

# WPS Medical Policy Updates

The Medical Affairs Medical Policy Committee approved second quarter medical policies on Sept. 15, 2017, and providers were notified of changes to those policies in late October. The policies become effective Jan. 1, 2018, unless otherwise noted below.

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- 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](mailto: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](mailto:medical.policies@wpsic.com) or 800-333-5003 ext. 77196.
- For questions regarding medical coding related to Medical Policy Committee policies, contact the Code Governance Committee at [codegovernance@wpsic.com](mailto:codegovernance@wpsic.com).

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## Medical Policy Highlights

### **New Policy! Corneal Treatments and Specialty Contact Lenses**

This policy was developed to assist with medical necessity review of newer technologies and to assist with interpretation of health plan limitations for refractive versus therapeutic vision procedures and products.

*Prior authorization is required for therapeutic service and devices.*

- PRK (photorefractive keratectomy) and LASIK (laser-assisted in-situ keratomileusis) type procedures to correct refractive vision problems are *typically an exclusion of the health plan*.
- PTK (phototherapeutic keratectomy) for therapeutic treatment of corneal disease (e.g., dystrophies, scars, recurrent corneal erosions, keratoconus nodules) are considered medically necessary.
- INTACS (Intrastromal Corneal Ring Segments) devices are considered medical necessary only if corneal transplant (criteria available) is the only other alternative.
- Collagen Corneal Crosslinking is considered experimental, investigational, and unproven.

### **Glaucoma Surgical Treatments**

*Prior authorization is required.*

- The use of Avastin (bevacizumab) to prevent scarring during or after glaucoma surgery is considered experimental, investigational, and unproven.

## Microprocessor-Controlled and Myoelectric Limb Prosthesis

*Prior authorization is required.*

- Language regarding replacement was clarified.
- Replacement of a prosthesis is limited by the health plan to no sooner than every three years after purchase. Replacement or repair of a prosthesis or a prosthetic part is considered medically necessary when documentation indicates either a change in the physiologic condition or functional level of the member; or when repairs, and the cost of such repairs, would be more than the cost of a replacement device or of the part being replaced. The prosthetist should also provide warranty status information.
- The Kenevo prosthetic knee intended for the K2 ambulator is considered experimental, investigational, and unproven.

## Stereotactic Radio Therapy

*Prior authorization is required.*

1. Added an indication for treatment of Essential Tremor (ET) with all the following:
  - a. ET Refractory to  $\geq 1$  year of medical therapy.
  - b. Deep Brain Stimulation (DBS) is not an option because of **any** of the following:
    - i. Chronic infections
    - ii. Coagulopathy or anticoagulant use
    - iii. Advanced age (e.g., frail elderly)
    - iv. Inability to comply with required frequent follow up
    - v. Patient refusal
  - c. Disability of one or more limbs from resting, positional, or kinetic tremor affecting safety, functional status, or quality of life.
2. There were no changes in indications for SBRT (Stereotactic Body Radiotherapy).
3. Robotic guidance systems such as the ViewRay System are considered experimental, investigational, and unproven to affect outcomes. They may also be considered integral to the primary procedure.

## Non-Covered Services and Procedures

Non-Covered Services typically are not prior authorized.

### Added:

- Cluneal nerve block for low back pain
- Electromechanical morcellation (EMM) of uterine fibroids
- Fecal calprotectin assay for monitoring postoperative recurrence of Crohn's disease
- Fecal calprotectin assay for monitoring disease activity in Crohn's disease

- Hydrogen or methane breath test (e.g., for detection of lactase deficiency, fructose intolerance, bacterial overgrowth, or oro-cecal gastrointestinal transit)
- i-Factor Bone graft (Cerapedics) for spinal fusion; *prior authorization is required for spinal surgery*
- iTotal knee replacement includes iTotal CD and oTotal PS Custom Implants
- Myocardial strain imaging
- NLRP3 Exon # sequencing genetic test (GeneDx) for Muckle-Wells syndrome and related disorders
- Prostate Health Index (PHI) protein biomarker test
- Skin substitutes/wound care products as listed:
  - AllowrapDS
  - Allowrap Dry
  - Arthroflex
  - Thera skin
  - Cytal (Matri-Stem urinary bladder matrix products)
- EndoStim lower esophageal sphincter stimulation system was added to the GERD procedures listing

**Reconfirmed continued non-coverage:**

- Cartiva synthetic cartilage implant for MTP joint
- Combined cardiac panel (GeneDx)
- Drug eluting stents after endoscopic nasal/sinus surgery
- Genetic counseling when provided by the proprietary lab performing the test
- GoodStart and GeneVu preconception carrier screening multigene tests
- Mechanical stretching devices (such as JAS and Dyna Splint) for prevention and treatment of joint contractures

**Removed from non-coverage:**

- Home INR monitors will be considered medically necessary when criteria are met
- Zio Patch for long term cardiac rhythm monitoring; *requires prior authorization*

The complete library of our medical policies and the quarterly Medical Policy Update reports can be found online at: [wpsic.com/providers/medical-policies/index.shtml](http://wpsic.com/providers/medical-policies/index.shtml). No password required!