

Arise Medical Policy Updates

The Medical Affairs Medical Policy Committee approved second quarter medical policies on June 16, 2017, and providers were notified of changes to those policies in late July. The policies become effective Oct. 1, 2017, unless otherwise noted below.

Disclaimer: Medical Policies are for informational purposes only and do not constitute medical advice, plan authorization, an explanation of benefits, or a guarantee of payment. Benefit plans vary in coverage, and some plans may not provide coverage for all services listed in a policy. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and federal law. Some benefit plans administered by the organization may not utilize Medical Affairs medical policy in all their coverage determinations. Contact Customer Service as listed on the member ID card for specific plan, benefit, and network status information. Medical policies are based on constantly changing medical science and are reviewed annually and subject to change. The organization uses tools developed by third parties, such as the evidence-based clinical guidelines developed by MCG to assist in administering health benefits. Medical Policies and MCG guidelines are intended to be used in conjunction with the independent professional medical judgment of a qualified health care provider.

- 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.
- If you have specific questions or comments regarding development of policy content, contact the Medical Policy Editor at medical.policies@wpsic.com or 800-333-5003, ext. 77196.
- For questions regarding medical coding related to Medical Policies policies, contact the Code Governance Committee at codegovernance@wpsic.com.

Medical Policy Highlights

New Policy! Artificial Disc Replacement

This policy was developed due to positive changes in coverage indications. Two contiguous levels of FDA-approved cervical disc devices between C3 and C7 now may be covered when medical necessity criteria for anterior cervical decompression and fusion (ACDF) are met. Artificial lumbar disc devices continue to be considered experimental, investigational, and unproven, and are therefore not covered. *Artificial disc devices and all spinal surgeries require prior authorization. Reminder: Intraoperative Neurophysiologic monitoring (IONM) during spinal surgery also requires prior authorization.*

Arise Chiropractic Services

The guidelines for documentation were clarified. Timelines for frequency of re-evaluation and revision of the treatment plan were clarified. When time-based services are billed, the time component must be documented. Modality machine settings (i.e., intensity, depth, etc.) must be documented. *This policy takes effect when posted.*

Back Pain Treatment: For All Back Pain Treatment Policies

- *Prior authorization is required.*
- Many member health plans have set maximum limits for pain injections per plan year or calendar year. These services are covered subject to medical necessity review. If a limit is not specified in the member health plan, the maximum follows the medical necessity guidelines in the policy. If a year is not described in the member health plan (e.g., per calendar year), a year is defined as the 12-month period starting from the date of service of the first approved treatment.



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- If more than one type of pain treatment is requested/performed on the same day, only one type will be considered medically necessary at the discretion of the health plan.

Back Pain Treatments: Epidural Injection

Cervical epidural injection is now considered medically necessary provided criteria are met (pertinent history and physical findings and radicular pain unresponsive to a six-week trial of conservative therapy). Clarification: Transforaminal injection requires documentation of radiculopathy at each nerve being targeted. *Prior authorization with documentation of the results of the previous injection is required for any subsequent injections.*

Back and Nerve Pain Treatments: Radiofrequency Ablation, Facet Joint, and Other Injections

The evidence for ablation of peripheral nerves for chronic pain, and ablation of nerves of the head and face to treat headache is poor. Radiofrequency ablation for chronic pain, including, but not limited to, occipital, genicular, supraorbital, and supratrochlear nerves is considered experimental, investigational, and unproven. Therapeutic facet injections continue to be considered experimental, investigational, and unproven, and are therefore not covered. *Prior authorization with documentation of the results of the previous injection is required for any subsequent injections.*

Back Pain Treatments Sacroiliac Joint (SIJ) and Coccygeal Treatments

Therapeutic SIJ and coccygeal injections are now considered medically necessary provided criteria are met (chronic pain, physical exam findings consistent with SIJ or coccygeal pain, and pain unresponsive to a six-week trial of conservative therapy). SIJ ablation continues to be considered experimental, investigational, and unproven for SIJ dysfunction, and is therefore not covered. *Prior authorization with documentation of the results of the previous injection is required for any subsequent injections.*

Hyperbaric Oxygen Therapy (HBOT)

Effective Oct. 1, 2017, for wound treatment beyond the initial approval (maximum of 30 days), documentation (with serial ruler/photographic measurement) of the effectiveness of the previous month's treatments must be provided. Inpatient days of treatment count toward the 30-day total.

Reminder: Physician progress notes are required for each date of service the physician is present during treatment. *Prior authorization is required.*

Infertility and Recurrent Pregnancy Loss (RPL) Testing and Treatment

- The policy title was amended to reflect additional information regarding evaluation and treatment of RPL.
- Many health plans have definitions, exclusions, benefits, prior authorization requirements, and treatment limits for the diagnosis and treatment of infertility and/or recurrent pregnancy loss that supersede the medical policy. *Prior authorization is required.*
- When not defined by the member's health plan, infertility is now defined as the physical inability to achieve a pregnancy after a year of regular, unprotected intercourse if the woman is under age 35, or after six months if the woman is over age 35.
- Genetic tests, including Cystic Fibrosis **diagnostic** genetic tests, Preimplantation Genetic Diagnosis and Preimplantation Genetic Screening (PGD and PGS) require prior authorization and must meet test validity and medical necessity criteria for the condition. Cystic Fibrosis **screening** is considered under the preventive services benefit.

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Total Ankle Arthroplasty

Requirement for non-nicotine use was removed. The format was corrected to include both:

- At least one of the following conditions must be present:
 - a. Severe osteoarthritis of the joint
 - b. Inflammatory (e.g., rheumatoid) arthritis of the joint
 - c. Post traumatic arthritis of the joint
- AND*
- At least one of the following must be present:
 - a. Severe arthritis of the contralateral ankle
 - b. Arthrodesis of the contralateral ankle
 - c. Arthritis in an adjacent joint, such as the subtalar joint
 - d. History of arthroplasty of the adjacent (ipsilateral) knee

Note: Coverage is provided for FDA-approved implant. It is the responsibility of the surgeon to choose an FDA-approved device. *Prior authorization is required.*

New Policy! Treatment of Gender Dysphoria

This policy is based on the World Professional Association for Transgender Health (WPATH) Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5), American Psychiatric Association recommendations, as well as other evidence-based publications. The policy addresses behavioral health services, hormonal treatment, and surgery. Documentation must demonstrate ongoing coordination and communication among the member's behavioral health provider, prescribing provider, and/or surgeons through the process. Some surgical services may be considered cosmetic or health plan exclusions. *Prior authorization is required.*

Non-Covered Services and Procedures (NCS) Highlights

Non-Covered Services typically are not prior authorized.

Added to NCS:

- I-Fuse device in conjunction with minimally invasive SIJ fusion for SIJ dysfunction
- Stem cell therapy for cardiac disease
- Minimally Invasive Transforaminal Lumbar Interbody Fusion (MITLIF)
- Extreme Lateral Interbody Fusion (XLIF; Nuvasive) also known as Lateral Lumbar Interbody Fusion (LLIF)
- Nerve ablation for chronic pain: including but limited to: genicular, occipital, supraorbital, supra-trochlear, and SIJ
- PCR multiplex testing for gastrointestinal (GI) pathogens: Infectious agent detection by nucleic acid (DNA or RNA) for GI pathogens including multiplex reverse transcription and, when performed, multiplex amplified probe techniques for greater than six targets is considered not medically necessary unless there is documentation by the ordering provider of the need for a rapid result and each of the pathogens listed in the panel

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Notable Items Reconfirmed on the NCS:

- Pharmacogenetic/Pharmacogenomic Testing—unless required as a “Companion” test for coverage of an FDA-approved drug
- GERD (Gastroesophageal Reflux Disease) and dysphagia endoscopic and laparoscopic treatments including but not limited to the LINX system, transoral incisionless fundoplication; and Peroral Endoscopic Myotomy (POEM) for achalasia
- OtoSCOPE multi-gene panel
- Autologous cell therapy for cardiac disease

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

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