<td>NCT01735032</td>
<td>Multimodal Imaging in Presurgical Evaluation of Epilepsy (EPIMAGE)</td>
<td>140</td>
<td>May 2016</td>
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<tr>
<td>NCT02077504</td>
<td>Gliomas Electromagnetic Signature Study by Magnetoencephalography (MEG)</td>
<td>20</td>
<td>August 2015</td>
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<tr>
<td>NCT02159300</td>
<td>Brain Rhythms in Fibromyalgia: A Magnetoencephalography (MEG) Study (FMP)</td>
<td>80</td>
<td>May 2015</td>
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<tr>
<td>NCT01317121</td>
<td>Multi-site Communication Deficits in Schizophrenia</td>
<td>144</td>
<td>Jun 2015</td>
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<td>NCT02132052</td>
<td>Defining Phenotypes of Movement Disorders: Parkinson Plus Disorders (PD), Essential Tremor, (ET), Cortical Basal Degeneration, (CBD), Multiple Systems Atrophy (MSA), Magnetoencephalography (PHENO)</td>
<td>18</td>
<td>May 2014</td>
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<td>NCT02069613</td>
<td>Multimodal Approach to Testing the Acute Effects of Mild Traumatic Brain Injury (mTBI)</td>
<td>200</td>
<td>Feb 2017</td>
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<tr>
<td>NCT01974427</td>
<td>Functional Brain Imaging in Healthy Volunteers to Study Cognitive Functions</td>
<td>120</td>
<td>Apr 2023</td>
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</table>

\(\text{a Estimated}\)

\(\text{b Estimated}\)
Summary of Evidence

Published evidence on magnetoencephalography (MEG) is suboptimal, with no clinical trials demonstrating clinical utility. Literature on diagnostic accuracy has methodologic limitations, primarily selection bias and ascertainment bias. Available studies report that this test has high concordance with the Wada test, which is currently the main alternative for localizing eloquent functions. Management is changed in some patients based on MEG testing, but it has not been demonstrated that these changes in management lead to improved outcomes. Clinical input obtained in 2011 indicated consensus for use of MEG as a substitute for the Wada test in determining the laterality of language function in patients being considered for surgery to treat epilepsy, brain tumors, and other structural brain lesions. Clinical input also demonstrated consensus on use of MEG as part of the preoperative evaluation of patients with intractable epilepsy when standard techniques, such as magnetic resonance imaging (MRI), are inconclusive.

Based on available scientific literature, results of clinical input, and a strong indirect chain of evidence that outcomes are improved, MEG/magnetic source imaging (MSI) may be considered medically necessary as a substitute for the Wada test for the purpose of determining laterality of language function. MEG also may be considered medically necessary as part of the preoperative evaluation of patients with intractable epilepsy when standard techniques such as MRI are inconclusive.

Supplemental Information

Practice Guidelines and Position Statements

The American Clinical Magnetoencephalography Society (ACMEGS)

In 2009, ACMEGS released a position statement that supported routine clinical use of MEG/MSI for presurgical evaluation of patients with medically intractable seizures (see Rationale).10

In 2011, ACMEGS issued clinical practice guidelines on magnetic evoked fields (MEFs) addressing different aspects of this technology (recording and analysis of spontaneous cerebral activity,19 presurgical functional brain mapping using MEFs,20 MEG-EEG reporting,21 and qualifications of MEG-EEG personnel22). Method of guideline development was not described.

Guideline 2 on presurgical functional brain mapping states:

“Magnetoencephalography shares with EEG high temporal resolution, but its chief advantage in pre-surgical functional brain mapping is in its high spatial resolution. Magnetic evoked fields are therefore done for localization; unlike electrical evoked potentials (EPs), MEF latencies and latency asymmetries are not typically used to detect abnormalities.”20

Proposed indications for MEG include localization of somatosensory, auditory, language, and motor evoked fields.20

U.S. Preventive Services Task Force Recommendations

Use of magnetoencephalography is not a preventive service.

Medicare National Coverage

There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.
References

13. Blue Cross and Blue Shield Association Technology Evaluation Center (TEC). Magnetoencephalography (MEG) and magnetic source imaging (MSI): presurgical localization of epileptic lesions and presurgical function mapping. TEC Assessments 2003; Volume 18, Tab 6.


**Documentation Required for Clinical Review**

**Please provide the following documentation:**

- History and physical from referring physician and/or consultation notes including:
  - Previous treatment plan and response
  - Diagnostic imaging reports, if applicable

**Post Service**

- Magnetoencephalography or magnetic source imaging report

**Coding**

This Policy relates only to the services or supplies described herein. Benefits may vary according to benefit design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement.
**Medical Policy**

**MN/IE**

The following service/procedure may be considered medically necessary in certain instances and investigational in others. Services may be medically necessary when policy criteria are met. Services are considered investigational when the policy criteria are not met or when the code describes application of a product in the position statement that is investigational.

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<thead>
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<th>Type</th>
<th>Code</th>
<th>Description</th>
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<td></td>
<td>95966</td>
<td>Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)</td>
</tr>
<tr>
<td></td>
<td>95967</td>
<td>Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (eg, sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)</td>
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<tr>
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<td>S8035</td>
<td>Magnetic source imaging</td>
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**ICD-9 Procedure**

None

**ICD-10 Procedure**

For dates of service on or after 10/01/2015

**ICD-9 Diagnosis**

All Diagnoses

**ICD-10 Diagnosis**

For dates of service on or after 10/01/2015

All Diagnoses

**Policy History**

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
<th>Reason</th>
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<tr>
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<td>4/1/2005</td>
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<td>4/5/2007</td>
<td>Policy Revision</td>
<td>Medical Policy Committee</td>
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<tr>
<td>9/12/2008</td>
<td>Policy Revision</td>
<td>Medical Policy Committee</td>
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<tr>
<td>10/7/2011</td>
<td>Policy revision without position change</td>
<td>Medical Policy Committee</td>
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</table>
Definitions of Decision Determinations

**Medically Necessary:** A treatment, procedure or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

**Investigational/Experimental:** A treatment, procedure or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

**Split Evaluation:** Blue Shield of California / Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a Split Evaluation, where a treatment, procedure or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

**Prior Authorization Requirements**

This service (or procedure) is considered **medically necessary** in certain instances and **investigational** in others (refer to policy for details).

For instances when the indication is **medically necessary**, clinical evidence is required to determine **medical necessity**.

For instances when the indication is **investigational**, you may submit additional information to the Prior Authorization Department.

Within five days before the actual date of service, the Provider MUST confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should also be directed to the Prior Authorization Department. Please call 1-800-541-6652 or visit the Provider Portal www.blueshieldca.com/provider.

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available.