

WPS Medical Policy Updates

Highlights from the March 11, 2016 Medical Policy Committee Meeting

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 WPS may not utilize WPS medical policy in all their coverage determinations. Contact Customer Service as listed on the member 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. WPS uses tools developed by third parties, such as the evidence-based clinical guidelines developed by MCG Health® to assist in administering health benefits. Medical Policies and MCG Health® 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: 1-800-333-5003. For general medical policy or MCG requests, email medical.policies@wpsic.com.

Medical Policy Highlights

Medical Policies Effective 7/1/2016:

- Acupuncture: This is often an exclusion of the member's health plan. Verify the member's specific coverage and benefit limits through Customer Service.
- Bariatric Surgery
 1. This is often an exclusion of the member's health plan. When there is a benefit, prior authorization is needed.
 2. For a member with COPD, surgery must be recommended in consultation with the member's treating pulmonologist.
 3. Remember to include psychological and dietitian evaluations along with the other office notes.
- Biofeedback:
 1. This is often an exclusion of the member's health plan or subject to specific limits. When there is a benefit, prior authorization is needed.
 2. Verify the member's specific coverage and benefit limits through customer service.
 3. Indications were expanded to include treatment of tension headache and migraine headache.
- Blepharoplasty, Blepharoptosis, Brow Lift and Related Procedures
 1. Prior authorization is needed.
 2. Indication criteria were added for canthopasty, lower lid blepharoplasty, and entropion/ectropion repair.
- Cranial Orthotic Device
 1. This is often an exclusion of the member's health plan unless associated with craniosynostosis surgery.
 2. Prior authorization is needed.
 3. When there is a benefit for a device not associated with craniosynostosis surgery, the diagonal difference (asymmetry) measurement needed to treat positional plagiocephaly has been increased to 10 mm.

- Neuropsychological Testing: Prior authorization is needed with the exception of the initial assessment to determine the need for and extent of neuropsychological testing.
- Occipital Nerve Block
 1. Prior authorization is needed.
 2. More than four injections in a 12-month period is considered not medically necessary. Bilateral injections are counted as two injections.
 3. Occipital nerve block using Botox (botulinum toxin) for cervicogenic headache and /or occipital neuralgia is considered Experimental, Investigational, and/or Unproven.
- Osteogenic Stimulator
 1. Prior authorization is needed.
 2. Nicotine use: Documentation must be provided that the member, is:
 - A non-nicotine user; OR
 - Has ceased nicotine use for six weeks prior to initiation of bone stimulator treatment (if the request is for nonunion or planned spinal fusion surgery); OR
 - Ceased nicotine use upon initial orthopedic treatment if request is for high-risk fresh fracture.
- Changes to PET Scan policy 3-11-16 with comparison to 2015 version
Please see our complete PET Scan Policy on our website; effective 7/1.
 - I. Additions:
 - A. Initial Treatment Strategy/Staging: PET is now considered medically necessary for the following malignancies:
 1. Adrenal cancer (WPS previously silent)
 2. Gallbladder and extrahepatic bile duct cancer (previously a limitation of coverage)
 3. Kidney (renal) cancer (previously a limitation of coverage)
 4. Liver (hepatocellular carcinoma) and intrahepatic bile duct cancer (WPS previously silent)
 5. Breast cancer: added option for 18F-NaF PET scan
 6. Skin cancer (except basal cell carcinoma) (previously a limitation of coverage)
 7. Paraneoplastic syndrome (WPS previously silent)
 8. Bladder (urinary), small intestine, uterine, and penile cancer (previously a limitation of coverage)
 - B. Subsequent Treatment Strategy/Restaging, PET is now considered medically necessary for:
 1. Prostate cancer, **one of the following**:
 - a) PET scan with 18F-FDG; or
 - b) PET scan with 18F-NaF when current bone scan is inconclusive; or
 - c) PET scan with Choline C-11.

Note: If a PET scan with either 18F-FDG, 18F-NaF, or Choline C-11 is indicated, performing **more than one** PET scan (using a different tracer for each scan) is considered not medically necessary.

2. Occult cancer/cancer of unknown primary origin: only if other imaging is inconclusive (WPS previously silent).
3. Breast cancer: added option for 18F NaF scan, provided bone scan/other imaging is inconclusive.

- II. Deletions
 - A. Initial Treatment Strategy/Staging (no deletions).
 - B. Subsequent Treatment Strategy/Restaging, with each of the following malignancies: 2015 policy considered PET medically necessary. For 2016, they are no longer considered medically necessary:
 1. Osteosarcoma/Ewing's tumor
 2. Endometrial cancer
 3. Gastric cancer
 4. Mesothelioma
 5. Thymic cancer

- III. Additional Criteria: Brain cancer with extracranial metastasis indication stipulates that other imaging must be inconclusive before PET is considered medically necessary (previously not required).

- Selective Internal Radiation Therapy (SIRT) for Liver Tumors
 1. Prior authorization is needed.
 2. Documentation of which standard therapies, such as surgical resection, systemic chemotherapy, TransArterial Chemoembolization (TACE), cryoablation, percutaneous ethanol injection, radio frequency ablation (RFA), have failed or why they are contraindicated or documented to be medically inferior alternatives to SIRT must be submitted.

- Artificial Disc/Disc Arthroplasty:
 1. Prior authorization is needed.
 2. Criteria are unchanged. Single-level cervical disc is indicated for cervical single-level degenerative disc disease after failure of three months of conservative treatment. Lumbar artificial disc is considered experimental investigational, and unproven to improve outcomes.
 3. MCG Health[®] 20th edition guidelines will replace the medical policy as the primary reference.

- Urine Drug and Alcohol screening
 1. Documentation of the reason testing is needed when quantitative/confirmatory testing is performed.

- Non-covered services Quarterly Updates:
 1. The specific services on this list are not covered so prior authorization is not needed.
 2. Percutaneous Vertebroplasty and Kyphoplasty were added. Published science evidence has failed to accumulate to continue coverage. The Percutaneous Vertebroplasty, Kyphoplasty, and Sacroplasty Policy was retired.
 3. Several new proprietary, renamed and revised genetic panels, gene expression profiles, and biomarker tests were added. Reminder: Prior authorization is needed for genetic tests that are potentially considered medically necessary. For instance, OncotypeDx Breast continues to be covered when medical necessity criteria are met. If there is confusion as to whether the test in question is on the NCS list, a request for prior authorization will be honored to clarify.
 4. Clarified: Brachytherapy is not covered for: anal, brain, breast, esophageal, hepatobiliary, lung, and rectal cancer, including Accelerated Partial Breast Irradiation (APBI)-and the SAVI device.
 5. Added as non-covered:
 - Transurethral waterjet ablation of prostate (e.g., Aquabean).
 - Collagen Crosslinking of cornea (CXL) procedure.
 - Drug eluting stents after endoscopic nasal/sinus surgery.
 - Percutaneous Pulmonary Valve Implantation (transcatheter or catheter-based pulmonary valve implantation or replacement) using the Melody valve system or the Edwards Sapien valve system.
 - Suction-Assisted Protein Lipectomy (SAPL) for treatment of severe lymphedema.
 - Two Stage Portable Pneumatic Compression Devices for treatment of lymphedema (e.g., Flexitouch[®] System).