PROVIDENCE Health Plan

Healthcare Services Medical & Pharmacy Policy Alerts

Number 232

February 1, 2019

This is the February 1, 2019 issue of the Providence Health Plans Medical and Pharmacy Policy Alert to our providers. The focus of this update is to communicate to providers' new or revised Medical or Pharmacy policy changes. Providence Health Plans has a standard process to review all Medical & Pharmacy Policies annually. Policies will be available for review on ProvLink based on the Effective date noted below.

This Policy Alert, Prior Authorization Requirements, and Medical/Pharmacy policies are available through PHP ProvLink.

As of 1/1/2019, Prior Authorization has been removed for J0585, J0586, J0587, and J0588 for OHP lines of business only. In place of the prior authorization requirement, these codes will deny for medical documentation when the diagnosis billed is migraine, overactive bladder or incontinence. All other diagnosis codes will be subject to the Prioritized List of Health Services.

PROVIDENCE Health Plan

Here's what's new from the following policy committees:

MEDICAL POLICY COMMITTEE

New Policies or Major Changes

Effective April 1, 2019

Speech Generating Devices **DME344**	**Annual Update** This policy is based primarily on: • Centers for Medicare and Medicaid Services LCD L33739. LCD Title: Speech Generating Devices • Centers for Medicare and Medicaid Services LCA A52469. LCA Title: Speech Generating Devices • National Coverage Decision NCD 50.1. Manual Section Title: Speech Generating Devices; and • Medicare Claims Processing Manual, Chapter 20 - Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS). Section 90 - Payment for Additional Expenses for Deluxe Features (Rev. 1, 10-01-03) B3-5107, PM AB-02-114. The medical directors have elected to cover iPad/tablets for speech generating devices if: • limited to use by a patient with a severe speech impairment; and • is primarily used for the purpose of generating speech; and • medical necessity for an speech generating device is met ; and • is billed with E2510.
Knee: Ablative Procedures of Peripheral Nerves to Treat Knee Pain **SUR436**	**New Policy** This non-coverage policy was created to address various ablative procedures to treat chronic knee pain. Radiofrequency ablation (e.g., non-pulsed/conventional, cooled, pulsed) chemical ablation and cryoablation are not covered as treatments for chronic knee pain due to any cause, including but not limited to osteoarthritis, or knee arthroplasty. These treatments are considered not medically necessary for Medicare and investigational for all other lines of business. **Codes:** Two specific codes were added to the policy and we'll be configured in the following ways: • 64640: currently not reviewed for any line of business. We will pair this code with 110-150 knee-specific ICD codes to deny as investigational per this policy. • 0441T: currently denies as not medically necessary for Medicare based on the Non-covered Services LCD (L35008). ○ For all other lines of business, we will this pair this code with the same ICD codes that 64640 to deny as investigational. *Note:* Due to the large number of ICD codes that will be paired to these two CPT codes to deny, we have added language in the Billing Guidelines section of the Policy directing reviewers to a Billing Guidelines Appendix, which contains the list of non-covered diagnosis codes.

Knee: Autologous Chondrocyte Implantation (ACI) for Cartilaginous Defects **SUR263** *Previously:* *Knee: Cartilaginous Defects of the Knee: Autologous Chondrocyte Implantation (ACI)*	**Annual Update** This policy now addresses second-generation autologous chondrocyte implantation (ACI), and considers it to be equivalent to the first-generation ACI. The following changes have been made to the criteria: • (I.) Clarified that ACI may be used for single or multiple defects as long as medical necessity criteria are met. • (I. A.) Minimum age was changed from 15 to 18 years old. • (I.C.) Indicate that physiotherapy must be attempted as one of the conservative treatments failed prior to ACI. • Removed the requirement of "inadequate response to prior arthroscopic or surgical repair". • (I.D.) Added coverage for cartilage defects of the patella, in addition to femoral condyle and trochlear defects. • (I.E.) Provided two scales to determine what qualifies as a full-thickness defect. ○ Also clarified I.E. to define what "normal" meniscus, ligament and joint space constitute. • (I.H.) Added a list of six contraindications for ACI. • (II.) Added investigational criterion, listing out some examples of investigational indications. **Codes:** • Code 29879 will be removed from coding table and added to Billing Guidelines section of policy as not appropriate for ACI. In addition, the PA edit will be removed from 29879. • The PA edits will be removed from arthrotomy codes 27332 and 27333.

Knee: Meniscal Allograft Transplantation and Other Meniscal Implants
SUR266
 	
Previously:
Meniscal Allograft Transplantation
	Annual Update
	The medical necessity criteria for meniscal allograft transplantation (MAT) have been significantly revised. In addition, an investigational criterion has been added for meniscal implants made of materials such as collagen and polyurethane (III. – V.).
	• The following changes have been made to the allograft criterion (I.):
	  ○ Clarified what constitutes "no significant cartilaginous degeneration" by referencing the Outerbridge scale added to the other knee policies described above.
	  ○ Liberalized on the maximum age for which these allografts are allowed. Changing the age from <45 years to <55 years.
	  ○ Now require the following additional criteria to be met:
	  ▪ Body mass index (BMI) of <35; and
	  ▪ Conservative treatment
	  ▪ Meniscus absence must be shown by imaging (e.g., MRI or arthroscopy); and
	  ▪ Radiographic evidence of normal joint spacing; and
	  ▪ Aligned knee with intact meniscus and functional ligaments (intact or reconstructed). These procedures may be performed concurrently or sequentially.
	• Added non-coverage criteria III. –V. for meniscal implants made of materials like collagen and polyurethane.
	  ○ Procedures using collagen implants are considered not medically necessary for Medicare patients and investigational for all other lines of business.
	  ○ Polyurethane implants are considered investigational for all lines of business.

	Codes: • Added HCPCS code G0428, which addresses collagen meniscal implants. This code will deny as not medically necessary for Medicare, and investigational for all other lines of business. • Removing PA edit from 29868.
Knee: Osteochondral Allografts and Autografts for Cartilaginous Defects **SUR264** *Previously:* *Knee: Cartilaginous Defects: Procedures and Implants*	**Annual Update** The medical necessity criteria has been significantly revised for both the allografting and autografting (OATS and mosaicplasty) procedures. In addition, the investigational criterion has been revised and expanded. The following changes have been made to the allograft criterion (I.): ○ We will no longer have medical necessity criteria for microfracture, as this procedure is considered standard of care. ○ Revised the size of the lesion from "at least 1cm (often >3 cm in diameter and > 1 cm in depth)" to "2cm^2 in area or greater". ○ No longer require the lesion to be unipolar. ○ Allow for allograft for lesions on the medial, lateral or trochlear femoral condyle; or the patella. ○ Added the following requirements for medical necessity: ▪ Disabling localized knee pain from acute or repetitive trauma unresponsive to conservative treatment. ▪ Confirmation of defect size and thickness by MRI, CT or arthroscopy ▪ The lesion is surrounded by normal or nearly normal cartilage ▪ The knee has normal alignment or will be surgically corrected (osteotomy) at the time of the allograft procedure ▪ No inflammatory arthritis or osteoarthritis is present anywhere in the joint (surrounding the lesion or the opposing surface) The following changes have been made to the autograft (includes OATS and mosaicplasty) criterion (III.): ○ Revised the size of the lesion from "<2cm" to "1.0 to 2.5 cm^2 in area". ○ Now allow for autograft for lesions on the patella. ○ Added the following requirements for medical necessity: ▪ The patient is skeletally mature with documented closure of growth plates (e.g., 15 years or older) ▪ The patient is considered too young to be an appropriate candidate for total knee arthroplasty (e.g., patient is under 55 years of age) ▪ Body mass index (BMI) of <35 ▪ Disabling knee pain from acute or repetitive trauma unresponsive to conservative treatment ▪ It must be a focal, unipolar, full thickness defect (grade III or IV on the Outerbridge scale) ▪ Stable and aligned knee (or achieved concurrently at time of autograft procedure) ▪ Documented minimal to absent degenerative changes in the surrounding articular cartilage (Outerbridge grade II or less), and normal-appearing hyaline cartilage surrounding the border of the defect The following changes have been made to the investigational criteria (V.): • The term "morcellized cartilage" has been changed to "minced cartilage" to reflect that current naming convention. Other terms used are indicated in the description section of the policy. • Clarified that BioCartilage, DeNovo NT and DeNovo ET are classified as "minced cartilage allograft products" • Added the following investigational procedures and implants to the policy (based on insufficient evidence): ○ Combination OATS/autologous chondrocyte implantation (ACI) procedures.

	○ Minced autograft cartilage, including cartilage processed using systems such as the Cartilage Autograft Implantation System (CAIS) or the Reveille Cartilage Processor. ○ Decellularized Osteochondral Allograft Plugs (e.g., Chondrofix) ○ Reduced Osteochondral Allograft Discs (e.g., ProChondrix and Cartiform) ○ Procedures using synthetic products, including but not limited to: ▪ Granules (e.g., TRUGRAFT™) ▪ Plugs (e.g., TruFit® Plugs, POLYGRAFT™) **Codes:** • Removed 29868 from the policy, as it is specific to meniscal transplants, which are addressed in another policy. • Code 29879 will be removed from coding table and added to Billing Guidelines section of policy as not appropriate for OATS or osteochondral allografting. In addition, the PA edit will be removed from this code.

No Major Changes

Effective February 1, 2019

Back: Lysis of Epidural Adhesions **SUR122**	**Annual Update** No change to criteria designating lysis of epidural adhesions as investigational for the treatment of chronic back pain.
Chelation Therapy for Non-Overload Conditions **MED182**	**Annual Update** No change to criteria designating chelation therapy as investigational in the treatment of non-overload conditions.
Electrothermal Capsular Shrinkage **SUR111**	**Annual Update** No change to criteria designating Electrothermal Capsular Shrinkage “not medically necessary” for all indications.
Gastric Electrical Stimulation **SUR227**	**Annual Update** No change to criteria designating gastric electrical stimulation (GES) as medically necessary for the treatment of gastroparesis; and investigational for all other indications.
Gastroesophageal Reflux: Magnetic	**Annual Update** No change to criteria designating implantable magnetic esophageal ring (MSA) (e.g., LINX Reflux Management System) as not medically necessary

<table>
<tr><td>Esophageal Ring
SUR229</td><td>and not covered in the treatment of gastroesophageal reflux (GERD).</td></tr>
<tr><td>Investigational and Non-Covered Medical Technologies (All Lines of Business Except Medicare)
MED288
&

Investigational and Non-Covered Medical Technologies (Medicare Only)
MED393</td><td>Interim Update
Both policies were updated to include 8 new codes for the AngelMed Guardian System (remote intracardiac ischemia monitoring system). These codes will be set to deny investigational.
Codes:
<table>
<tr><td>0525T</td><td>Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; complete system (electrode and implantable monitor)</td></tr>
<tr><td>0526T</td><td>Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; electrode only</td></tr>
<tr><td>0527T</td><td>Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; implantable monitor only</td></tr>
<tr><td>0528T</td><td>Programming device evaluation (in person) of intracardiac ischemia monitoring system with iterative adjustment of programmed values, with analysis, review, and report</td></tr>
<tr><td>0529T</td><td>Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis, review, and report</td></tr>
<tr><td>0530T</td><td>Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; complete system (electrode and implantable monitor)</td></tr>
<tr><td>0531T</td><td>Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; electrode only</td></tr>
<tr><td>0532T</td><td>Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; implantable monitor only</td></tr>
</table></td></tr>
<tr><td>Salivary Hormone Testing (All LOBs except Medicare)</td><td>Annual Update
No change to criteria designating salivary cortisol testing as medically necessary and covered when used in the diagnosis of suspected endogenous Cushing’s syndrome; and investigational for any other indication.</td></tr>
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LAB339	
Salivary Hormone Testing (Medicare Only) **LAB387**	**Annual Update** LCD (L36857) has been updated since last policy update, but with no changes to coverage determination or language.

Effective April 1, 2019

Knee Braces (Functional) **DME260**	**Annual Update** No change to coverage criteria. Policy criteria are based on Local Coverage Determination (LCD): Knee Orthoses (L33318) and Local Coverage Article: Knee Orthoses – Policy Article (A52465). **Codes:** The following coding changes will be made for this update: • A4467 will change from "not a covered benefit" to not medically necessary. • 13 base HCPCs codes will be paired with additional accessory HCPCs codes to deny as not medically necessary as they are either incompatible or not separately reimbursable with the base code. • Annual limits (per calendar year) will be put in place for K0672.

Archived Policies

Effective February 1, 2019

Behavioral Interventions (All Lines of Business Except CMS) **BH146**	**Archive Policy** Archiving as of 2/1/2019 as this medical policy is not being used and none of the codes are reviewed.

Effective April 1, 2019

Knee: Arthroscopy, Arthroscopically Assisted Surgery **SUR261**	**Archive Policy** As of 4/1/19 the codes on this policy will no longer require PA and medical necessity review.

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PHARMACY & THERAPEUTICS COMMITTEE

No Updates