

WPS Medical Policy Updates

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To obtain a referenced MCG guideline specific to your patient's review, contact Medical Affairs toll-free: 1-800-333-5003. For general medical policy or MCG requests, email medical.policies@wpsic.com.

Medical Policy Highlights

Medical Policies Effective 10/1/2016

Back Pain Procedures—Radiofrequency Ablation, Facet and other Injections

This **new policy** combines the previous Radiofrequency Ablation, Facet Joint injection, and Sacroiliac Joint Treatments and Coccydynia policies into one convenient document. Please see the medical policy for full details.

- Prior authorization is needed.
- Neuroablation of cervical or lumbar spine regions for chronic pain without radicular symptoms: conservative treatment changed to six weeks (in the last six months) of conservative treatment and requires two (2) positive comparative diagnostic blocks. Each block requires prior authorization.
- Due to the high rate of placebo effect and confounding variables, such as addition of steroid to the injection, a confirmatory injection of a positive block, using an anesthetic with a different duration of action than the initial diagnostic block, is required. Documentation of the patient response after each diagnostic injection must include onset AND duration of analgesia, degree of pain relief, and report of patient's changes in functional status. If there is no documentation of the anesthetic used and the onset and duration of analgesia, the injection will be considered therapeutic.
- The initial diagnostic block must provide 50% relief from baseline scores, appropriate duration of analgesia, and improvement in functional status to be considered positive.

Documentation of functional status includes:

- Work status/work restrictions
- Specific Activities of Daily Living (ADL)
- Current pain medication use
- Measurable physical status indicators (e.g., range of motion, muscle strength)

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- More than two spinal ablation or diagnostic facet levels in one session is considered not medically necessary. If all of the above are met, a maximum of two levels will be approved for ablation per six months. Bilateral ablations will count as one level only if performed on the same date of service. Sequential dates of service to complete ablations at the contralateral level rather than bilateral ablation (same date of service) are considered not medically necessary. Fluoroscopic guidance is required during medial branch neuroablation.
- Neuroablation done at the same level on the same side can be repeated when symptoms recur after six months, if there is documentation of at least a 50% reduction in pain sustained over at least six months following the ablation.
- More than four diagnostic facet or Medial Branch Block injections, regardless of location/level, in a 12-month period are considered not medically necessary.
- Therapeutic Facet injections continue to be considered Experimental/Investigational/Unproven to affect health outcomes.
- SI joint injections and or ablations for SI joint pain/dysfunction are now considered Experimental/Investigational/Unproven to affect health outcomes due to the paucity of consistent evidence.

Back Pain Procedures—Epidural Injections (ESIs)—New Title

- Prior authorization is needed.
- Each injection must be prior authorized. A series of injections will not be approved. Evidence of 50% reduction in pain, documentation of the results of post-injection attempts at PT, chiropractic, or home exercise program, and documentation of changes in pre- and post-procedure functional status is required for additional injections to be authorized. The six-week minimum time frame between injections remains unchanged.
 - Documentation of functional status includes:
 - Work status/work restrictions
 - Specific Activities of Daily Living (ADL)
 - Current pain medication use
 - Measurable physical status indicators (e.g., range of motion, muscle strength)
- Indications for ESI include therapeutic lumbar injection for radicular pain and diagnostic lumbosacral hardware injection for potential removal of hardware.
- Cervical ESI, Thoracic ESI, SI joint injections and ablations (for SI joint pain, dysfunction, or insufficiency) are considered experimental, investigational and unproven to affect health outcomes due to the paucity of consistent evidence.

Total Ankle Arthroplasty

- Prior authorization is needed.
- The prosthetic device must be FDA-approved. It is the responsibility of the surgeon to choose the FDA-approved device.

- Added :
Documentation required that the patient is a non-nicotine user, or has ceased nicotine use for at least six weeks prior to surgery.
Visco supplementation injections are considered experimental, investigational, and unproven to affect health outcomes, and are not FDA approved for this use.
Preoperative imaging studies CT/MRI with customized prosthetic ankle replacement are considered experimental, investigational and unproven to affect health outcomes.

Hyperbaric Oxygen Therapy

- Prior authorization is needed.
- Added indications for central retinal artery occlusion, crush injury or compartment syndrome, and intracranial abscess under specified conditions.

Infertility Testing and Treatment

Refer to the member's health plan for definitions, exclusions, benefits, and prior authorization requirements for the diagnosis and treatment of infertility including: determining the cause (etiology) of the infertility, treatment of the presumed cause of infertility, limits to the number of courses of treatment (such as courses of in-vitro fertilization).

- Pre-conception Cystic Fibrosis genetic testing is considered medically necessary, regardless of infertility benefit (provided there is a benefit for genetic testing).
- Added genetic testing information. Genetic testing requires prior authorization. Verify coverage with the member's health plan.
- Pre-implantation genetic testing requires Medical Director review.
- Cryopreservation is typically not a covered benefit under the member health plan.

Non-Covered Services and Procedures highlights

Note: Non-Covered Services typically are not prior authorized. However, a prior authorization submission will be reviewed if coverage clarification is requested.

Additions:

- Genetic counseling when performed by the Genetic Lab is typically an exclusion of the member health plan
- Posterior vertebral joint arthroplasty (facet joint replacement)
- Genecept Assay—pharmacogenetic test for behavioral health conditions
- Portable multichamber segmented programmable pneumatic compression device

Deletions:

- Cologuard® multitarget stool DNA test was removed from the non-covered list

Continued Non-Coverage:

- Assays for diagnosis and management of Inflammatory Bowel Disease, Crohn's Disease, and Ulcerative Colitis
- ZioPatch for long-term cardiac rhythm monitoring
- GERD endoscopic treatments; Note: Endophyx, Enteryx, and Gatekeeper devices have been removed from the market

Reminder Regarding Genetic Testing: Prior authorization is required for genetic testing. To expedite authorization, please provide documentation *directly from the ordering provider*.