Omnibus Policy
Commercial/Medicare

POLICY NUMBER	LAST REVIEW DATE	APPROVED BY
M20190011	3/28/2024	MPC (Medical Policy Committee)

IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:

 The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes and welcomes further relevant information. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test or procedure over another. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies(LMRP). All coding and web site links are accurate at time of publication.

Coverage Summary

All CPT/HCPCS codes/services addressed in this policy are noted in the table below.
CPT® is a registered trademark of the American Medical Association.

CPT Code	Description:	Conclusion:
0662T	Scalp cooling, mechanical; initial measurement and calibration of cap	See comments
0663T	Scalp cooling, mechanical; placement of device, monitoring, and removal of device (List separately in addition to code for primary procedure)	See comments
19499	Unlisted procedure, breast (when used to report laser interstitial thermotherapy)	See comments
20999	Unlisted procedure, musculoskeletal system, general (when used to report extracorporeal shockwave therapy)	Unproven
20999	Unlisted procedure, musculoskeletal system, general (when used to report laser interstitial thermotherapy)	Unproven
27599	Unlisted procedure, femur or knee (when used to report laser interstitial thermotherapy)	Unproven
27599	Unlisted procedure, femur or knee (when used to report UniSpacer™ Knee System)	Unproven
28890	Extracorporeal shock wave, high energy, performed by a physician or other qualified health care professional, requiring anesthesia other than local, including ultrasound guidance, involving the plantar fascia	Unproven
29799	Unlisted procedure, casting or strapping (when used to report when used to report strapping of the back [or the therapeutic taping of any indication, e.g., Kinesio®, Spidertech™, McConnell, KT TAPE/KT TAPE PRO])	Unproven

30999	Unlisted procedure, nose (when used to report cryoablation for chronic rhinitis, e.g., ClariFix)	Unproven
31299	Unlisted procedure, accessory sinuses (when used to report cryoablation for chronic rhinitis, e.g., ClariFix)	Unproven
31599	Unlisted procedure, larynx (when used to report oral cancer screening systems for detecting cancers of the esophagus, oral cavity, pharynx, or larynx; e.g., OralCDx® BrushTest®, WATS3D [formerly known as EndoCDx], ViziLite™[Zila Inc.], VELscope® [LED Medical Diagnostics], Microlux™/DL [AdDent, Inc.], Orascoptic™ DK™ [Sybron Dental Specialties, Inc.], OraRisk® HPV Salivary Diagnostic Test [OralDNA Labs], TRIMIRA™ Identafi™ 3000 (TRIMIRA, LLC], Dentlight Oral Exam Light Kit [DentLight, Inc.])	See also Oral Cancer Screening and Testing
32999	Unlisted procedure, lungs and pleura (when used to report laser interstitial thermotherapy)	Unproven
33340	Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation (Cardiac left atrial appendage (LAA) closure devices)	See comments
33418	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; initial prosthesis	See comments
33419	Transcatheter mitral valve repair, percutaneous approach, including transseptal puncture when performed; additional prosthesis(es) during same session (List separately in addition to code for primary procedure)	See comments
33999	Unlisted procedure, cardiac surgery (when used to report implanted extra-aortic counterpulsation device [EACD])	Unproven
33999	Unlisted procedure, cardiac surgery (when used to report left partial ventriculectomy (Batista procedure/ventricular reduction surgery [aka ventricular remodeling])	Unproven
40899	Unlisted procedure, vestibule of mouth (when used to report oral cancer screening systems for detecting cancers of the esophagus, oral cavity, pharynx, or larynx; e.g., OralCDx® BrushTest®, WATS3D [formerly known as EndoCDx], ViziLite™[Zila Inc.], VELscope® [LED Medical Diagnostics], Microlux™/DL [AdDent, Inc.], Orascoptic™ DK™ [Sybron Dental Specialties, Inc.], OraRisk® HPV Salivary Diagnostic Test [OralDNA Labs], TRIMIRA™ Identafi™ 3000 (TRIMIRA, LLC], Dentlight Oral Exam Light Kit [DentLight, Inc.])	See also Oral Cancer Screening and Testing
41599	Unlisted procedure, tongue, floor of mouth (when used to report oral cancer screening systems for detecting cancers of the esophagus, oral cavity, pharynx, or larynx; e.g., OralCDx® BrushTest®, WATS3D [formerly known as EndoCDx], ViziLite™[Zila Inc.], VELscope® [LED Medical Diagnostics], Microlux™/DL [AdDent, Inc.], Orascoptic™ DK™ [Sybron Dental Specialties, Inc.], OraRisk® HPV Salivary Diagnostic Test [OralDNA Labs], TRIMIRA™ Identafi™ 3000 (TRIMIRA, LLC], Dentlight Oral Exam Light Kit [DentLight, Inc.])	See also Oral Cancer Screening and Testing

42999	Unlisted procedure, pharynx, adenoids, or tonsils (when used to report oral cancer screening systems for detecting cancers of the esophagus, oral cavity, pharynx, or larynx; e.g., OralCDx® BrushTest®, WATS3D [formerly known as EndoCDx], ViziLite™[Zila Inc.], VELscope® [LED Medical Diagnostics], Microlux™/DL [AdDent, Inc.], Orascoptic™ DK™ [Sybron Dental Specialties, Inc.], OraRisk® HPV Salivary Diagnostic Test [OralDNA Labs], TRIMIRA™ Identafi™ 3000 (TRIMIRA, LLC], Dentlight Oral Exam Light Kit [DentLight, Inc.])	See also Oral Cancer Screening and Testing
43497	Lower esophageal myotomy, transoral (ie, peroral endoscopic myotomy [POEM])	Covered
43499	Unlisted procedure, esophagus (when used to report oral cancer screening systems for detecting cancers of the esophagus, oral cavity, pharynx, or larynx; e.g., OralCDx® BrushTest®, WATS3D [formerly known as EndoCDx], ViziLite™[Zila Inc.], VELscope® [LED Medical Diagnostics], Microlux™/DL [AdDent, Inc.], Orascoptic™ DK™ [Sybron Dental Specialties, Inc.], OraRisk® HPV Salivary Diagnostic Test [OralDNA Labs], TRIMIRA™ Identafi™ 3000 (TRIMIRA, LLC], Dentlight Oral Exam Light Kit [DentLight, Inc.])	See also Oral Cancer Screening and Testing
44799	Unlisted procedure, small intestine (when used to report endoscope retrograde imaging/illumination colonoscope device (implantable) (E.g., Third Eye® Panoramic™ Device for Colonoscopy)	Unproven
47399	Unlisted procedure, liver (when used to report laser interstitial thermotherapy)	Unproven
49419	Insertion of tunneled intraperitoneal catheter, with subcutaneous port (ie, totally implantable) (when used for internal insulin pumps)	Unproven
53899	Unlisted procedure, urinary system (when used to report laser interstitial thermotherapy)	Unproven
55874	Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed (SpaceOAR® rectal spacer injection)	See comments
55899	Unlisted procedure, male genital system (when used to report laser interstitial thermotherapy)	Unproven
58999	Unlisted procedure, female genital system (nonobstetrical) (when used to report speculoscopy for the screening or diagnosis of cervical cancer [Aka cervicography, e.g., PapSure®])	Unproven
64555	Posterior tibial neurostimulation, percutaneous needle electrode, single treatment, includes programming (when used to report peripheral nerve stimulation or peripheral nerve field stimulation for chronic pain)	Unproven
64575	Open implantation of neurostimulator electrode array; peripheral nerve (excludes sacral nerve) (when used to report Peripheral nerve stimulation or peripheral nerve field stimulation for chronic pain)	Unproven
64585	Revision or removal of peripheral neurostimulator electrode array (when used to report peripheral nerve stimulation or peripheral nerve field stimulation for chronic pain)	Unproven

64590	Insertion or replacement of peripheral or gastric neurostimulator pulse generator or receiver, direct or inductive coupling (when used to report peripheral nerve stimulation or peripheral nerve field stimulation for chronic pain)	Unproven
64595	Revision or removal of peripheral or gastric neurostimulator pulse generator or receiver (when used to report peripheral nerve stimulation or peripheral nerve field stimulation for chronic pain)	Unproven
64999	Unlisted procedure, nervous system (when used to report laser interstitial thermotherapy) (when used to report peripheral nerve stimulation or peripheral nerve field stimulation for chronic pain)	Unproven
64999	Unlisted procedure, nervous system (when used to report IB-Stim percutaneous electrical nerve field stimulation (PNFS) for irritable bowel syndrome (IBS) pain	Unproven
64999	Unlisted procedure, nervous system (when used to report laser interstitial thermotherapy [LITT] for epilepsy)	See comments
67299	Unlisted procedure, posterior segment (when used to report transpupillary thermotherapy for retinoblastoma)	Unproven
84999	Unlisted chemistry procedure (when used to report Prometheus Labs Anser Tests-Anser ADA®, Anser IFX®, Anser UST®, Anser VDZ®)	See Laboratory Testing for the Diagnosis of Inflammatory Bowel Disease
92499	Unlisted ophthalmological service or procedure (when used to report computer-based technology designed to superimpose time-lapsed retinal images [e.g. MatchedFlicker])	Unproven
93702	Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s) when used to report BIS for breast cancer	Proven

No Specific Code	Acticon™ Neosphincter artificial bowel sphincter	See Fecal Incontinence Treatment
No Specific Code	Apos (All Phase of Step) Therapy® (AposTherapy®)	Unproven
No Specific Code	Biomarker testing for managing neuroendocrine tumors	Unproven
No Specific Code	Breast ductal endoscopy (aka fiberoptic ductoscopy or mammary ductoscopy) for breast cancer screening	Unproven
No Specific Code	Cardiac hemodynamic monitors, implantable left atrial (E.g., HeartPOD System, Promote LAP System)	Unproven
No Specific Code	Cryotherapy — whole body; any indication	Unproven
No Specific Code	DermaClose® RC Continuous External Tissue Expander for wound management	Unproven

No Specific Code	Double balloon enteroscopy	Unproven
No Specific Code	Electronic nicotine delivery systems for smoking cessation (ENDS)	Unproven
No Specific Code	Heart rate variability testing (Anscore™)	Unproven
No Specific Code	Intracellular micronutrient testing — all indications	Unproven
No Specific Code	INVOcell™ Intravaginal Culture (IVC) system	Unproven
No Specific Code	Comprehensive Stool Analysis [Bio-Reference]	Unproven
No Specific Code	Neuroendocrine lab testing of saliva/urine for evaluating neurotransmitters/hor	Unproven
No Specific Code	Plethysmography (air-displacement) — total body for determining body composition	Unproven
No Specific Code	Idiopathic environmental Intolerance (IEI) (formerly called multiple chemical sensitivity [MCS] or clinical ecological illness, clinical ecology, environmental illness, chemical AIDS, environmental/chemical hypersensitivity disease, total allergy syndrome, cerebral allergy or 20th century disease)	See comments
No Specific Code	Boston Heart Cholesterol Balance Test	See Cardiovascular Disease Risk Assessment policy

20999, 28890, 0101T

UpToDate: ESWT has been more extensively studied than any other single treatment modality. Based upon randomized controlled trials, there is high-quality evidence that it is ineffective in treating plantar fasciitis.
Extracorporeal shock wave therapy – A systematic review published in 2005 included 11 trials and performed a pooled analysis of data from six trials involving 897 participants [95]. The authors concluded that there was no clinically important benefit of shock wave therapy, despite a small statistically significant benefit in morning pain of less than 0.5 cm on a 10 cm visual analogue scale. Further, no statistically significant benefit was observed in a sensitivity analysis that only included studies at low risk of bias. Subsequent systematic reviews have included additional trials and concluded that shock wave therapy is more effective than placebo [96,97]. However, these reviews overestimated benefits of shock wave therapy due to omission of high-quality trials [96] and/or errors in data extraction and data analysis [97]. Revised pooled estimates from one of the aforementioned systematic reviews that corrected for errors in data extraction no longer demonstrated a benefit of shock wave therapy [98]. One open trial reported that outcomes from shock wave treatment were inferior to glucocorticoid injection in people with acute symptoms (<6 weeks' duration) up to 12 weeks [99,100] A randomized placebo-controlled trial including 250 patients reported superior outcomes of focused shock wave therapy in terms of percentage change in pain from baseline and mean scores on the Roles and Maudsley scale [101]. However, no raw data were provided to verify that the differences were of clinical importance, and the validity of use of the Roles and Maudsley four-point categorical scale for plantar fasciitis and its analysis as a continuous measure was not reported. Success of blinding was also not reported. The major reported adverse effect of ESWT is transient pain at the time of

33267, 33268, 33269, 33340

Either the Watchman or Amplatzer™ Amulet™ is covered when all the following are applicable:

- Nonvalvular sustained or paroxysmal atrialfibrillation
- Elevated risk of embolic stroke (e.g., CHA2DS2-VASc score of 2 or more, ATRIA score of6 or more
- Medical management (anticoagulation) not preferred due to 1 or more of the following:
  - Thromboembolism while on oral anticoagulant (i.e., while on therapeutic dosage, or INR in therapeuticrange)
  - Elevated risk of bleeding on oral anticoagulant (e.g., HAS-BLED score of 3 ormore)
  - Other contraindication to long-termanticoagulation
  - Patient unable or unwilling to use long-term anticoagulation
- Short-term (months) postprocedural antithrombotic treatment and long-term aspirin is not contraindicated and is acceptable topatient
- Cardiac anatomy is amenable toprocedure

55874

Consistent with NGS Local Coverage Determination (LCD) Prostate Rectal Spacers

Polyethylene-glycol (PEG) hydrogel (e.g, SpaceOAR®) is covered **ONCE** in patients with clinically localized prostate cancer with **BOTH** the following:

1. Inclusion criteria including **ALL** of thefollowing:
   a. Low* or Favorable Intermediate Prostate Cancer Risk Group (1-5) (AUA or NCCN criteria (6,7))
   b. Dose escalated (≥ 76 Gy) IG-IMRT planned(8,9)
   c. Eastern Cooperative Oncology Group (ECOG) performance status ≤ 1(4)
   d. Modern localization techniques insufficient to improve oncologic cure ratesand/or reduce side effects due to **AT LEAST ONE** of the following(7):
      i. Anatomic geometry precluding ideal rectal constraints (V70 <10%,V65 <20%, V40 <40%) (10)
      ii. Medication usage (e.g., anticoagulants)(8,11,12)
      iii. Comorbid conditions (e.g., increased age, Hx MI or CHF) (11)
2. No Exclusion criteria including **ALL** of the following:
   a. Less than 5-year life-expectancy and asymptomatic(7)
   b. Prior prostate cancer treatment (surgery or RT)(1,3,4,8)
   c. Active bleeding disorder or clinically significant coagulopathy(8)
   d. Active inflammatory or infectious disease in the perineum or injection area(e.g., prostatitis, anorectal IBD)(1,3,8)
   e. Prostate volume > 80 cc(1,3,4)

*Life expectancy ≥ 20 y (very low risk); ≥ 10 y (low risk) (7)

Prostate rectal spacers are various materials or devices placed between the prostate and anterior wall of the rectum for use in men receiving radiation therapy for prostate cancer. The anterior wall of the rectum is considered a major dose-limiting factor in radiation therapy of prostate cancer.

Physical separation is proposed to allow reduced toxicity and treatment intensification. Covered with ICD-10 C61 only.

0662T, 0663T, E0218, E0236

ConnectiCare considers scalp cooling (e.g., using ice-filled bags/bandages, cryogel packs, or specially designed products (e.g., Chemo Cold Cap, DigniCap, ElastoGel, Paxman Scalp Cooling System and Penguin Cold Cap) medically necessary as a means to prevent hair loss during chemotherapy.

Note: Cooling caps and other products for scalp cooling are considered incidental to the chemotherapy administration and are not separately reimbursed. Cooling caps and other scalp cooling products purchased by the member are considered supplies that are generally excluded from coverage under plans that exclude supplies.

29799

Therapeutic elastic or rigid taping (e.g., Kinesio®, Spidertech™, McConnell, KT TAPE/KT TAPE PRO) is considered investigational and unproven for all indications, including but not limited to back pain, radicular pain syndromes, other back-related conditions, lower extremity spasticity, meralgia paresthetica, post-operative subacromial decompression, wrist injury, performance enhancement, prevention of ankle sprains).

(For Medicare members, see Billing and Coding: Outpatient Physical and Occupational Therapy Services)

Peluso R, Hesson J, Aikens J, Bullock M. An Update on Physical Therapy Adjuncts in Orthopedics. Arthroplast Today. 2022;14:163-169. Published 2022 Mar 18. doi:10.1016/j.artd.2022.02.013.

19499, 20999, 27599, 32999, 47399, 53899, 55899, 61736, 61737, 64999

Laser interstitial thermotherapy (LITT) is considered investigational and unproven for all indications (e.g., ultrasound-guided laser interstitial thermo-therapy [US-LITT] except as noted below).

Note: CPT codes 61736 and 61737 (specific to LITT for intracranial lesions) are covered for Medicare members. LITT for epilepsy (64999) is covered for Commercial members when there is documentation of both: Disabling seizures despite the use of two or more tolerated antiepileptic drug regimens, and when there are ≤ 2 well delineated epileptogenic foci accessible by laser.

Hayes Inc. Health Technology Assessment. Laser interstitial thermal therapy (LITT) for treatment of Glioblastoma in Adults. Lansdale, PA: Hayes, Inc.; September 2019; updated March 2021.

Hayes Inc. Health Technology Assessment. Laser interstitial thermal therapy (LITT) refractory temporal lobe epilepsy. Lansdale, PA: Hayes, Inc.; February 2020; updated March 2021.

National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology. Breast Cancer. V2.2024.

National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology. Bone Cancer. V2.2024.

National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology. Central Nervous System Cancers. V1.2023.

National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology. Non-Small Cell Lung Cancer. v3.2024.

National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology. Prostate Cancer. V3.2024.

30999, 31299

The ClariFix cryosurgical ablation tool for the destruction of unwanted tissue during surgical procedures, including in adults with chronic rhinitis, is considered investigational and unproven.

Hayes Evolving Evidence Review. Mar. 07, 2022. ClariFix (Arrinex Inc.) for Treatment of Chronic Rhinitis.

92499

Use of computer-based technology designed to superimpose a series of time-lapsed retinal images (e.g., MatchedFlicker) is considered investigational and unproven for monitoring the progression of retinal disease and for all other indications.

MCG #A-0127 Diabetic Retinopathy, Screening and Follow-Up with Photographic or Video Systems

64555, 64575, 64585, 64590, 64595, 64999

Peripheral nerve stimulation (PNS) and peripheral nerve field stimulation (PNFS) are considered experimental, investigational or unproven for chronic pain (e.g., Moventis PNS, SPRINT PNS System [the Smartpatch is marketed under the name SPRINT], StimQ PNS System [formerly marketed as Smartpatch], StimRouter Neuromodulation System, Reactiv8 Implantable Neurostimulation System for pain associated with multifidus muscle dysfunction), IB-Stim percutaneous electrical nerve field stimulation [PNFS] for irritable bowel syndrome [IBS] pain)

Hayes, Inc. Health Technology Assessment. Percutaneous Peripheral Nerve Stimulation for Treatment of Chronic Pain. May 5, 2022.

Hayes, Inc. Health Technology Assessment. Peripheral Nerve Field Stimulation for Treatment of Chronic Low Back Pain.

Hayes, Inc. Evolving Evidence Review. ReActiv8 Implantable Neurostimulation System (Mainstay Medical Ltd.) for Chronic Low Back Pain. May 20, 2022.

Hayes Inc. Evolving Evidence Review. IB-Stim (NeurAxis) for Treatment of Pain Associated With Irritable Bowel Syndrome in Adolescents. July 14, 2022.

Revision History

DATE	REVISION
03/28/2024	Removed 30468 RE Latera (See Rhinoplasty and Septoplasty policies) Removed 64999 RE Axon Therapy (see 0766T, on Experimental Investigational or Unproved Services policy) Added 64999 RE laser interstitial thermotherapy for therapy for epilepsy Added 93702 RE Bioimpedance spectroscopy for breast cancer Added and updated cross-referencing links
08/12/2022	Added Axon Therapy
07/15/2022	Removed 0191T (del. 01/01/2022) (See Glaucoma Surgery policy) Removed 0308T (see MCG) Removed 0345T (see MCG) Removed 0376T (del. 01/01/2022) (See Glaucoma Surgery policy) Removed 0466T, 0467T and 0468T (del. 01/01/2022) (see Obstructive Sleep Apnea Diagnosis and Treatment policy) Moved 0600T and 0601T to Experimental Investigational or Unproved Services policy Added 0662T, 0663T, E0218, and E0236 regarding cooling devices Added 30999 and 31299 RE ClariFix Added 33267, 33268, 33269 RE Amplatzer™ Amulet™ Added 33999 for Batista procedure and EACD Redirected users to ConnectiCare's Rhinoplasty and Septoplasty policies RE 30468 Added 64555, 64575, 64585, 64590, 64595 and 64999 RE PFS and PNFS for pain Removed 69799 RE nasal endoscopy, surgical; balloon dilation of eustachian tube (e.g., ACCLARENT AERA™ Eustachian Tube Balloon Dilation System, XprESS ENT Dilation System). (See Experimental, Investigational or Unproven Services policy for codes 69705 and 69706) Added 19499, 20999, 27599, 32999, 47399, 53899, 55899, 61736, 61737 and 64999 RE laser interstitial thermotherapy Added 29799 RE therapeutic taping Added 92499 RE MatchFlicker Redirected users to Rhinoplasty and Septoplasty policies RE 30468 Changed per-oral endoscopic myotomy (POEM) for the treatment of swallowing disorders (e.g., achalasia) from unproven to covered Removed Idiopathic Environmental Intolerance (IEI) section (See Experimental, Investigational or Unproven Services policy)
07/14/2021	Added Boston Heart Cholesterol Balance Test
07/02/2021	Added Idiopathic Environmental Intolerance (IEI)
02/25/2021	Added CPT code 84999-Anser IFX (Remicade/infliximab), b. Anser ADA (Humira/adalimumab), c. Anser VDZ (Entyvio/vedolizumab), d. Anser UST (Stelara/ustekinumab)
10/15/2020	Added Extracorporeal shock wave (ESWT) for plantar fasciitis
09/11/2020	Added IB-Stim percutaneous electrical nerve field stimulation (PNFS) for irritable bowel syndrome (IBS) pain

01/01/2020	Effective date of policy
11/2019	Reformatted and reorganized policy, transferred content to new template with new Medical Policy Number. (Formerly Medical Technology Database)