

# Arise Medical Policy Updates: March 2017

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The Medical Affairs Medical Policy Committee approved first quarter medical policies on March 17, 2017, and providers were notified of changes to those policies in late April. The policies become effective July 1, 2017.

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- To obtain a referenced MCG guideline specific to your patient's review, call Medical Affairs at 920-490-6901 or toll-free at 888-711-1444.
- For general medical policy or MCG requests, email [medical.policies@wpsic.com](mailto:medical.policies@wpsic.com).
- If you have specific questions or comments regarding development of policy content, contact the Medical Policy Editor at [medical.policies@wpsic.com](mailto:medical.policies@wpsic.com) or 800-333-5003 ext. 77196.
- For questions regarding medical coding related to Medical Policies policies, please contact the Code Governance Committee at [codegovernance@wpsic.com](mailto:codegovernance@wpsic.com).

## Medical Policy Highlights (effective July 1, 2017)

### **New Policy! Cell Free Fetal DNA Testing**

This policy was developed to clarify and simplify the criteria for coverage of genetic screening tests for fetal aneuploidy, performed on maternal blood during pregnancy. Cell free fetal DNA screening is indicated for high-risk singleton pregnancy. Screening in multiple gestation pregnancy, and for microdeletions, monogenic disorders, and sex linked disorders is considered experimental, investigational, and unproven. *Genetic tests require prior authorization.*

### **Acupuncture Therapy**

In the absence of health plan exclusions, specific coverage indications, or visit limits, a maximum of twelve (12) acupuncture treatments per year can be approved. *Acupuncture is often a health plan exclusion. Prior authorization is required.*

### **Bariatric Surgery**

Additional information about surgery for individuals under age 18, based on the combined Pediatric Guidelines from the endocrine and bariatric surgery societies is included. Reconfirmed that gastric stimulation is considered unproven. *Bariatric surgery is often a health plan exclusion. Prior authorization is required.*

### **Biofeedback**

Information was added regarding neurostimulation devices which are often used in conjunction with biofeedback. Medical necessity criteria are available for tibial nerve stimulators; pelvic floor neurostimulation is considered unproven. *Biofeedback and home biofeedback units are often health plan exclusions. Prior authorization is required.*



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## **Blepharoplasty, Blepharoptosis Repair, Brow Lift**

Added indications for blepharoplasty in conjunction with myomectomy. Criteria for blepharoplasty for chronic benign essential blepharospasm was clarified. *Prior authorization is required.*

## **Cranial Orthotic**

Added criteria regarding caregiver agreement to the wearing protocol prescribed by the provider. *Health plan exclusions and limits may apply. Prior authorization is required.*

## **Neuropsychological testing (NPT)**

Specified the requirement for documentation of a neurobehavioral status exam or thorough evaluation by a neurologist, psychiatrist, or psychologist indicating the need for NPT. More than eight hours of NPT testing requires physician review. *Prior authorization is required.*

## **Occipital Nerve Block and Headache Treatments**

The title was changed from **Occipital Nerve Block** to reflect the inclusion of headache treatment indications and criteria. *Prior authorization is required.* Clarified criteria for occipital neuralgia.

Specified that each of the following treatments are considered unproven:

- Occipital neurectomy/nerve decompression for headache and occipital neuralgia
- Radiofrequency ablation (thermal or pulsed) or denervation for treatment of occipital neuralgia or headaches, including migraine, cluster, and cervicogenic headache
- Neurostimulation for treatment of occipital neuralgia or headaches, including migraine, cluster, and cervicogenic headache
- Electrical stimulation for treatment of occipital neuralgia or headaches, including migraine, cluster, and cervicogenic headache

## **Osteogenic Stimulator (Bone Growth Stimulator)**

Effective immediately, high-risk indications will include smoker status. The policy was retired to MCG guidelines. *Prior authorization is still required.*

All other indications are unchanged:

- Electrical and Electromagnetic bone growth stimulators continue to be indicated as an adjunct to lumbar spine fusion when there are risk factors for fusion failure; treatment of delayed union or non-union of fractures continues to be considered experimental, investigational, and unproven.
- Ultrasonic bone growth stimulators continue to be indicated as an adjunct to treatment of specific acute fractures and delayed (fracture or osteotomy) healing of long bones.

## **PET Scans**

Added Gallium Ga-68 dotatate (NETSPOT) as a covered tracer for evaluation of neuroendocrine tumors. *To facilitate claims processing, please specify the use of the gallium tracer in the prior authorization documentation. Prior authorization is required for PET scans.*

## **Selective Internal Radiation Therapy (SIRT)**

Indications are unchanged. Added information regarding the SIRT in combination with chemotherapies unproven; clinical trials are in progress and health plan limitations may apply. *Prior authorization is required.*

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## Urine Drug and Alcohol Screening and Testing

Policy was reformatted. Documentation requirements were clarified. Documentation must include medical and behavioral health history, why the specific tests were ordered for this patient, the clinical interpretation of test results and rationale for specific confirmatory tests, and what changes in care will be made as a result. Added a requirement that the provider document having checked the state prescription drug monitoring program.

## Non-Covered Services and Procedures (NCS) Highlights

Non-Covered Services typically are not prior authorized. However, a request for prior authorization will be honored if clarification is requested. *Genetic tests, biomarker assays, and some other procedures require prior authorization.* See the [Arise Prior Authorization List](#) on our website.

### Removed from NCS; covered when criteria are met:

- Suction assisted protein lipectomy for severe lymphedema; *prior authorization is required*
- AlloMap heart transplant rejection genetic test; prior authorization is not required post-transplant
- Portable multichamber programmable pneumatic compression devices for lymphedema; *prior authorization is required for standard and programmable devices*

### Added to NCS:

- Laser-assisted spinal surgery; *spine surgery requires prior authorization*
- L-Dex device was added as an example for Bioimpedence Spectroscopy for lymphedema
- Any sublingual antigens that are not FDA approved; *the FDA-approved prescription sublingual antigens require pharmacy prior authorization*
- Viscosupplementation injections for all joints (see full article in our **Summer 2017 Provider Newsletter**)
- ReMed Air Mini CPAP device for travel; *prior authorization is required for PAP devices*
- Veristrat proteomic biomarker test
- Off-bypass Mini-maze and Hybrid Mini-maze procedures; *prior authorization is required*

### Notable items reconfirmed on the NCS:

- Pharmacogenetic/Pharmacogenomic Testing, Cytochrome P450 (CYP450) Genotyping and/or assays and algorithmic analyses; *prior authorization is required*
- Percutaneous Vertebroplasty/Kyphoplasty; *spine surgery requires prior authorization*
- Prometheus IBD sgi; *prior authorization is required*
- Cartilage, chondrocyte, and meniscus procedures; expanded the non-indications to all joints

The complete library of our medical policies can be found at:

[arisehealthplan.com/providers/policies/coverage\\_policy\\_bulletins](http://arisehealthplan.com/providers/policies/coverage_policy_bulletins) No password required!

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