# MEDICAL POLICY

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| **Medical Policy Title** | **Bioimpedance Devices for Detection and Management of Breast Cancer Related Lymphedema** |
| **Policy Number** | **2.01.52** |
| **Current Effective Date** | **January 22, 2026** |
| **Next Review Date** | **January 2027** |

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service. (Link to Product Disclaimer)

## POLICY STATEMENT(S)

I. Bioimpedance spectroscopy (BIS) may be considered **medically necessary** for the diagnosis or surveillance of subclinical breast cancer-related lymphedema (BCRL) when **ALL** the following are met:

   A. History of breast cancer treatment and **ANY** of the following:

      1. Axillary lymph node dissection;
      2. Sentinel lymph node biopsy with greater than six (6) nodes removed;
      3. Regional node irradiation;
      4. Taxane based chemotherapy;
      5. Sentinel lymph node biopsy with BMI greater than 30 $kg/m^2$ ; or
      6. Mastectomy in the setting of invasive breast cancer.

II. Bioimpedance spectroscopy (BIS) is considered **investigational** for **ALL** other indications.

## RELATED POLICIES

Corporate Medical Policy

11.01.03 Experimental or Investigational Services

## POLICY GUIDELINE(S)

I. Recommended bioimpedance measurement intervals after treatment for breast cancer include:

   A. Baseline;

   B. Years 1-3: every 3 months;

   C. Years 4-5: every 6 months;

   D. Years 6+: annually or as clinically indicated; and

   E. Following completion of BCRL treatment:

1. Abnormal: continue intervention; or
2. Return to normal: screen quarterly for 3 years post-treatment.

## DESCRIPTION

Lymphedema is the abnormal accumulation of lymph fluid in the subcutaneous tissues of an affected body part due to an obstruction of the lymphatic flow. Secondary lymphedema is most commonly caused by surgery, especially lymph node dissection for breast cancer, radiation therapy (axillary, supraclavicular, cervical, or inguinal lymph node system), trauma, lymphatic obstruction by a tumor, or lymphatic filariasis. Secondary lymphedema may also result from compression of the lymphatic and venous channels, resulting from leakage of fluid into interstitial tissues in patients with chronic venous insufficiency. In the United States, breast cancer treatment is the most common cause of lymphedema.

Lymphedema is diagnosed based upon a patient's history and physical examination, which is staged by observing the patient's physical condition. One challenge, especially in women with breast cancer after surgery, is identifying the presence of clinically significant limb swelling through simple noninvasive methods. Patient education regarding the signs and symptoms of developing lymphedema, as well as early identification and treatment of lymphedema, when it is reversible, is believed to yield better patient outcomes.

One approach suggested for the management of lymphedema is treatment of subclinical (Stage 0) disease. Subclinical lymphedema occurs when there are early changes within the tissues without obvious noticeable swelling or symptoms. Subclinical lymphedema may exist for months or years before overt edema is noted and detection of lymphedema at this stage is difficult. Bioimpedance Spectroscopy (BIS) has been proposed as a diagnostic test for detection of subclinical lymphedema.

Bioimpedance involves applying a very mild electrical current to the body. To detect lymphedema in the upper extremity, the current is applied to the arm. As the current travels through the arm there is resistance. The level of impedance or resistance of a patient's arm to the current can be measured and converted into clinically useful measurements. If an increase in extracellular fluid in the arm (lymphedema) is present, the bioimpedance measurement will increase. Measurement of the extracellular fluid in the patient's upper limb over time allows for tracking fluid changes in the arm and assessing for early signs of lymphedema. Bioimpedance measurements are taken prior to surgery and then at regular follow-up intervals post-surgery. Patients are instructed to avoid caffeine, exercise two hours prior to the measurement being taken, and to avoid alcohol for at least 12 hours prior to the measurement being taken.

## SUPPORTIVE LITERATURE

Ridner et al (2019 and 2022) conducted a multicenter, international, randomized controlled trial (RCT) [PREVENT trial] comparing bioimpedance (n=263 at interim, 482 at final) to volume measurements calculated from arm circumference using a tape measure (n=245 at interim, 481 at final). The primary aim of the study was to determine if subclinical detection of extracellular fluid

accumulation via BIS and subsequent early intervention reduces the rate of progression to clinical lymphedema relative to the rates seen using standard tape measurements. Included participants were women over 18 years of age with newly diagnosed breast cancer who received surgical treatment including one or more of the following: mastectomy, axillary treatment, regional node irradiation, or taxane-based chemotherapy. Patients requiring early intervention were prescribed a compression sleeve and gauntlet for 4 weeks and then re-evaluated. Predetermined thresholds were used to trigger early intervention. The implementation threshold for patients in the bioimpedance group was initially a change that was ≥10 L-Dex units (3 standard deviations) higher than the presurgical baseline measure, but the protocol was changed in 2016 to include all patients with ≥6 L-Dex units. Patients in the tape measure group triggered when they had a volume change in the at-risk arm that was between ≥5 and <10% above the presurgical baselines. Progression to clinical lymphedema was defined as a 10% or greater increase in tape measure volume from baseline in the at-risk arm.

At interim analysis, 109 of 508 (21.9%) patients received early intervention due to reaching the pre-determined threshold. Patients randomized to bioimpedance had a lower rate of trigger and longer times to trigger. A total of 12 triggering patients progressed to clinical lymphedema (10 in the tape measure group [14.7%] and 2 in the BIS group [4.9%]). The difference between groups was not statistically significant (p=.130) and did not meet stopping criteria specified in the study protocol. At final analysis (median of 32.9 months follow-up), BIS triggered an intervention at a lower rate than TM patients (20.1% vs 27.5%; p=.011); however, fewer patients in the BIS group progressed compared with tape measure (7.9% vs 19.2%; relative risk, 0.41; 95% CI, 2.8-4.5; p=.001).

This study had several limitations, including an open-label design, which may have introduced bias in outcome assessment, treatments, or the decision to trigger an intervention. Important health outcomes such as patient-reported symptoms, quality of life (QOL), and function were not assessed. Additionally, 39 patients who progressed prior to an intervention being triggered were excluded from the analysis. The authors concluded that compared to TM, BIS provides a more precise identification of patients likely to benefit from an early compression intervention. Clinical Trial Registration number: NCT02167659

Shah et al (2024) conducted a secondary analysis on data from the PREVENT RCT to investigate the onset and progression of subclinical breast cancer-related lymphedema (sBCRL) and clinical breast cancer-related lymphedema (cBCRL). The aim was to provide guidance on the optimal screening frequency and duration for BCRL. A cohort of 919 women at risk of developing cBCRL were regularly screened using either bioimpedance or tape measure (TM) for up to 36 months following their breast cancer treatment. Women at risk of cBCRL (N=919) were regularly screened for up to 36 months post breast cancer treatment using either bioimpedance or TM. In total, 209 patients (23%) developed sBCRL (bioimpedance: n=89, TM: n=120) and were eligible for intervention. Subsequently, 30 patients progressed to cBCRL post-intervention (BIS: 7, TM: 23). More than half of the patients exhibited measurements consistent with sBCRL within 9 months of breast cancer treatment. Initial detections of sBCRL persisted, regardless of the screening method used, with rates remaining stable in the second and third years (p>0.24) post-surgery. Furthermore, 39 patients progressed to cBCRL without previously developing sBCRL or receiving intervention over the 3-year

period. The timing of sBCRL detection highlights that patients remain at risk years after treatment and may continue to progress to cBCRL long after surgery. Early detection of sBCRL facilitates timely intervention, thereby reducing the likelihood of progression to cBCRL. Consequently, patients should be diligently monitored for a minimum of 3 years following the completion of cancer treatment, with particular emphasis on focused and targeted monitoring during the initial 9-month period.

Boyages et al (2023) published secondary analysis of the PREVENT trial data to identify chronic breast cancer–related lymphedema (cBCRL) risk factors on the basis of axillary treatment. Between June 2014 and September 2018, 881 patients received sentinel node biopsy (SNB; n=651), SNB and regional node irradiation (RNI; n=58), axillary lymph node dissection (ALND; n=85), or ALND and RNI (n=87). The primary outcome was the 3-year cBCRL rate requiring complex decongestive physiotherapy (CDP). After a median follow-up of 32.8 months, 69 of 881 patients (7.8%) developed cBCRL. For tape measurement (TM), 43 of 438 (9.8%) developed cBCRL versus 26 of 443 (5.9%) for BIS (P=.028). The 3-year actuarial risk of cBCRL was 4.4% (95% CI, 2.7 to 6.1), 4.2% (95% CI, 0 to 9.8), 25.8% (95% CI, 15.8 to 35.8), and 26% (95% CI, 15.3 to 36.7). Rural residence increased the risk in all groups. For SNB, neither RNI (SNB, 4.1% v SNB and RNI, 3.4%) nor taxane (4.4%) increased cBCRL, but risk was higher for patients with a BMI of ≥30 (6.3%). For SNB and RNI, taxane use (5.7%) or supraclavicular fossa (SCF) radiation (5.0%) increased cBCRL. For ALND patients, BMI ≥25 or chemotherapy increased cBCRL. For ALND and RNI, most patients received SCF radiation and taxanes, so no additional risk factors emerged. The authors concluded that this analysis showed the extent of axillary treatment is a significant risk factor for cBCRL. Increasing BMI, rurality, SCF radiation, and taxane chemotherapy also increased risk. The authors created a cBCRL risk table which included intermediate risk (5-10%) as SNB patients with BMI greater than or equal to 30, rural residence, greater than or equal to three (3) nodes removed, taxane treatment, or SCF radiation. Also in this risk group are ALND patients with BMI less than 25. Highest risk (greater than 10%) included ALND patients with BMI greater than or equal to 25, RNI, taxane treatment, or SCF radiation. Limitations of the study include the short follow up period of 3 years, and the original PREVENT study was funded by ImpediMed.

Jeffers et al (2023) published long term follow up and surveillance recommendations based on a cohort of 148 female patients with breast cancer who had axillary lymph node dissection (ALND) from November 2014 to December 2017. They aimed to review patients undergoing ALND with longer surveillance to understand timing and multidisciplinary risk factors of BCRL to guide surveillance recommendations based on early detection and implementation of home interventions. Prospectively collected data from a single academic institution's comprehensive lymphedema program was retrospectively reviewed. Baseline BIS measurements and postoperative follow-up occurred every 3 months for 1 year, biannual for 1 year, and then annually. An elevated BIS triggered evaluation and initiation of at-home interventions with reassessment for resolution versus persistent BCRL (pBCRL). Follow-up patient information and BIS were collected through August 2022, during which 65 patients (44%) had an abnormal BIS that qualified for a lymphedema diagnosis. Of these, 34 (52%) were subclinical stage 0 and 25 (38%) were stage 1. The remaining 7 (11%) patients were already stage 2 and 3 (9.1% and 1.5% respectively). With home intervention, 54 (82%) resolved and once BIS measurements returned to the patient's baseline range, they were classified as reversed BCRL

(rBCRL). Persistent BCRL was found in 12 (8%) patients. Average time to first abnormal BIS was 11.7 months. None of the stage 0 patients (0/34) and only 5/25 (20%) of stage 1 patients had pBCRL. All stage 2 and stage 3 patients (7/7) had pBCRL. pBCRL correlated with number of positive nodes, percentage of positive nodes, stage of lymphedema at diagnosis, and recurring abnormal BIS measurements ($p < 0.05$). The pBCRL group had a slightly higher mean BMI of 32 compared with 29 in those who did not, but this was not statistically significant ($p = 0.1$). The authors concluded their analysis showed patients undergoing ALND had a BCRL rate of 8% when BCRL was identified early with BIS and home interventions were performed. They recommended that patients at high risk for pBCRL should have routine surveillance starting at 9 months postoperatively to identify an opportunity for early intervention as the data demonstrates that BIS can accurately detect reversible subclinical lymphedema. Limitations of this study include being a single-institution, retrospective review.

Ward et al (2024a) conducted a comparative study of volume measurements and bioimpedance spectroscopy using a stand-on device for assessment of unilateral breast cancer-related lymphedema. Female participants with indocyanine green lymphography confirmed unilateral arm lymphedema (n=197) and healthy controls (n = 267) were assessed using a cross-sectional study design. BIS and volumetric measures were obtained in a single session. The BIS lymphedema index (L-Dex) method had a significantly higher sensitivity than the excess volume approach (area under the curve = 0.832 vs. 0.649, $p = 0.0001$). The threshold of L-Dex 6.5 had a higher true positive rate (70.6%) than L-Dex 10 (68.5%) although false positive rate increased from 0.4% to 2.6%. A threshold of 5% excess volume improved the true positive rate (68.5%) compared with 10% excess volume (49.7%) however the false positive rate increased to an unacceptable 47%. The authors noted the L-Dex ranges in this study were not significantly different from previously published ranges. The authors concluded this study found that the BIS (L-Dex) method had a higher true positive rate with a smaller false negative rate than the excess volume approach and the existing BIS (L-Dex) thresholds for presence of BCRL were also validated. Limitations of the study include retrospective design, and volumetric measurements were obtained using several different techniques (perometry, DXA, geometric calculation). Similarly, BIS measurements were obtained using different BIS devices and for some control participants while supine and converted to their standing equivalents. This study cohort only included participants with ICG-confirmed BCRL and was cross-sectional with measurements at a single time-point only. Also, participants were included irrespective of lymphedema stage although BIS was originally conceived for detection of early-stage lymphedema.

Ward et al (2024b) published a follow-up study that aimed to compare different normative ranges for BIS L-Dex scores in the detection of BCRL. They analyzed data from 158 women with clinically ascribed and indocyanine green confirmed BCRL. BIS measurements were obtained using an ImpediMed standing device, and L-Dex scores were calculated using published normative ranges for healthy individuals. Statistical analysis was performed to compare the concordance between different reference ranges in classifying individuals with lymphedema. The study found that L-Dex scores calculated using different normative ranges were highly correlated and essentially interchangeable in detecting BCRL. Approximately 90% of participants exceeded the L-Dex threshold for lymphedema, with minimal discrepancies between reference ranges. False negative rates were observed in some

participants, likely due to early-stage BCRL with minimal lymph accumulation. The authors concluded that their analysis showed BIS L-Dex scores are a valid indicator of BCRL, regardless of specific normative ranges used. Detection rates of clinically confirmed BCRL were consistent across different reference ranges, with minimal discrepancies. BIS remains a valuable tool for early detection and monitoring of BCRL. Future research should focus on longitudinal assessments and use of change in L-Dex scores for lymphedema monitoring and progression. Limitations of the study include that the findings are only appropriate to BIS when used for assessment of unilateral BCRL. Bilateral lymphedema poses difficulty in assessment since there is no contralateral limb for normalization of impedance.

## PROFESSIONAL GUIDELINE(S)

Shah et al (2023) published expert consensus breast cancer-related lymphedema (BCRL) assessment clinical practice guidelines. This expert consensus states, “BIS should be considered for patients undergoing any surgical lymph node evaluation (sentinel lymph node biopsy alone, targeted axillary excision or axillary lymph node dissection), receiving regional node irradiation, and/or receiving taxane based chemotherapy; of note, while mastectomy was included as a criteria for the recent randomized trial and previous guidelines, patients undergoing mastectomy for prophylaxis or DCIS may not require BCRL surveillance, while those undergoing mastectomy for invasive malignancy should be considered”. They further make the following recommendations:

- Screen patients meeting at least one of the following criteria:
  - Axillary Management: Axillary Lymph Node Dissection or Sentinel Lymph Node Biopsy with>6 nodes removed
  - Regional Node Irradiation
  - Taxane based chemotherapy
  - BMI>30 kg/m2
  - Mastectomy in the setting of invasive breast cancer
- How often should patients have L-Dex measurements:
  - Baseline
  - Years 1–3: Quarterly
  - Years 4–5: Semi-annually
  - Years 6+: Annually as clinically indicated
- When to initiate BCRL treatment:
  - Change of L-Dex Score>6.5 over baseline
  - Compression garment×4 weeks
- Management Post Early-intervention:
  - Measure following completion of intervention:

- If remains abnormal, refer for complex decongestive physiotherapy
- For those returning to normal following intervention, follow quarterly for at least 3 years post-treatment.

The National Comprehensive Cancer Network (NCCN) Clinical Practice Guidelines in Oncology: Breast Cancer (V.5.2025) state that lymphedema is a potential side effect after the treatment of axillary lymph node surgery resulting from damage to the lymphatic system. Early detection/diagnosis of lymphedema is key for optimal management. Factors associated with increased risk of lymphedema include extent of axillary surgery, axillary radiation, infection, and patient obesity. The panel recommends educating patients on lymphedema, monitoring for lymphedema, and referring for lymphedema management as needed.

The NCCN Clinical Practice Guidelines on Survivorship (V.2.2025) recommend that pretreatment baseline objective measurements should be obtained for patients with treatment-related or individual risk factors. Validated volumetric tools such as perometry, 3D camera or tape measures, and/or tools that measure extracellular fluid, such as bioimpedance spectroscopy are recommended. Early detection/diagnosis of lymphedema is key for optimal management because stages 0 and 1 are reversible, while stages 2 and 3 are less responsive to treatment. They recommend survivors at risk for lymphedema should be regularly screened for lymphedema by symptom assessment, clinical exam, and validated volumetric tools and/or tools that measure extracellular fluid.

The Agency for Healthcare Research and Quality (AHRQ) published a technology assessment for the diagnosis and treatment of secondary lymphedema (Oremus 2010). The AHRQ assessment identified 8 studies that reported the sensitivity and specificity of tests to diagnose secondary lymphedema. Two of the 8 selected studies evaluated BIS devices. They state there is consistent evidence to indicate that lymphedema can be reliably measured using circumferential measures or volume displacement. There is too little evidence to draw conclusion about the reliability of other tests such as tonometry, ultrasound, lymphoscintigraphy, or bioimpedance.

The International Society of Lymphology (ISL) 2023 consensus document for the diagnosis and treatment of peripheral lymphedema recommends the prospective surveillance model which “involves a preoperative cancer treatment assessment where baseline limb volume (both limbs) and functional mobility measurements are established. Some clinics with the availability of bioimpedance spectroscopy (BIS), tissue dielectric constant (TDC), or other measuring devices may utilize these to detect early changes in tissue fluid accumulation. Patients are then followed in a prospective manner (e.g., 3-month intervals for the first year during and post-cancer treatment and then less frequently)”. They recommend assessment of early fluid changes using BIS TDC analysis and stress early intervention is crucial to prevent further complications. ISL defines the four (4) stages of lymphedema as follows:

- “Stage 0, which refers to a latent or subclinical condition where swelling is not yet evident despite impaired lymph transport, subtle alterations in tissue fluid/composition, and changes in subjective symptoms.
- Stage I represents an early accumulation of fluid relatively high in protein content (e.g., in

comparison with "venous" edema) which subsides with limb elevation. Pitting may occur.

- Stage II involves the permanent accumulation of pathologic solids such as fat and proteins and limb elevation alone rarely reduces tissue swelling, and pitting is manifest. Later in Stage II, the limb may not pit as excess subcutaneous fat and fibrosis develop.
- Stage III encompasses lymphostatic elephantiasis where pitting can be absent and trophic skin changes such as acanthosis, alterations in skin character and thickness, further deposition of fat and fibrosis, and warty overgrowths have developed."

The National Lymphedema Network published a position statement (2025) regarding lymphedema diagnosis and treatment. They explain "secondary lymphedema is an acquired condition resulting from injury to lymphatic structures. It affects 1 in 1,000 individuals, accounting for 99% of adult and 3% of pediatric lymphedema cases. This more common and often debilitating form is frequently associated with cancer treatments like surgery and radiation therapy... Although it is not curable, lymphedema is manageable, and progression is preventable with early diagnosis. Prospective surveillance involves longitudinal monitoring of at-risk patients using objective and patient-reported outcome measures to facilitate early diagnosis and treatment. Lymph node removal, particularly through dissection for staging cancers, is a major risk factor for lymphedema. Risk factors for breast cancer related lymphedema include axillary lymph node dissection (ALND), regional nodal irradiation, high BMI (>25 kg/m²), cellulitis, subclinical swelling, Black race, and Hispanic ethnicity. Less clear factors include axillary web syndrome (AWS), taxane based chemotherapy, and genetic predisposition. An ideal prospective surveillance program includes preoperative baseline measurements, objective longitudinal assessments, patient education, and self-monitoring. Screening should continue for at least five years, given the cumulative incidence during this period. A risk-stratified approach is suggested for prospective surveillance, with close monitoring for high-risk individuals and less frequent screening for low-risk patients emphasizing self-monitoring. BIS uses a spectrum of electrical frequencies to differentiate fluid compartments, making it effective in detecting extracellular fluid changes, particularly in early-stage lymphedema. In BCRL, BIS may aid in early detection and reduce progression to complex decongestive therapy (CDT). Compared to excess volume-based methods, BIS lymphedema index (L-Dex) shows superior sensitivity (AUC = 0.832 vs. 0.649) in detecting BCRL. Devices yield high positive predictive value (96.7%) but moderate sensitivity (72.5%) and specificity (87.5%). Subclinical lymphedema, often detected via limb volume increases (3%-5%) or bioimpedance changes (L-Dex increase ≥6.5), may be present without visible swelling or symptoms.

## REGULATORY STATUS

The U.S. Food and Drug Administration (FDA) regulates BIS as medical devices. All BIS including related components require FDA approval before marketing and use in the United States to ensure they are safe and effective for human use. Refer to the FDA Medical Device website. Available from: https://www.fda.gov/medical-devices [accessed 2025 Dec 29]

The FDA lists the most serious type of medical device recalls as well as early alert communications about corrective actions being taken by companies that the FDA believes are likely to be the most

serious type of recalls. Available from: https://www.fda.gov/medical-devices/medical-device-safety/medical-device-recalls-and-early-alerts [accessed 2025 Dec 29]

ImpediMed L-Dex U400 BIS Extra Cellular Fluid Analysis was FDA cleared through the 510(k) process in 2008 (K080825). This was a bioelectrical impedance analyzer/monitor utilizing impedance ratios that supports the measurement of extra cellular fluid volume differences between the arms to aid in the clinical assessment of unilateral lymphedema of the arm in women. This device is not intended to diagnose or predict lymphedema of an extremity. The L-Dex U400 was discontinued by its manufacturer in November 2018.

MoistureMeterD (Delfin Technologies) was FDA cleared through the 510(k) process in 2015 (K143310). This device utilized inter-arm ratios of tissue dielectric constant (TDC) that supports local assessment of tissue water differences between affected and contralateral non-affected arm tissues to aid in forming a clinical judgement of unilateral lymphedema in women. This device is not intended to make diagnosis or predict arm lymphedema.

SOZO (ImpediMed) was FDA cleared through the 510(k) process in 2018 (K180126). Indications for use include adults at risk of lymphedema including patients who will have or have had had lymph nodes from the axillary or pelvic regions, either removed, damaged, or irradiated.

## CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

### CPT Codes

| Code | Description |
|---|---|
| 93702 | Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s) |



### HCPCS Codes

| Code | Description |
|---|---|
| Not Applicable | |

### ICD10 Codes

| Code | Description |
|---|---|
| I89.0 - I89.9 | Other noninfective disorders of lymphatic vessels and lymph nodes (code range) |
| I97.2 | Postmastectomy lymphedema syndrome |
| Z90.10-Z90.13 | Acquired absence of breast and nipple (code range) |

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## SEARCH TERMS

Bioimpedance, bioelectrical impedance spectroscopy

## CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Bioimpedance devices for the detection and management of lymphedema are not addressed in National or Regional Medicare coverage determinations or policies.

## PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, medical policy criteria apply to the benefit.
- If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.
- If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product)

covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.

- If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.

| **POLICY HISTORY/REVISION** | |
|---|---|
| **Committee Approval Dates** | |
| 08/17/17, 05/17/18, 05/16/19, 05/21/20, 05/20/21, 05/19/22, 05/18/23, 05/16/24, 05/22/25, 01/22/26 | |
| **Date** | **Summary of Changes** |
| 01/22/26 | • Off cycle policy update, policy statement added bioimpedance spectroscopy medically necessary for breast cancer related lymphedema, policy title change. |
| 05/22/25 | • Annual review, policy intent unchanged. |
| 01/01/25 | • Summary of changes tracking implemented. |
| 08/17/17 | • Original effective date |