Arise Medical Policy Updates

The Medical Affairs Medical Policy Committee recently approved medical policies that will become effective Sept. 1, 2020, 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. 77137.
- For questions regarding medical coding related to Medical Policy Committee policies, contact the Code Governance Committee at codegovernance@wpsic.com.

Medical Policy Highlights

Back Pain Procedures—Epidural Injections

Prior authorization is required.

Indications of Coverage:

Clarified: Diagnostic Injection—A single epidural injection is considered medically necessary for diagnostic purpose to direct further care (e.g. prior to spinal surgery, including surgery to remove hardware) when ALL of the following conditions are met:

Note: This will count toward the limit of sessions (see Injection Limits below)

1. The individual has been evaluated by a surgeon who has recommended possible surgery.
2. All criteria for the specific surgical procedure that is recommended are met.
3. There is a discrepancy between clinical findings and diagnostic studies. For example: chronic symptoms in an extremity are described, but the imaging reports do not confirm the presence of nerve root impingement, compression, entrapment, displacement, or irritation that is consistent with the individual's physical symptoms.
4. The injection will be performed at the level that is suspected to be the cause of the symptoms or to identify the level of pathology at the site of previous surgery.

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Changed Injection Limits from three epidural sessions to three injection sessions because either epidural or dorsal ganglion root could be involved.

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

Prior authorization is required.

Removed from **Limitations of Coverage:**

- The need for documentation of the individual's ability to perform previously painful maneuvers following the initial/first facet joint injection/medial branch block
- The confirmatory (second) diagnostic injection procedure must be performed at the same side and same level as the initial injection using an anesthetic with a different duration of action

Back Pain: Sacroiliac and Coccydynia Treatments

Prior authorization is required.

Removed from **Limitations of Coverage:**

- Sacroiliac joint injections provided without the use of fluoroscopic or computed tomography (CT) guidance are not current standard medical practice and will be denied as not medically necessary

Hyperbaric Oxygen Therapy

Prior authorization is required for nonemergent indications.

Added to **Limitations of Coverage:**

- Limb-encasing hyperbaric oxygen devices
- Use of low-pressure fabric hyperbaric chambers for any diagnosis or condition other than acute altitude (mountain) sickness

Sleep Disorder Testing

Prior authorization is required.

Allow use of Type IV portable monitoring devices for home sleep apnea testing.

Note: Devices must measure airflow and at least two other channels and provide apnea-hypopnea index (AHI); or measure at least three channels including pulse oximetry, actigraphy, and peripheral arterial tone.

Sleep Disorder Treatment

Prior authorization is required.

Added to **Limitations of Coverage:**

- NightBalance, Lunoa System

Arise™ HEALTH PLAN

Moved **Limitation of Coverage** regarding CPAP cleaning devices and supplies (e.g. SoCleane2® CPAP Cleaner and Sanitizing Machine) from Experimental, Investigational, or Unproven to considered convenience items. Most member plans have a general exclusion for convenience items. In the absence of plan language, these are considered not medically necessary.

Telehealth, Telemedicine (COVID-19 Temporary Medical Policy)

Please see our website for the most up-to-date information.

Noncovered Services and Procedures

Additions:

- MitoSwab®
- Cunningham Panel

Removed:

- Amniotic Fluid Epidural Injection
- Antigen Leukocyte Cellular Antibody (ALCAT) automated food intolerance test
- Antineoplaston Cancer Therapy
- Autogenous Urine Therapy, Antineoplaston Therapy
- Balloon Dilatation of the Eustachian Tube (ET)
- Bovine Collagen Implants
- Cellular Bone Matrix Products and Bone Graft Substitutes
- Central Auditory Processing Disorder (CAPD) diagnostic testing and/or treatment
- Cold Laser, Low Level Laser
- Conjunctival Challenge Testing (also known as conjunctival allergen provocation testing)
- Coronary Calcium Screening CT
- Craniosacral Therapy
- CUSTOMFLEX Artificial Iris
- Deep Brain Stimulation
- Directional Deep Brain Stimulation
- Eclipse System® (vaginal insert for fecal incontinence)
- Enterocutaneous Fistula (ECF) Plug
- Exhaled Nitric Oxide (FeNO)
- Freespira Breathing System (Palo Alto Health Sciences Inc) for treatment of Panic Disorder
- Hair Analysis
- i-Factor® Bone Graft
- inFlow Urinary Prosthesis
- Intracranial and Vertebral Artery Angioplasty and Stenting for atherosclerotic vertebral artery or intracranial artery stenosis

- Knotless TightRope Syndesmosis Implant System for Syndesmotic Injury
- LipiFlow® interferometry; LipiView® II thermal pulsation treatment for Meibomian gland dysfunction
- LipiScan Dynamic Meibomian Imager
- Magnetic Resonance Elastography (MRE) liver elastography
- Magnetic Resonance Guided Focused Ultrasound Therapy (MRgFUS); (ExAblate®; and others) for palliation of bone metastases
- Medial Femoral Articular Autograft for Lunate Reconstruction
- Metabolic testing of resting energy expenditure combined with respiratory quotient
- Microwave Ablation (Also known as Microwave Thermotherapy or Microwave Therapy)
- Monochromatic Infrared Energy (MIRE)
- Percutaneous Endoscopic Lumbar Discectomy (PELD) for Primary or Recurrent Lumbar Disc Herniation
- Percutaneous Pulmonary Valve Implantation (transcatheter or catheter-based pulmonary valve implantation or replacement) using the Melody valve system or the Edwards Sapien valve system
- Percutaneous Tibial Nerve Stimulation (PTNS)
- Salivary Hormones
- Sidus® Stem-Free Shoulder System
- Sonography-Guided Transcervical Fibroid Ablation System (Sonata®)
- Sublingual Antigen and Sublingual Immunotherapy Treatments (except FDA approved drugs)
- Synthetic Resorbable Polymers / Synthetic Grafts (including, but not limited to: TruFit®, TruGraft®, PolyGraft® PGS)
- Temporal Interference
- Urine Auto injection
- Vagus Nerve Stimulation (VNS)

Reminder

All genetic, genomic, pharmacogenetic, pharmacogenomic, molecular genetic, mRNA, DNA, chromosome, telomere, single nucleotide polymorphism (SNP), gene sequencing, gene expression profiles, and gene-related panels, tests, and analyses require prior authorization BEFORE the testing is completed.

Determination of genetic panel coverage is based on assessment of the test's analytical and clinical validity, the clinical utility of the test, and evidence demonstrating a positive impact of the test panel on the care of individuals with, or at risk for, the conditions being tested. The Medical Policy Committee (MPC) considers multi-gene test panels experimental, investigational, and unproven to affect health outcomes unless otherwise determined during prior authorization review.

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!