

Arise Medical Policy Updates

The Medical Affairs Medical Policy Committee recently approved medical policies that will become effective Oct. 1, 2018 unless specified 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 customer 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

Artificial Disc Replacement

Prior authorization is required.

Indications of Coverage:

- Changed: The required conservative treatment trial must include a six (6) week trial of physical therapy or chiropractic treatment **and** a six (6) week trial of anti-inflammatory medication.
- Clarified: Disc disease or herniated disc with cervical radiculopathy and/or myelopathy must be documented with the physical exam findings or on EMG report.
- Added: Radiographic studies confirming pathology also show adjacent narrowing and/or degeneration of the disc space.

Reminder: Artificial disc replacement to lumbar or thoracic level is considered experimental, investigational, or unproven to affect health outcomes.



Back Pain Procedures—Epidural Injection (Caudal Epidural, Selective Nerve Root Block, Interlaminar, Transforaminal, Translaminar Epidural Injection)

Prior authorization is required.

Indications of Coverage:

- Terminology changed from “injection” to “session.” A session is defined as one date of service in which there is either a single interlaminar or caudal epidural steroid injection (ESI), a bilateral transforaminal epidural steroid injection (TFESI) at a single level, or TFESIs at two nerve root levels unilaterally. A session may involve the lumbar or cervical region, but not both regions on the same date of service.
- If a limit is not specified in the customer health plan, a maximum of three (3) epidural sessions (regardless of level, location, or side) in a year will be considered medically necessary when criteria (indications for coverage) are met for each injection.
- Added: The requirement for physical therapy or chiropractic manipulation may be waived if the customer received relief for at least three months from a prior epidural injection that was given within the past 12 months at the same level for the same specific condition.
- Added: When the injection is requested/performed for spinal stenosis or neurogenic claudication, the MRI or CT findings must confirm severe central spinal stenosis at the targeted level.

Added to Limitations of Coverage:

- More than two transforaminal epidural steroid injections (TFESI) or selective nerve root blocks (single TFESI bilaterally at a single level, or TFESIs at two unilateral levels) in one session, on the same date of service.
- Performing interlaminar epidural steroid injection at two levels in one session, on the same date of service.
- Performing an interlaminar or caudal epidural steroid injection in the same session, on the same date of service as a transforaminal epidural steroid injection.
- Performing a session involving both the lumbar and cervical region on the same date of service.

Back and Nerve Pain Procedures—Radiofrequency Ablation, Facet, and Other Injections

Prior authorization is required.

Indications of Coverage:

- Change in allowed total maximums:
 - A maximum limit of two (2) diagnostic facet or medial branch block sessions in the cervical spine region and a maximum limit of two (2) diagnostic facet or medial branch block sessions in the lumbar spine region may be allowed per year. If the left and right injections are performed on two separate dates of service, this will count as two (2) sessions.
 - If the criteria for neuroablation are met, a maximum of one (1) neuroablation session/date of service for each covered spinal region may be approved per six (6) months. (Maximum of one cervical neuroablation session per six months and maximum of one lumbar neuroablation session per six months). If left and right neuroablations are performed on two separate (sequential) dates of service, this will count as two (2) sessions and only one (1) of the two will be considered medically necessary.
- Inclusion of radicular symptoms allowed, if the provider documents the coexistence of both radicular and axial symptoms.



- Added to indications for Repeat Neuroablation:
 - The initial/prior neuroablation was performed within 18 months of the planned repeat neuroablation.
 - The requirement for physical therapy/chiropractic manipulation may be waived before repeat neuroablation if the customer has had successful neuroablation within the past 18 months at the same level and side, for the same condition, with relief of at least six (6) months.

Added to **Limitations of Coverage:**

- Added as considered not medically necessary:
 - Performing a session involving both the lumbar and cervical regions, on the same date of service.
 - Neuroablations that meet criteria after appropriate blocks are considered not medically necessary if performed on more than one date of service (e.g., one date of service for the right side and one date of service for the left side).
- Added: Destruction or neurolysis of the medial branch nerve, or any other nerve, by any method other than thermal neuroablation (e.g., chemical, thermal, cryotherapy, or electrical) is typically considered experimental, investigational, and unproven to affect health outcomes and requires review by the Health Plan's Medical Director for rare instances of medical necessity.
- Added as considered experimental, investigational, and unproven to affect health outcomes:
 - Ablation, cryotherapy, or treatment intended to cause nerve dysfunction (e.g., iovera, Coolief).
 - The following nerve blocks including, but not limited to, sphenopalantine ganglion block/injection for treatment of pain/headache, genicular nerve block/injection for knee pain, peripheral nerve block for knee pain, and cluneal nerve block/injection for treatment of low back pain.
 - Injection or neuroablation of lumbar or sacral facets or medial/lateral nerve branches or dorsal rami for treating sacroiliac joint pain.

Reminders:

- Facet joint injections or medial branch block injections are for *diagnostic purpose in preparation for neuroablation*. Using these for therapeutic purpose is considered experimental, investigational, and unproven to affect health outcomes.
- Neuroablation (facet neurotomy), facet injection, and medial branch block (MBB) of the thoracic spine is considered experimental, investigational, and unproven to affect health outcomes.
- A facet joint arthrogram in conjunction with a facet joint injection is included in the fluoroscopic guidance for the injection, is considered an integral component of the procedure, and is not reimbursed separately.

Back Pain: Sacroiliac and Coccydynia Treatments

Prior authorization is required.

Indication of Coverage:

- Change in maximum allowed from two to four sacroiliac injections in a year (if a limit is not specified in the customer health plan) when criteria are met for each injection. Note that bilateral injections count as two injections.
- Added: If the symptoms are severe (requiring urgent medical care), the trial of conservative treatments may not be required.
- Change in repeat coccyx injection indications: Amount of time of symptom relief required from initial coccyx injection decreased from two weeks to one week.



Hyperbaric Oxygen Therapy

Prior authorization is required.

Limitations of Coverage:

- Added to the list of conditions for which hyperbaric oxygen therapy is considered investigational:
 - Cancer of head, neck, or uterine cervix
 - Chronic Fatigue Syndrome
 - Coronary Artery Disease
 - Femoral Head Necrosis
 - Medication-related Osteonecrosis of Jaw

Infertility and Recurrent Pregnancy Loss Testing and Treatment

Prior authorization is required.

Indications of Coverage:

- Added: For CTFR Gene Mutation Carrier genetic testing for cystic fibrosis (if testing to determine the cause of infertility is a benefit of the customer's plan), the individual must meet the clinical indications/criteria in MCG Guideline, Cystic Fibrosis-CFTR Gene and Mutation Panel ACG: A-0597 (AC).

Limitations of Coverage:

- Added as considered experimental, investigational, and unproven to affect health/pregnancy outcomes:
 - Microarray testing of products of conception
 - Treatment with TruClear 5C Hysteroscope for uterine abnormalities
- Screening for thyroid antibodies from the list of tests/treatments for recurrent pregnancy loss is no longer considered experimental, investigational, and unproven.

Reminder: Refer to the customer health plan for definitions, exclusions, benefits, and prior authorization requirements for the diagnosis and treatment of infertility and/or recurrent pregnancy loss including determining the cause (etiology) of the condition, treatment of the presumed cause of the condition, limits to the number of courses of treatment (such as courses of in-vitro fertilization), treatment related to voluntary sterilization or failed reversal of voluntary sterilization, and whether complications related to a non-covered service are a benefit.

Reduction Mammoplasty for Symptomatic Macromastia

Prior authorization is required if not an exclusion of the individual's health plan.

Title of policy:

- Changed to: Reduction Mammoplasty (Breast Reduction Surgery) for Symptomatic Macromastia

Indications of Coverage:

- Added to criteria related to chronic intertriginous dermatitis: The medical record must document which dermatologic treatments have been trialed/applied, the length of time of the trials, and the success or failure of each, as well as photographs of the condition.
- Added: If individual is 40 years old or older, there must be documentation of a mammogram negative for cancer performed within two years of the planned reduction mammoplasty surgical date.

Limitations of Coverage:

- Added as considered not medically necessary:
 - Repeat reduction mammoplasty for macromastia
 - Mastopexy (unless performed as a component of breast reconstruction following mastectomy for breast cancer)

Reminder: Reduction mammoplasty (except when performed as a component of breast reconstruction following mastectomy for breast cancer) may be listed as an exclusion (not a covered benefit) in some plans/policies. When the procedure is a covered benefit of the plan, it requires prior authorization medical necessity review.

Total Ankle Arthroplasty

Prior authorization is required.

Title of policy:

- Changed to: Ankle Arthroplasty, Total (Total Ankle Replacement)

Indications of Coverage:

- Decreased the physical therapy trial requirement from six months to eight weeks.

Documentation Required section:

- Documentation of nicotine status no longer required.
- Documentation of prior ankle injuries and surgeries is required.

Treatment of Gender Dysphoria

Prior authorization is required.

Title of policy:

- Changed to: Gender Dysphoria Treatment

Indications of Coverage:

- Breast reduction was removed from list of surgical procedures that may be considered medically necessary as well as from procedure(s) that may be done as “stand-alone” procedure, without having genital reconstruction procedures or completion of hormone therapy prior to procedure.

Limitations of Coverage:

- Added to the list of procedures considered cosmetic or exclusions when performed as part of gender reassignment:
 - Bicep implantation
 - Body sculpting, Ultherapy, CoolSculpting
 - Body lift procedures
 - Brachioplasty (arm lift)
 - Buttocks augmentation or buttocks enhancement procedures
 - Collagen injections
 - Neck tightening
 - Nipple/areola reconstruction
 - Otoplasty (ear shaping surgery)
 - Removal of redundant skin
 - Thighplasty (thigh lift)

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:

- Amniure ROM Test for detection of fetal membrane rupture
- Billing for 3D interpretation and reporting of imaging studies
- Added to Cartilage and Osteochondral Treatments:
 - Added to Indications: Bony Defects
 - Autologous Chondrocyte Implantation (ACI) to joints other than the knee
 - Cartiform
 - Matrix-induced Autologous Chondrocyte Implantation (MACI) to joints other than the knee
 - Meniscal Transplant
 - Subchondroplasty
- Cellular Bone Matrix Products and Bone Graft Substitutes (such as, but not limited to):
 - i-Factor Bone Graft
 - Optimesh Graft Containment
 - Osteocel
 - Osteocel Plus
 - OsteoVive
 - ViviGen
- Deep Brain Stimulation for treatment of obsessive compulsive disorder
- Enterocutaneous Fistula (ECF) Plug
- Laser Interstitial Thermotherapy for treatment of breast cancer
- Monochromatic Infrared Energy (MIRE) for treatment of wounds or peripheral neuropathy
- Added to the Nerve Ablation for Chronic Pain section:
 - Lateral branch ablation for SI joint dysfunction
- Percutaneous Endoscopic Lumbar Discectomy (PELD) for Recurrent Lumbar Disc Herniation
- Percutaneous Laser Disc Decompression for Lumbar Disc Herniation (PLDD)
- Relizorb
- Added to Skin Substitute and Wound Products Not Covered section:
 - BioDFence
 - DermACELL Human Acellular Matrix
 - Grafix Cryopreserved Placental Membrane
- Sphenopalatine Ganglion Block (SPG) for headache treatment (also known as Pterygopalatine Ganglion, Nasal Ganglion, Meckel's Ganglion, and Sluter's Ganglion)
- Stem Cell Therapy/Injection for osteoarthritis of knee, joint pain, Alzheimer's Disease, or avascular necrosis of the hip
- Stem Cell Transplantation for Crohn's Disease, Sickle Cell Disease, or Lyme Disease

- Superficial Radiation Therapy for treatment of non-melanoma skin cancer
- Superior Interspinous Spacer System
- Transcutaneous Vagus Nerve Stimulator: gammaCore
- Added to the genetic services section:
 - APOE (Apolipoprotein E) Genetic Testing for Alzheimer's Disease
 - Cxbladder Detect
 - GI Microbial Assay Plus (GI MAP)
 - Oncotype DX Colon Recurrence Score Test
 - Plasminogen Activator Inhibitor-1 (PAI-1) 4G/5G
 - Prostaglandin Assay for Management of Multiple Sclerosis
 - Retinal Dystrophy Gene Panel

Removed from non-coverage:

- Panniculectomy for Symptomatic Panniculi: Panniculectomy may be listed as an exclusion (not a covered benefit) in some plans/policies. When the procedure is a covered benefit of the plan, it requires prior authorization medical necessity review.

Retired Medical Policies:

- Selective Internal Radiation Therapy (SIRT) for liver tumors (SIR Spheres, TheraSpheres, Radioembolization with Yttrium-90 microspheres, Transarterial Radioembolization, TARE)
- Stereotactic Radiotherapy-SRT [Stereotactic Radiosurgery (SRS), Stereotactic Body Radiation Therapy (SBRT), CyberKnife, Gamma Knife, Peacock, Trilogy, X-Knife, LINAC (linear accelerator), Novalis ExacTrac Robotic system]

Note: Oncologic indications for chemotherapy and radiation therapy continue to require prior authorization and are reviewed by ARC. Non-oncologic indications for SRT continue to require prior authorization and will be reviewed using MCG Guidelines.

Reminder: Genetic testing/services require prior authorization. Documentation from the physician (not just the servicing lab) should be included with the prior authorization request. It should describe how and why, based on the results of the genetic testing, the individual's treatment plan would be different from the current or expected treatment plan based on a clinical assessment without genetic testing. Genetic testing we consider experimental/investigational/unproven will not be covered.

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.

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