Arise Medical Policy Updates

The Medical Affairs Medical Policy Committee recently approved medical policies that will become effective Oct. 1, 2019, 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 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

Ankle Arthroplasty, Total (Total Ankle Replacement)

Prior authorization is required.

- Decreased six-month trial of NSAID or other pain medication to six-week trial
- Changed weight indication from less than 250 pounds to body mass index of less than 30

Indications of Coverage:

- Removed requirement for eight-week trial of physical therapy
- Removed requirement for six-month trial of bracing

Removed from **Limitations of Coverage**:

- Peripheral neuropathy

Back Pain: Sacroiliac and Coccydynia Treatments

Prior authorization is required.

- Changed required time between initial injection and repeat injection from one week to four weeks

Added to **Limitations of Coverage**:

- Peripheral nerve field stimulation for treatment of coccydynia
- Ganglion impar block or radiofrequency thermocoagulation for treatment of chronic coccydynia

Arise HEALTH PLAN

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

Prior authorization is required.

Indications of Coverage:

- Changed severe central spinal stenosis to moderate to severe spinal stenosis
- Removed documentation of the individual's current functional status compared to the pre-injection report
- Changed limit to three sessions per covered spinal region (cervical or lumbar) in a year

Added to **Limitations of Coverage**:

- Use of amniotic fluid
- Dorsal Root Ganglion (DRG) blocks

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

Prior authorization is required.

Indications of Coverage:

- Added section to policy addressing trigger point injections: these do not require prior authorization; however, indications and limitations were added to the policy
- Removed from Documentation Required section: documentation of functional status pre- and post-injection
- Removed from criteria for confirmatory injection: documentation of the individual's response after the first injection, including onset and duration of analgesia, and report of the individual's changes in functional status
- Added that facet injections and medial branch blocks require fluoroscopic or CT guidance
- Removed language regarding the onsets and durations of anesthetics

Removed from **Limitations of Coverage**:

- Neuroablations that meet criteria after appropriate blocks are considered not medically necessary if performed on more than one date of service

Added to **Limitations of Coverage**:

- Pars interarticularis injections
- Neuroablation (facet neurotomy) and facet injection/medial branch block (MBB) of the sacral spine (except L5-S1 medial branch block)
- Ultrasound guidance for trigger point injections
- Occipital and dorsal root ganglion added to list of nerve blocks and neuroablations considered experimental, investigational, and unproven
- Ganglion impar block or radiofrequency thermocoagulation for the treatment of chronic coccydynia
- Intraosseous radiofrequency ablation of the basivertebral nerve (e.g., The Intracept Procedure/ Intracept Intraocceous Nerve Ablation System®)
- Occipital Neurectomy/Nerve Decompression (supra orbital, supratrochlear, zygomaticotemporalor greater occipital nerve) for treatment of headache or occipital neuralgia
- Dry needling of trigger points
- Monitored Anesthesia Care (MAC) for adults for trigger point injections, medical branch blocks, and facet joint injections
- Regenerative procedures

Biofeedback Treatments and Devices

Prior authorization is required.

Added to **Limitations of Coverage**:

- The Eclipse System™ for fecal incontinence

Gender Dysphoria Treatment

Prior authorization is required.

Added to **Limitations of Coverage**:

- Chemical peels, dermabrasion, torso masculinization or feminization, and cricothyroid approximation

Infertility and Recurrent Pregnancy Loss Treatment

Prior authorization is required.

Removed from **Limitations of Coverage**:

- TruClear hysteroscope

Reduction Mammoplasty (Breast Reduction Surgery) for Symptomatic Macromastia

Prior authorization is required; often an exclusion of customer health plans—verify benefits.

- Indication changed from symptoms for one year to symptoms that have not improved with conservative treatment
- Removed requirement for specialty evaluations
- Decreased conservative treatment trial from three months to six weeks and removed home exercise from conservative treatment

Added to **Limitations of Coverage**:

- Liposuction-only reduction mammoplasty

New Medical Policies

Prior authorization is required.

- Capsule Endoscopy
- Fecal Microbiota Transplant (FMT)
- Home Health Services
- Panniculectomy, Abdominoplasty, and Repair of Diastasis Recti
- Spinal Cord Stimulators
- Tumor Testing Fields (Alternating Electric Field Therapy)
- Bone Growth Stimulators
- Deep Brain Stimulation and Responsive Cortical Stimulation
- Meniscal Allograft Transplantation
- Pneumatic Compression Devices

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:

- Intraosseous Radiofrequency Ablation of the Basivertebral Nerve (e.g., The Intracept Procedure/ Intracept Intraocceous Nerve Ablation System®) for back pain
- TransPyloric Shuttle™ (TPS) Intragastric Device for weight loss/obesity
- Genome-Wide Association Studies (GWAS)
- 3D Bioprinted Skin Substitutes for Treatment of Burns
- Diagnostic Injections of the dorsal root ganglion
- Pulsed Radiofrequency (PRF) Application to the dorsal root ganglion for neck/back pain
- Dorasal Root Ganglion Diagnostic or Therapeutic Injections/Nerve Blocks for neck/back pain
- Colon Capsule Endoscopy, Large Intestine Capsule Endoscopy (such as, but not limited to, Pillcam Colon® or Colon2®)
- Cryanoacrylate-based adhesive (Venaseal) for varicose veins
- Dorsal Root Ganglion or Dorsal Ramus Stimulation for Complex Regional Pain Syndrome
- Dorsal Root Ganglion (DRG) Radiofrequency Ablation (RFA) for back pain
- Sinuva bioaborbable steroid-releasing sinus implant
- Fractional Laser Treatment for burn treatment and traumatic scars
- Ganglion Impar Block for chronic coccydynia
- Ganglion Impar Radiofrequency Thermocoagulation for chronic coccydynia
- Gastric Motility Capsule/Wireless Gastric Motility Capsule (such as, but not limited to, SmartPill®)
- Gastrointestinal Patency Capsule (such as, but not limited to, Agile®)
- Liposuction-only Reduction Mammoplasty; NOTE: This does not apply to breast reconstruction following a mastectomy for breast cancer
- NeuroAD Therapy System for Alzheimer's disease
- Neuromodulation for migraine
- Occipital Nerve Stimulation for chronic cluster headache, chronic migraine, fibromyalgia, occipital neuralgia
- Sphenopalatine Ganglion Stimulation for headache
- Vertebral Body Tethering for adolescent idiopathic scoliosis
- 4Kscore Test for prostate cancer
- CANCERPLEX
- Aerobika Oscillating Positive Expiratory Pressure (OPEP) Therapy System for chronic obstructive pulmonary disease (COPD)
- Embrace2 Wearable Biosensor for detection of seizures/epilepsy
- Nerivio Migra for migraine
- Percutaneous Tibial Nerve Stimulation for neurogenic lower urinary tract dysfunction
- Prolaris Biopsy Test and Prolaris Post-Prostatectomy were added to the already existing Prolaris section for clarification
- Directional Deep Brain Stimulation
- Motor Cortex Stimulation
- Temporal Interference
- Meniscal Prosthesis, Polyurethane Meniscal Implant, Collagen Meniscal Implant, Tissue-Engineered Meniscal Implant, Meniscal Scaffold Technology/System

Removed

- Mechanical Stretching Devices for Prevention and Treatment of Joint Contractures
- RosettaGX Reveal
- ThyraMIR
- ThyGenX

Updates

- Deep Brain Stimulation: Indications not covered updated from Obsessive Compulsive Disorder to: Major Depressive Disorder, Neuropathic Pain, Eating Disorders, Impulse Control Disorders, Choreiform Disorders, Seizure Disorders, Tic Disorders, Tourette Syndrome, Multiple Sclerosis, and Bipolar Disorder
- Indications for Pneumatic Compression Devices updated to state: Please see medical policy, Pneumatic Compression Devices for covered indications/criteria and limitations of coverage

Medical Policies Scheduled for Review in 2019, Effective Jan. 1, 2020

Subject to change.

- **July**
  - Gastrointestinal (GI) Pathogen Testing Using Multiplex Polymerase Chain Reaction (mPCR)
  - Glaucoma Surgical Treatments (Micro-bypass Stents, Filtration Devices, and Shunts)
  - Wearable Cardiac Defibrillator (WCD, Wearable Cardioverter Defibrillator, Life Vest), Implantable Cardiac Defibrillator (ICD)
  - Non-covered Services and Procedures
- **August**
  - Sleep Disorder Testing: Polysomnogram, Split Night Polysomnogram, Sleep Study, Multiple Sleep Latency Test (MSLT), Maintenance of Wakefulness Testing (MWT), Home Sleep Apnea Test (HSAT), Home Sleep Study Testing (HST), Actigraphy, Pulse Oximetry, Apnea Link™ devices
  - Sleep Disorder Treatment: Positive Airway Pressure Devices and Oral Appliances (CPAP, BPAP, BiPAP®, BiPAP® ST, BiPAP® with backup, BiPAP®-Auto SV, VPAP, VPAP™ Adapt, VPAP™ adapt SV, APAP, Adaptive Servo-Ventilation (ASV), oral device, mandibular advancement device
  - Microprocessor-Controlled and Myoelectric Limb Prosthesis (including, but not limited to, Intelligent Prosthesis (Blatchford, U.K.), the Adaptive (Endolite, England), the Rheo (Ossur, Iceland), the C-Leg and Genium Prosthetic Systems (Otto Bock Orthopedic Industry, Minneapolis, Minn.), and Seattle Power Knees (models include Single Axis, 4-bar, and Fusion, from Seattle Systems), PowerFoot BiOM, iWalk, Bedford, Mass.; Proprio Foot, (Ossur, Aliso Viejo, Calif.), Power Knee (Ossur, Foothill Ranch, Calif.), MotoKnee, Electric and Body Powered Fingers)
- **September**
  - Hip Replacement Surgery (Total Hip Arthroplasty, Hemiarthroplasty, Hip Resurfacing Arthroplasty, Revision or Replacement of Total Hip Arthroplasty)
  - Knee Replacement Surgery (Total Knee Arthroplasty, Patellofemoral Arthroplasty, Bicompartmental Knee Arthroplasty, and Unicompartmental Knee Arthroplasty)
  - PET Scan (Positron Emission Tomography); *for groups not using NIA*
  - Magnetic Resonance Angiography (MRA) and Magnetic Resonance Venography (MRV); *for groups not using NIA*
  - Magnetic Resonance Spectroscopy (MRS), Nuclear Magnetic Resonance Spectroscopy (NMRS); *for groups not using NIA*

Reminder: All genetic testing requires prior authorization

The complete library of our medical policies and the quarterly Medical Policy Update reports can be found online at Arise Coverage Policy Bulletins.
No password required!