Arise Medical Policy Updates

The Medical Affairs Medical Policy Committee approved medical policies on March 16, 2018. The policies become effective July 1, 2018, 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 use Medical Affairs medical policy in all their coverage determinations. Contact Customer Service as listed on the customer 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. 78993.
- For questions regarding medical coding related to Medical Policy Committee policies, contact the Code Governance Committee at codegovernance@wpsic.com.

Medical Policy Highlights

Chiropractic Services

Prior authorization is not required.

Clarification/additional information added regarding required documentation, including:

Modalities:

- Rationale for use.
- Time component.
- Modality machine settings (i.e., intensity, depth).
- Only one (1) modality per anatomic area.
- After six (6) weeks, the use of passive modalities is considered not medically necessary for an episode of care.

Active Care:

- Specific exercise(s) and/or activity(ies) and the rationale for implementation.
- Date of onset on the HCFA/CMS form must be related to the current episode of care and correlate with the clinical documentation.

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Delegated Massage Therapy (if not an exclusion of the health plan):

- Rationale for use in the current treatment plan.
- Frequency and duration must be documented in the current treatment plan.
- Specific goals to improve ADLs in the current treatment plan.
- Objective measures to evaluate treatment effectiveness in the current treatment plan.
- Treatment time for each session.
- Manual assessment of the spine/body area to be treated on each session.
- Manual treatment that must correlate with the location of symptoms and physical findings on each session.
- Massage therapy that does not demonstrate functional improvement upon reassessment is considered maintenance/custodial.
- National Correct Coding Initiative (NCCI) claim edits bundle manual therapy to chiropractic adjustment codes when performed in the same anatomic region.

Initial Visit and Subsequent Visits:

- Informed consent.
- Complicating factors.
- Absolute or relative contraindications to manipulation present.
- Progress toward goals/improvement within the first two (2) weeks of treatment.
- Treatment numbers and total treatments.

The following modalities or devices were removed from the list considered medically necessary when there is documentation of the rationale for use:

- Thermal therapies not specified above.
- Ultrasound.
- Strength and conditioning exercise instruction.
- Electrotherapy.

Bariatric Surgery

Prior authorization is required.

Bariatric surgery is often a health plan exclusion.
Added to or clarified in **Indications of Coverage**:

- Documentation of complete history and physical (including evaluation and treatment of obesity-related comorbidities, and evaluation of surgical risks). Clinical record documentation must include a summary of historical (failed attempts) as well as details of present exercise program participation (e.g., physical activity, workout plan), nutrition program (e.g., calorie intake, meal plan, diet followed), and BMI history. Cardiac, pulmonary, endocrine, and GI evaluation is obtained as indicated.
- Repeat/revisional bariatric surgery requires physician review (when it is not an exclusion of the policy or health plan).

- Repeat or revisional bariatric procedures for failure to achieve weight-loss goals, continued comorbid disease, or weight regain are considered not medically necessary and may also be an exclusion of the health plan. Routine gastric band adjustments are not considered revisional surgery.
- Revisional surgery is considered medically necessary when all are met:
  - To treat acute or chronic serious complications of the original bariatric surgery, such as obstruction, stricture, erosion, band migration, or staple line failure.
  - When the complication causes severe symptoms, such as abdominal pain, weight loss to 80% or less of ideal body weight, inability to eat or drink, or vomiting of prescribed medications.
  - The condition meets medical necessity criteria for surgical intervention.
  - The health plan allows for coverage.

Removed from **Indications of Coverage**:

- Separate nutritional evaluation section.
- Participation in a professionally supervised multidisciplinary weight-loss program.

Added **Limitations of Coverage**:

- Band over bypass sleeve.
- Conversion of sleeve to Roux-en-Y for GERD.
- Single-anastomosis duodenal switch (SADS).
- Repeat or revisional bariatric procedures for failure to achieve weight-loss goal, continued comorbid disease, or weight regain. (Routine gastric band adjustments are not considered revisional surgery.)

Blepharoplasty, Blepharoptosis Repair, Brow Lift, and Related Procedures

Prior authorization is required.

Clarified: The criteria in this policy are used to determine medically necessary treatment to improve function versus cosmetic treatment performed to improve appearance in the absence of a functional abnormality.

Added to **Indications of Coverage**:

- If both blepharoplasty and blepharoptosis repair are requested, criteria must be met for both procedures and there must be demonstration of visual impairment that cannot be addressed by one procedure alone.
- Upper eyelid blepharoptosis repair: High-quality photographs demonstrate the MRD of 2.0 mm or less and the eyelid at or below the upper edge of the pupil.
- Brow ptosis surgery: At least 12 degrees or at least 24% superior visual field difference is demonstrated between visual field testing before and after taping of the eyebrow.

Urine Drug/Alcohol Screening and Testing

Prior authorization is not required.

Additional required documentation:

- Interim history and results of previous screening/testing and documentation of results in the context of the medical history. Include history of opioid use and the history of the medical condition associated with the indication for opioid therapy.
- Presence or absence of aberrant behaviors related to chronic pain management or addiction (e.g., self-escalation of dose, doctor-shopping, indications/symptoms of illegal drug use, evidence of diversion, or other documented change in affect or behavioral pattern).
- Current treatment plan, including timeline for future testing and changes in management based upon the previous result(s).

Added to **Limitations of Coverage:**

- Routine analysis for specimen integrity is considered not medically necessary and will not be reimbursed separately.
- Drug screening/testing on hair or oral fluids (saliva) is considered experimental, investigational, unproven, and not medically necessary, and may also be an exclusion of the health plan.
- Routine reflex testing of positive preliminary results to confirmatory testing.

Neuropsychological Testing

Prior authorization is required (with the exception of neurobehavioral status exam).

Added to **Limitations of Coverage**:

- Baseline neuropsychological testing (including ImPACT) in asymptomatic persons.

Cell-Free Fetal DNA Testing

Prior authorization is required.

Added to **Limitations of Coverage**:

- Performing a repeat cell-free DNA screen during the same pregnancy because of an indeterminate, uninterpretable, or “no call” initial result is not medically necessary.

MCG Guidelines

The Medical Policy Committee approved use of the updated 22nd Edition of MCG Guidelines.

Added to Prior Authorization List

PCR Multiplex Panel Testing (Multiplex Polymerase Chain Reaction, mPCR) for Gastrointestinal Infections for greater than five pathogens. PCR testing for greater than five pathogens is considered not medically necessary, unless there is documentation from the ordering provider of the need for rapid result and need to test for each of the pathogens identified in the panel. Prior authorization is required for PCR testing for greater than five pathogens.

Non-Covered Services and Procedures

We do not advise providers to submit prior authorization requests for items on our Non-Covered Services and Procedures Medical Policy, as they are not covered.

Added:

- Freespira™ Breathing System
- Micra™ Transcatheter Pacing System
- Cxbladder Monitor™
- Rezum System™
- iovera™ for knee pain management

Removed from non-coverage:

- DevACT™ Clinical Management Panel
- TheraSEEK™ Sequence Analysis for Functional Disorders

The complete library of our medical policies and the quarterly Medical Policy Update reports can be found online at arisehealthplan.com/providers/policies/coverage_policy_bulletins.
No password required!

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