WPS Medical Policy Updates: November 2016

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: 1-800-333-5003. For general medical policy or MCG requests, email medical.policies@wpsic.com.

Medical Policy Highlights

New Medical Policy: Glaucoma Surgical Treatments Became Effective 10/1/16

The I-stent was the first of several new surgical bypass micro-stents being developed to be FDA-approved. These micro-stents help treat glaucoma refractory to pharmacologic treatment and/or traditional trabeculectomy surgery. The I-stent is indicated for treatment of mild to moderate Open Angle Glaucoma in the context of cataract surgery.
Note: Any stent or shunt device used must be FDA-approved. It is the responsibility of the surgeon to choose an FDA-approved device.

Medical Policies Effective 1/1/2017

Microprocessor Controlled + Myoelectric Limb Prosthetics

For requests to upgrade to a more advanced model, documentation (medical, physical therapy (rehabilitation) and prosthetist records) of specific activities/difficulties with current prosthetic that can be addressed with the new prosthetic must be provided.

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

Pediatric indications were expanded in recognition of the risk of accumulated radiation exposure and risks of invasive technology with traditional CT Angiography (CTA) or catheter angiography. MRV and MRA indications are now grouped together by body location.

Magnetic Resonance Spectroscopy

Indications were expanded to include differentiating neoplasms from non-neoplastic cystic lesions in the brain.

Stereotactic Radiotherapy

Clarified medical necessity indications for treatment of epilepsy.

Non-Covered Services and Procedures Highlights

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

Additions:

- Hybrid Total (Artificial) Disc Replacement with ACDF surgery
  Note: All spinal surgery requires prior authorization. Some indications are available for artificial cervical disc when medical necessity criteria are met.
- Guardant360 multi-gene blood test to assess solid tumors
- TAADNext multi-gene panel
  Note: Some gene-specific tests for Familial Thoracic Aortic Aneurysm and Aortic Dissection (TAAD) are covered when medical necessity criteria are met. Prior authorization is required.

Continued non-coverage:

- 3-D mammography (breast tomosynthesis)
- Piriformis injection for treatment of piriformis syndrome-related pain
- Dry needling
  Note: This is also identified as experimental/investigational in the HSM Magellan therapy review guidelines.

Deleted:

- Knee walker (durable medical equipment)
  Note: Health Plan limitations and prior authorization requirements may apply. Contact member services (phone number on the back of the member ID card) to verify.

Clarification Regarding Back Pain Procedures—Radiofrequency Ablation, Facet Joint, and Other Injections Effective 10/1/16:
Diagnostic facet and medial branch block injections are considered medically necessary ***only in the context of preparation*** for treatment of spine pain using neuroablation, and only after conservative treatment and evaluation. Therapeutic facet, medial branch, and sacroiliac joint (SI joint) injections are considered experimental, investigational, and unproven to affect health outcomes in all other situations.