

WPS Medical Policy Updates

The Medical Affairs Medical Policy Committee recently approved medical policies that will become effective July 1, 2019, unless specified below.

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 customer 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 at medical.policies@wpsic.com or 800-333-5003, ext. 78993.
- For questions regarding medical coding related to Medical Policy Committee policies, contact the Code Governance Committee at codegovernance@wpsic.com.

Medical Policy Highlights

Artificial Disc Replacement

Prior authorization is required.

Added to **Limitations of Coverage:**

- Previous fusion at adjacent cervical level(s)
- Intervertebral disc used must be U.S. Food and Drug Administration (FDA)-approved.

Bariatric Surgery

Prior authorization is required.

Indications of Coverage:

- Changed an Indication of Coverage from: Age 18 or older with a BMI greater than 35 AND one of the following comorbid conditions to: Age 18 or older with a BMI of 35 or greater AND one of the following comorbid conditions.
- Added: Age 18 or older with BMI of at least 30 and type 2 diabetes that is inadequately controlled (as demonstrated by hemoglobin A1c of greater than 8% despite optimal medical management with oral medication and insulin).

Limitations of Coverage:

- Added: Routine liver biopsy during bariatric surgery for detection of non-alcoholic fatty liver disease (NAFLD) in the absence of signs or symptoms of liver disease (e.g., elevated liver enzymes, enlarged liver) will be denied as not medically necessary.
- Removed: Conversion of sleeve gastrectomy to Roux-n-Y for GERD

Corneal Treatments and Specialized Contact Lenses (Corneal Remodeling, Corneal Transplant, Corneal Collagen Crosslinking, Intrastromal Rings-INTACS, Keratoconus treatments, Keratoplasty, Scleral Lenses)

Prior authorization is required.

Indications of Coverage:

- Added indications of coverage for conventional (epithelium-off) corneal collagen cross-linking.

Added to Limitations of Coverage:

- Transepithelial corneal collagen cross-linking (T-CXL), partial epithelium-off corneal cross-linking (P-CXL), and any collagen cross-linking procedure other than conventional epithelium-off (C-CXL)
- Accelerated corneal collagen cross-linking (A-CXL)
- Topography-guided corneal collagen cross-linking (TG-CXL)
- Keratoplasty performed solely for correction of refractive errors or astigmatism
- Conventional corneal collagen cross-linking for the treatment of LASIK-related ectasia
- More than one conventional (epithelium-off) corneal collagen cross-linking (C-CXL) procedure per eye per individual's lifetime
- Conventional corneal collagen cross-linking used in conjunction with other treatments (e.g., CXL-plus, intrastromal corneal ring segments [INTACS], PRK, phakic intra-ocular lens implantation)
- Conventional corneal collagen cross-linking performed with a device, drug solution, or protocol that is not U.S. Food and Drug Administration (FDA)-approved for the procedure
- Use of BostonSight Prosthetic Replacement of the Ocular Surface Ecosystem (PROSE) for the treatment of dry eye disease (DED)

Hyperbaric Oxygen Therapy

Prior authorization is required.

Added to Indications of Coverage:

- Acute thermal burn injury

MCG Guidelines

The updated edition (23rd edition) was approved by the Medical Policy Committee.

Occipital Nerve Block and Headache Treatments

This medical policy will be retired effective July 1, 2019. Note: Occipital Nerve Block (for all indications except treatment of pain due to malignancy involving head or neck) has been added to the Non-Covered Services and Procedures medical policy effective July 1, 2019.

Non-Covered Services and Procedures:

We do not advise providers to submit prior authorization requests for items on our Non-Covered Services and Procedures Medical Policy, as they are not covered.

Added:

- Cardiac Contractility Modulation: including, but not limited to: Optimizer Smart System® (Impulse Dynamics)
- CUSTOMFLEX Artificial Iris
- Intellijoint Hip was added to the Computer-assisted Musculoskeletal Surgical Navigation subsection
- Extracorporeal Shock Wave Therapy (ESWT) also called Pulsed Acoustic Cellular Expression (PACE) Therapy. Including, but not limited to: DermaPACE® System
- Neurostimulation or Electrical Stimulation for the Treatment of Occipital Neuralgia or Headaches
- Occipital Nerve Block for all indications except treatment of pain due to malignancy involving head or neck
- Occipital Neurectomy/Nerve Decompression (supra orbital, supratrochlear, zygomaticotemporal, or greater occipital nerve) for treatment of headache or occipital neuralgia
- Percutaneous Carpal Tunnel Release (PCTR)
- Sprint PNS System was added to the Peripheral Field/Peripheral Nerve Stimulation (PNS) subsection
- Radiofrequency Ablation (thermal or pulsed) or Denervation for treatment of occipital neuralgia or headache
- Aquacel Ag Advantage was added to the Skin Substitute and Wound products not covered subsection
- Vagus Nerve Stimulation for treatment-resistant depression
- Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT) Genetic Testing
- GPS Cancer assay
- MicroGenDx
- Tempus xT Panel

Changes to “Indication” Section

- Added Not Covered Indications to Bioimpedance Spectroscopy (BIS) subsection: Body Composition Assessment, Cancer Survival Estimation, Fluid Status Evaluation in Dialysis Patients, Melanoma Detection, and Prostate Cancer Grade Assessment
- Added to “All Indications Except” for Cold Laser/Low Level Laser: Low Back Pain
- Added to Collagen Cross-Linking of Cornea subsection: All types are non-covered, except conventional corneal collagen cross-linking (C-CXL) following Dresden protocol using Photrexa® or Photrexa Viscous® with the Avedro KXL® System
- Added Not Covered Indication to Peripheral Field/Peripheral Nerve Stimulation: Chronic Pain
- Added to “All Indications Except” for Salivary Hormone Testing: Late night salivary cortisol levels to aid in the diagnosis of Cushing’s syndrome (if not an exclusion of the customer’s plan)
- Added to “All Indications Except” for Pneumatic Compression Devices: Hip fracture, total hip arthroplasty, total knee arthroplasty, and post-operative prevention of DVT in an immobilized individual
- Added to Negative Pressure Wound Therapy-Disposable, Single-use subsection: Non-powered, Mechanical; added examples of Snap and UNO; indication changed from surgical site incisions to Treatment of Wounds or Incisions

Removed

- Fecal Calprotectin (FC) Array
- Hydrogen Breath Testing
- Prometheus Anser ADA
- Prometheus Anser IFX
- Prometheus Anser VDZ
- Familial Hypercholesterolemia genetic testing (FHNext)
- MammaPrint gene expression assay
- BluePrint gene expression assay
- BRCAvantage Plus (BRCA1, BRCA2, TP53, STK11, PTEN, CDH1, PALB2)
- BreastTrue High Risk Panel (BRCA1, BRCA2, TP53, STK11, PTEN, CDH1, PALB2)
- Invitae Breast Cancer High Risk Panel (BRCA1, BRCA2, TP53, STK11, PTEN, CDH1, PALB2)

Reminder: All genetic testing requires prior authorization.

The complete library of our medical policies and the quarterly Medical Policy Update reports can be found online at wpshealth.com/resources/provider-resources/medical-policies.shtml.

No password required!