

WPS Medical Policy Updates

The Medical Affairs Medical Policy Committee recently approved medical policies that will become effective Jan. 1, 2020, 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

Hip Replacement Surgery (Total Hip Arthroplasty, Hemiarthroplasty, Hip Resurfacing Arthroplasty, Revision or Replacement of Total Hip Arthroplasty)

Prior authorization is required.

- Removed requirement for preoperative physical therapy
- Decreased initial inpatient (acute) rehabilitation facility length of stay from seven days to five days

Added to **Limitations of Coverage:**

- HipGrid® System with PhantomMSK, HipGrid®, HipGrid Nine®
- Bone marrow aspirate concentrate (BMAC) injection/treatment
- Microfragmented adipose tissue (MFAT) injection/treatment (such as, but not limited to, Lipogems®)
- Platelet Lysate (PL)

Knee Replacement Surgery (Total Knee Arthroplasty, Patellofemoral Arthroplasty, Bicompartamental Knee Arthroplasty, and Unicompartmental Knee Arthroplasty)

Prior authorization is required.

- Removed requirement for preoperative physical therapy
- Decreased initial inpatient (acute) rehabilitation facility length of stay from seven days to five days

Added to **Limitations of Coverage:**

- Mi-eye 2 camera-enabled probe (mi-eye 2 arthroscope)
- Intraoperative kinetic balance sensors (such as, but not limited to, Verasense®)
- Bone marrow aspirate concentrate (BMAC) injection/treatment
- Microfragmented adipose tissue (MFAT) injection/treatment (such as, but not limited to, Lipogems®)
- Platelet Lysate (PL)

Microprocessor Controlled and Myoelectric Limb Prosthesis

Prior authorization is required.

- Added Indications of Coverage/criteria section for myoelectric upper limb prosthesis

Added to **Limitations of Coverage:**

- MyoPro® Orthosis for upper extremity paralysis/paresis after stroke
- Robotic rehabilitation/robot-mediated therapy (RMT) of upper extremities in individuals with degenerative neurological conditions

Sleep Disorder Testing

Prior authorization is required.

- Removed requirement for in-lab sleep study to be ordered by a Sleep Medicine Specialist
- Added new section to policy: Repeat Polysomnogram
- Added indications of coverage for pediatric polysomnogram

Added to **Limitations of Coverage:**

- A repeat sleep study for an individual with diagnosed obstructive sleep apnea (OSA) on Positive Airway Pressure (PAP) therapy, but without clinical OSA symptoms, will be denied as not medically necessary

Sleep Disorder Treatment: Positive Airway Pressure Devices and Oral Appliances

Prior authorization is required.

- Added: Replacement of continuous positive airway pressure (CPAP) or automatic positive airway pressure (APAP) device is considered medically necessary every five years
- Added documentation requirement for oral appliance: sleep medicine specialist must provide documentation of positive airway pressure (PAP) device intolerance and the interventions tried to improve positive airway pressure (PAP) device compliance

Wearable Cardiac Defibrillator (WCD), Wearable Cardioverter Defibrillator (Life Vest), Implantable Cardiac Defibrillator (ICD)

Prior authorization is required.

- Initial time approved increased from two months to three months

New Medical Policies

Prior authorization is required.

- Autologous Chondrocyte Implantation (ACI) and Matrix-induced Autologous Chondrocyte Implant (MACI®)
- Cartilage Transfer Procedures: Osteoarticular Transfer System (OATS) and Mosaicplasty
- Negative Pressure Wound Therapy (NPWT), Vacuum-Assisted Wound Closure (VAC)
- Otoplasty and Reconstruction of External Ear
- Pectus Excavatum, Pectus Carinatum, and Poland Syndrome Treatment
- Septoplasty and Rhinoplasty
- Shoulder Replacement Surgery (Shoulder Arthroplasty, Shoulder Hemi-arthroplasty, Reverse Shoulder Arthroplasty, Arthroplasty Revision or Replacement, Shoulder Resurfacing)
- Surgical Removal of Redundant Skin and Face/Neck Lift Procedures

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:

- ABTHERA® Open Abdomen Negative Pressure Therapy System
- Acellular dermal extracellular matrix for shoulder capsular reconstruction
- Autologous cartilage chip transplant
- Avance Nerve Graft for treatment of peripheral nerve discontinuities
- Barostim Neo System
- Bone marrow aspirate concentrate (BMAC) injection/treatment
- DCISionRT test for ductal carcinoma in situ (DCIS)
- DeNovo ET® engineered tissue graft
- Endolumenal Functional Lumen Imaging Probe (EndoFLIP) for evaluation of esophageal and gastric disorders and guiding laparoscopic banding
- Endoscopic Sleeve Gastrectomy for obesity
- FirstStepDx PLUS
- Hearing loss genetic testing for known or suspected postlingual nonsyndromic hearing loss
- HipGrid System (HipGrid with Phantom MSK, Hip Grids, HipGrid Nine)
- IB-Stim percutaneous electrical nerve field stimulator for irritable bowel syndrome
- Intense Pulsed Light Therapy for treatment of dry eye disease, Meibomian gland dysfunction
- Intraoperative kinetic balance sensors (such as, but not limited to Verasense®)
- Matriderm—added to wound products section
- MI TumorSeek
- Mi-eye 2 camera-enabled probe (mi-eye 2 arthroscope) for evaluation of joints
- Microfragmented adipose tissue (MFAT) injection/treatment (such as, but not limited to, Lipogems®)
- Minced cartilage or biopaste extracellular matrix products, either synthetic, autograft, or allograft (including, but not limited to, BioCartilage®)

- Negative pressure wound therapy with instillation (NPWTi)
- Ovarian or Internal Iliac Vein Embolization
- Platelet Lysate
- PreTRM test for testing during pregnancy
- ProACT adjustable continence therapy for male urinary incontinence
- Sidus Stem-Free Shoulder System
- Stravix and Stravix PL
- Synthetic resorbable polymers/synthetic grafts (including, but not limited to, TruFit®, TruGraft®, PolyGraft® PGS)
- Transcatheter Tricuspid Valve Replacement (TTVR) for tricuspid valve disease
- WoundVision Scout®

Removed

- EpiFix

Updates

- Updated section regarding computer aided detection (CAD) to: Computer Aided Detection (CAD) for MRI or CT for imaging procedure other than mammography

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

No password required!