

WPS Medical Policy Updates: December 2016

The Medical Affairs Medical Policy Committee approved fourth quarter medical policies and providers were notified of changes to those policies in December. The policies were posted Jan. 1, 2017. Changes to medical policies that were considered enhancements to coverage became effective on Jan. 1, 2017. Changes that could be seen as limitations took effect March 1, 2017.

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 member 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, contact Medical Affairs toll-free at 800-333-5003. 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 by email at medical.policies@wpsic.com or call 800-333-5003 ext. 77196.

For questions regarding medical coding related to Medical Policies policies, please contact the Code Governance Committee at codegovernance@wpsic.com.

Medical Policy Highlights (effective Jan. 1, 2017)

New Omnibus Policy for Drugs Reviewed in Medical Affairs

This policy addresses review of certain drugs identified as needing review by clinicians to correctly interpret specific member health plan benefits, such as hormonal treatments, treatment of sexual dysfunction, or obesity. To view the list of drugs that require prior authorization, who performs the review, and how to contact them, see our WPS and Arise Health Plan Drug Prior Authorization List.

Intraoperative Neurophysiologic Monitoring (IONM)

Acoustic neuroma was added to the Indications of Coverage. The prior authorization process was clarified: prior authorization is required for spinal surgery. The surgeon performing the operative procedure must document in the prior authorization request for the primary surgical procedure the intent to involve IONM. Prior authorization requests received from the monitorist will be processed upon approval of the primary surgery.

Reduction Mammoplasty for Symptomatic Macromastia

No changes to criteria.

Sleep Disorder Testing

- The requirement for a Board Certified Sleep Medicine provider to order an in-lab sleep study was removed.
- Clear documentation of witnessed apnea alone or report of having fallen asleep while driving a motor vehicle now meet stand-alone criteria for a polysomnogram (PSG).

- The list of comorbidities that will allow an in-lab PSG was clarified.
- Definitions of acceptable devices for home study were clarified.
- Clarified that Epworth, Berlin, and STOP Bang scores alone are not acceptable as sole criteria for polysomnogram approval.
- Berlin Score criteria were removed from the policy (effective March 1, 2017).

Sleep Disorder Treatment (PAP Devices and Oral Appliances)

- Clarified that oral appliances must be ordered by a sleep medicine specialist in the context of a comprehensive sleep program, per the 2015 Update of the American Academy of Sleep Medicine and American Academy of Dental Sleep Medicine Clinical Practice Guideline.
- Reconfirmed for all PAP devices: A rental of three months may be approved. Documentation (device download) of a minimum of four hours of use per night for 70% of the nights of the trial must be submitted with a prior authorization request for purchase of the CPAP prior to the end of the three-month rental. Continued rental beyond three months will not be approved. Payment of rental charges beyond the purchase price of the device is a limitation of many of our member health plans and provider contracts.
- Added: Only one Oral Appliance or PAP device will be approved for use at the same time. Note: This is not covered under many member health plans.

Varicose Vein Treatments

Clarified language regarding multiple treatment sessions for sclerotherapy: Effective March 1, 2017, more than one sclerotherapy date of service for each approved leg from 12 months from the start of sclerotherapy therapy is considered not medically necessary.

Magnetic Resonance Spectroscopy

No changes to criteria.

Magnetic Resonance Angiography (MRA) and Magnetic Resonance Venography (MRV)

Expanded indications include:

Brain MRA:

- Symptoms of exertional headache for suspected ICA or AVM.
- Evaluation of previously diagnosed subarachnoid hemorrhage.
- Evaluation of new or fluctuating neurologic symptoms: Acute, new, or fluctuating neurologic symptoms or deficits such as sensory deficits, limb weakness, speech difficulties, lack of coordination, or mental status changes.
- Evaluation of stroke risk (e.g., consider transfusion therapy treatment) in sickle cell patients (2–16 years of age) with a transcranial Doppler velocity >200.

Combined Head and Neck MRA:

Evaluation of pulsatile tinnitus.

Non-Covered Services and Procedures Highlights

Non-Covered Services typically are not prior authorized. However, a request for prior authorization will be honored if clarification is requested.

Removed from Non-Covered Services:

- Endovascular Mechanical Thrombectomy. Second-generation devices, for treatment of acute ischemic stroke within 12 hours, are covered.
- BD Veritor influenza test is covered.

Additions:

- CardioMEMS wireless pulmonary artery pressure monitoring for chronic heart failure.
- Central Auditory Processing Disorder testing and treatment. This is typically an exclusion of members' health plans when used for learning/school issues.
- Proteomics testing for prostate cancer.
- Theralink family assay.
- Vectra Biomarker test for rheumatoid arthritis (RA) management.
- Breast Cancer Index (BCI) genetic prognostic test for breast cancer.
- Oncotype Dx Genomic Prostate Score (GPS) Assay.
- RosettaGX Reveal for evaluation of indeterminate thyroid nodule biopsy.
- Minimally Invasive Surgical (MIS) procedures for treatment of atrial fibrillation includes off bypass mini-maze, hybrid maze.

Confirmed continued non-coverage includes:

- 3-D Mammography (breast tomosynthesis).
- Brachytherapy, APBI, and Savi for breast cancer
- Collagen crosslinking for keratoconus
- FeNo (Exhaled Nitric Oxide) for both diagnosis and management of asthma

The complete library of our medical policies can be found at:

<https://www.wpsic.com/providers/medical-policies/index.shtml>

No password required!

The quarterly Medical Policy update reports are posted on our website.



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