



MEDICAL COVERAGE POLICY

SERVICE: Digital Cognitive or Behavioral Therapy

Policy Number: 302

Effective Date: 05/01/2023

Last Review: 03/30/2023

Next Review Date: 03/30/2024

Important note:

Unless otherwise indicated, this policy will apply to all lines of business.

Even though this policy may indicate that a particular service or supply may be considered medically necessary and thus covered, this conclusion is not based upon the terms of your particular benefit plan. Each benefit plan contains its own specific provisions for coverage and exclusions. Not all benefits that are determined to be medically necessary will be covered benefits under the terms of your benefit plan. You need to consult the Evidence of Coverage (EOC) or Summary Plan Description (SPD) to determine if there are any exclusions or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and your plan of benefits, the provisions of your benefits plan will govern. However, applicable state mandates will take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, Federal mandates will apply to all plans. With respect to Medicare-linked plan members, this policy will apply unless there are Medicare policies that provide differing coverage rules, in which case Medicare coverage rules supersede guidelines in this policy. Medicare-linked plan policies will only apply to benefits paid for under Medicare rules, and not to any other health benefit plan benefits. CMS's Coverage Issues Manual can be found on the CMS website. Similarly, for Medicaid-linked plans, the Texas Medicaid Provider Procedures Manual (TMPPM) supersedes coverage guidelines in this policy where applicable.

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PRIOR AUTHORIZATION: Required.

POLICY: Not all plans cover this therapy. Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for details.

POLICY: Please review the plan's EOC (Evidence of Coverage) or Summary Plan Description (SPD) for coverage details.

For Medicare plans, please refer to appropriate Medicare NCD (National Coverage Determination) or LCD (Local Coverage Determination). If there is no applicable NCD or LCD, use the criteria set forth below.

For Medicaid plans, please confirm coverage as outlined in the Texas Medicaid TMPPM.

This policy addresses the use of practitioner-prescribed software applications for health management purposes for use on a mobile device (e.g. mobile phone, laptop, smartwatch, or tablet) with the intent to evaluate, diagnose or treat a medical condition. This policy does NOT address mobile-based software applications that are used in the management of another FDA-cleared or approved stand-alone hardware medical device. In addition, this policy does not address mobile-based software applications available to the general public for download (including direct-to-consumer or "over the counter" applications), applications that promote general wellness, or applications operated by a healthcare practitioner in a clinical setting for remote health monitoring.

A. Criteria for the mobile software application (MSA) (See table below):

1. The MSA has been approved or cleared by the Food and Drug Administration (FDA); and
2. There is credible scientific evidence which permits reasonable conclusions regarding the impact of the MSA on health outcomes; AND
3. The MSA has been proven materially to improve the net health outcome or be as beneficial as any established alternative;

AND

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B. Member criteria to evaluate the appropriateness of the MSA for the individual:

1. The MSA has been prescribed by a healthcare practitioner; AND
2. There is documentation supporting that the MSA was ordered for a covered purpose such as preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and in accordance with generally accepted standards of medical practice; AND
3. The requested MSA is not primarily for the convenience of the individual, caregiver, or healthcare provider

The following mobile software applications have been evaluated and have medical benefit (See “A” above). All others digital therapy applications are deemed experimental, investigational, unproven, because of a paucity of well-designed, controlled, clinical trials demonstrating clinical efficacy of the intervention:

Digital Therapeutic	Intervention or Treatment	Methodology	BSWHealthPlan Status
Somryst	Chronic Insomnia	Cognitive behavioral therapy 9-week Prescription Digital Therapeutic	Medically necessary if criteria met

OVERVIEW:

Digital therapy encompasses technologies, platforms, and systems that engage members for lifestyle, wellness, and other health-related purposes. These therapies use software programs to prevent, manage, or treat a medical disorder or disease. Similar to pharmaceutical agents and medical devices, digital therapies are evaluated and approved by the U.S. Food and Drug Administration (FDA).

CODES:

Important note:

CODES: Due to the wide range of applicable diagnosis codes and potential changes to codes, an inclusive list may not be presented, but the following codes may apply. Inclusion of a code in this section does not guarantee that it will be reimbursed, and patient must meet the criteria set forth in the policy language.

CPT Codes:	
CPT Not Covered:	98978 Remote therapeutic monitoring (eg, therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days
HCPCS Codes	A9291 Prescription digital cognitive and/or behavioral therapy, FDA-cleared, per course of treatment
HCPCS Codes Not covered	T1505 Electronic medication compliance management device, includes all components and accessories, not otherwise classified
ICD10 codes:	

CMS:

POLICY HISTORY:

Status	Date	Action
New	03/30/2023	New policy

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REFERENCES:

The following scientific references were utilized in the formulation of this medical policy. BSWHP will continue to review clinical evidence related to this policy and may modify it at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to BSWHP so the information can be reviewed by the Medical Coverage Policy Committee (MCPC) and the Quality Improvement Committee (QIC) to determine if a modification of the policy is in order.

1. Digital Health Center of Excellence. Available from FDA.
2. Hayes Reviews. Available at <https://evidence.hayesinc.com/>. Requires subscription.

Note: Health Maintenance Organization (HMO) products are offered through Scott and White Health Plan dba Baylor Scott & White Health Plan, and Scott & White Care Plans dba Baylor Scott & White Care Plan. Insured PPO and EPO products are offered through Baylor Scott & White Insurance Company. Scott and White Health Plan dba Baylor Scott & White Health Plan serves as a third-party administrator for self-funded employer-sponsored plans. Baylor Scott & White Care Plan and Baylor Scott & White Insurance Company are wholly owned subsidiaries of Scott and White Health Plan. These companies are referred to collectively in this document as Baylor Scott & White Health Plans.

RightCare STAR Medicaid plans are offered through Scott and White Health Plan in the Central Managed Care Service Area (MRSA) and STAR and CHIP plans are offered through SHA LLC dba FirstCare Health Plans (FirstCare) in the Lubbock and West MRSAs. Individual HMO plans are offered through FirstCare in West Texas.