PROVIDENCE Health Plan

Healthcare Services Medical & Pharmacy Policy Alerts

Number 234

April 1, 2019

This is the April 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.

New medical policies effective 6/1/2019 (detailed information provided below):

- **Genetic Testing: Whole Exome, Whole Genome and Proteogenomic Testing**
- **Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery (All Lines of Business Except Medicare)**
- **Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery (Medicare Only)**

PROVIDENCE Health Plan

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

MEDICAL POLICY COMMITTEE

New Policies or Major Changes

Effective June 1, 2019

Back: Ablative Procedures to Treat Back and Neck Pain (All Lines of Business Except Medicare) SUR130 *Previously:* *Back: Radiofrequency Ablation for Persistent Facet Pain (All Lines of Business Except Medicare)*	**Annual Update** The following changes have been made to the policy: • The scope of the policy has been expanded to address all types of ablative procedures for back and neck pain (currently only address RFA for facet pain). • Clarified that the medical necessity criteria (criterion I. and II.) for RFA for facet pain only applies to conventional non-pulsed RFA. Other types of ablative procedures for facet pain (e.g., cooled RFA, pulsed RFA, cryoablation and chemical ablation) are considered investigational (**criterion V.**). • **Criteria I.C.:** Removed requirement for CT or MRI imaging to exclude non-facet pathology. Radiographic imaging will suffice. • **Criteria I.E.:** We will now allow for either MBBs and/or IA injections to diagnose facet pain. • **Criteria II. (repeat RFA):** Revised to be in-line with ASIPP and EviCore guidelines. Additional restriction added regarding frequency limit of 2 per year, with a minimum of 6 months between ablations. • **Criterion III.A. (noncoverage of staged procedures):** Criterion removed. • Expanded the non-covered procedures and indications to include: 1. Non-pulsed RFA for non-facet back and neck pain is investigational (**criterion IV.**), including pain related to: a. The dorsal root ganglion. b. The ganglion impar (impar of Walther). c. The intraosseous basivertebral nerve. d. The sacrum or sacroiliac joint. e. Thoracic spine. 2. Other ablative procedures (e.g., pulsed RFA, cooled RFA, cryoablation, chemical ablation) are considered investigational and not covered for the treatment of all types of back and neck pain. • Added information to the Billing Guidelines section regarding RFA to treat sacroiliac joint pain. The 64640 code is the appropriate code to use for this treatment, but since it is non-covered per the medical policy criteria, the 64640 CPT code will be denied when billed with any of the ICD-10 diagnosis codes listed in the guidelines. **Codes:** The following codes have been added to the policy: • 64640: This code is currently not reviewed, but per this policy will be paired with approximately 20-30 ICD-10 codes to deny as investigational for sacroiliac joint pain. Coding instructions and the non-covered ICD codes have been added to the Billing Guidelines section.

	• C9752 and C9753: These codes are specific to the lumbar and sacral intraosseous basivertebral nerve destruction and may be used for any of the ablative procedures listed in this policy. These two codes will deny as investigational. • 4 unlisted codes have been added, which may be used for various investigational ablative techniques.
Back: Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy (Medicare Only) SUR125	**Annual Update** In lieu of the expansion of the non-covered procedures and indications in the Commercial policy, above, we have added the following non-coverage criteria to this policy (per PHP hierarchy) 1. Non-pulsed RFA for facet pain is considered not medically necessary at the level of a prior fusion. 2. Non-pulsed RFA for non-facet back and neck pain (Investigational) 3. Cryoablation for non-facet back and neck pain (Investigational) **Codes:** The following codes have been added to the policy (same as the commercial policy above): • 64640: This code is currently not reviewed, but per this policy will be paired with approximately 20-30 ICD-10 codes to deny as investigational for sacroiliac joint pain. Coding instructions and the non-covered ICD codes have been added to the Billing Guidelines section. • C9752 and C9753: These codes are specific to the lumbar and sacral intraosseous basivertebral nerve destruction and may be used for any of the ablative procedures listed in this policy. • 4 unlisted codes have been added, which may be used for various investigational ablative techniques.
Back: Intradiscal Procedures for Low Back Pain (All Lines Of Business Except Medicare) MED127 *Previously Titled: Back: Intradiscal Injections*	**Annual Update** • Content from "Back: Percutaneous Thermal Intradiscal Treatment for Low Back Pain" policy has been added to this policy. "Back: Percutaneous Thermal Intradiscal Treatment for Low Back Pain" will be archived on this policy's effective date. The policy title has been updated to reflect this change. • No change to criteria designating non-thermal intradiscal procedures as investigational for the treatment of low back pain.
Back: Intradiscal Procedures for Low Back Pain (Medicare Only) SUR434	**Annual Update** • The policy Back: Percutaneous Thermal Intradiscal Treatment for Low Back Pain (Medicare Only) has been expanded to address all intradiscal procedures for low back pain (thermal and non-thermal). • Medicare considers thermal intradiscal procedures to be not medically necessary. • Medicare does not address non-thermal intradiscal procedures; therefore, these will follow commercial criteria (investigational) in accordance with the Medicare hierarchy. **NCD/LCD:** **NCD 150.11 for Thermal Intradiscal Procedures**
Genetic Testing: Whole Exome, Whole Genome and Proteogenomic	**New Policy** The criteria for this new policy are as follows: • Whole Exome Sequencing (WES) for Hereditary Conditions: ○ WES may be considered medically necessary for children (<18 years) when criteria are met.

Testing **GT389**	▪ genetic counseling criteria must be met (criterion I.) ▪ typically the patient must have at least one congenital abnormality and/or symptoms indicating a neurodevelopmental disorder (criterion II. B.) ▪ symptoms are not specific AND previous genetic testing has failed to yield a diagnosis (criterion II.C.) ▪ a diagnosis, at this point, would require invasive testing (criterion II.D.) ▪ specific anticipated clinical utility must be documented with the request (criterion II.E.) ○ Comparator exomes of a first-degree relative(s) (e.g., parents, siblings) may be considered medically necessary and covered when criteria for WES of the affected child are met. Analysis of comparator exomes increases the diagnostic yield significantly, decreases the identification of variants of uncertain significance, the cost is similar to proband-only claims, and half of other payers allow for it. • The following tests are considered investigational: ○ Whole Genome Sequencing (WGS) for Hereditary Conditions ○ WES and WGS for Oncologic Indications, including evaluation of hereditary cancers, and testing to direct therapeutic management. ○ WES/WGS for Reproductive Purposes and Prenatal Testing ○ Proteogenomic Testing (e.g., GPS Cancer assay) **Codes:** The following codes will be added to the policy: • 3 CPT codes for whole exome for hereditary conditions: 81415 – 81417. All 3 codes currently require a PA for all LOB and will remain so. • 8 CPT codes for whole genome testing: 4 codes for hereditary conditions and 4 codes for oncologic indications. All 8 codes will deny as investigational. • 2 unlisted codes.
Non-Contact Wound Therapy (All Lines of Business Except Medicare) **MED379**	**Annual Update** No change to criteria designating non-contact low-frequency ultrasound wound therapy (i.e. MIST) as investigational. The policy now also addresses non-contact normothermic wound therapy as investigational. **Codes:** 3 codes added specific to normothermic wound therapy. These codes will all deny investigational. • A6000 • E0231 • E0232
Non-Contact Wound Therapy (Medicare Only) **MED 433**	**New Policy** New policy due to following differences from the commercial policy: • Medicare covers low-frequency ultrasound wound therapy (i.e. MIST Therapy) under LCD #L37228, which commercial policy denies as investigational. • Medicare considers noncontact normothermic wound therapy not medically necessary under NCD 270.2, which commercial policy denies as investigational. **Codes:** Same 4 codes as those on commercial policy. The normothermic codes will deny not medically necessary for Medicare and the 97610 will require PA. • 97610 • A6000

	• E0231 • E0232
Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery (All Lines of Business Except Medicare) SUR438	**New Policy** A new stereotactic body radiation therapy and stereotactic radiosurgery policy has been created. The criteria are based on the recommendations from the American Society for Radiation Oncology (ASTRO). **Codes:** SBRT and SRS will remain as no PA required. The following codes will be configured to pay with the specific diagnosis codes included in the ASTRO policies. The codes will deny not medically necessary when not billed with these diagnosis codes. The "Billing Guidelines" of the medical policy includes all of the diagnosis codes. • 77371, 77372, 77373, 77432, 77435, G0339, G0340
Stereotactic Body Radiation Therapy and Stereotactic Radiosurgery (Medicare Only) SUR439	**New Policy** A new stereotactic body radiation therapy and stereotactic radiosurgery policy has been created based on the Medicare LCD Stereotactic Radiation Therapy: Stereotactic Radiosurgery (SRS) and Stereotactic Body Radiation Therapy (SBRT)(L34151). **Codes:** SBRT and SRS will remain as no PA required. The following codes will be configured to pay with the specific diagnosis codes included in the LCD. They will deny not medically necessary when not billed with these diagnosis codes. The "Billing Guidelines" of the medical policy includes all of the diagnosis codes. • 77371, 77372, 77373, 77432, 77435, G0339, G0340

Archived Policies

Effective April 1, 2019

Eye: Corneal Collagen Crosslinking (Medicare Only) MED432	**Archive Policy** Medicare removed the corneal collagen crosslinking code (0402T) from the Non-Covered services LCD; therefore, we are archiving this policy and the code will pay for Medicare members.

Effective June 1, 2019

Back: Percutaneous Thermal Intradiscal Treatment for Low Back Pain (All Lines of Business Except Medicare) SUR129	**Archive Policy** Archiving this policy as the criteria and codes are now contained in the Back: Intradiscal Procedures for Low Back Pain (All Lines of Business Except Medicare) policy.

Back: Percutaneous Thermal Intradiscal Treatment for Low Back Pain (Medicare Only) **SUR434**	**Archive Policy** Archiving this policy as the criteria and codes are now contained in the Back: Intradiscal Procedures for Low Back Pain (Medicare Only) policy.

No Major Changes

Effective April 1, 2019

Genetic Testing: Non-Covered Genetic Panel Tests (Medicare Only) **GT420**	**Interim Update** Medicare has a new coverage LCD for the Gaurdant360 test. The Non-Small Cell Lung Cancer: Molecular Testing for Targeted Therapy (Medicare Only) policy has already been updated and approved to reflect this liberalization. Therefore, we have now removed this test from this policy, where it was also listed as an investigational test in criterion IV.

Genetic Testing: Pharmacogenetic Testing (All Lines of Business Except Medicare)
GT306
	Interim Update
	The following changes were made:
	• Added a note at the top of the criteria to clarify our non-coverage stance on multi-gene panels.
	• Added new medically necessary genetic tests to criteria II.:
	  ○ BRCA1/2 for testing prior to Talzenna for breast cancer
	  ○ FLT3 testing for Xospata therapy (acute myeloid leukemia)
	  ○ IDH2 testing for Tibsovo therapy (acute myeloid leukemia)
	• Added new codes to be used for the FoundationOne CDx and the BRACAnalysis genetic tests.

Genetic Testing: Pharmacogenetic Testing (Medicare Only) **GT423**	**Interim Update** Updated to add the new National Coverage Determination (NCD 90.2) for next generation sequencing (NGS) for advanced cancer indications. The intent of this NCD is to allow for coverage of single gene and multigene panel tests performed using NGS technology to aid in the therapeutic management of patients with recurrent, relapsed, refractory, metastatic, or advanced stage III or IV cancer. Based on this NCD, the following have been added to the policy: 1. **Criteria**: Medical necessity criteria from the NCD have been added to the policy criteria in the "Nationally Covered Indications" section. 2. **Policy Guidelines**: Added a list of all of the FDA-approved companion diagnostic tests that would be considered for coverage, as of 2/12/2019. As the FDA approves more tests, additional tests not listed in the policy may be covered. Therefore, we have provided a link for users to the FDA Companion Diagnostic website for a current test list. 3. **Billing Guidelines**: Added some guidelines based on language in the transmittal that is linked to in the NCD. 4. **Codes**: New codes to be used for the Foundation One CDx and the BRACAnalysis genetic tests have been added to the coding table.

	Also, added several tests to criterion XXII. for coverage based on the PHP hierarchy. Since Medicare does not directly address these genetic tests for these specific targeted therapies, they may be considered medically necessary based on commercial criteria:
	• BRAF V600 mutations for:
	  ○ Colon or rectal cancer to direct treatment with Zelboraf® (vemurafenib)
	  ○ Hairy-cell leukemia (HCL) to direct treatment with Zelboraf® (vemurafenib)
	  ○ Melanoma (cutaneous) to direct treatment with Cotellic® (cobimetinib)
	• BRCA1/2 testing for:
	  ○ Breast Cancer to direct treatment with Talzenna™ (talazoparib)
	  ○ Ovarian, fallopian tube, or primary peritoneal cancer to direct treatment with Rubraca® (rucaparib)
	• FLT3 testing for acute myeloid leukemia (AML) to direct treatment with either Xospata® (gilteritinib) or Rydapt® (midostaurin)
	• KIT D816V mutation testing for aggressive Systemic Mastocytosis (ASM) to direct treatment with Gleevec® (imatinib mesylate)
	• KRAS / NRAS testing for colon or rectal cancer to direct treatment with either Erbitux® (cetuximab) or Vectibix® (panitumumab)

Non-Small Cell Lung Cancer: Molecular Testing for Targeted Therapy (All Lines of Business Except Medicare) **LAB289**	**Interim Update** • Updated to ensure that we are in line with the current NCCN guidelines (updated 1/18/19) and PHP Pharmacy policies (effective 4/1/19). • The list of FDA-approved companion diagnostic tests in the Regulatory Status section of the policy was updated as well.
Non-Small Cell Lung Cancer: Molecular Testing for Targeted Therapy (Medicare Only) **LAB421**	**Interim Update** Several changes have been made, including: 1. Add the new National Coverage Determination (NCD 90.2) for next generation sequencing (NGS) for advanced cancer indications. Language form the NCD has been added to the following sections of the policy: criteria, policy guidelines, billing guidelines, coding table. Please see the entry above for Pharmacogenetic Testing (Medicare only) for additional details. 2. Removed the "Approved Gene Testing" criteria and accompanying language from the Policy Guidelines section. This LCA has been retired. 3. Removed the "Comprehensive Genetic Testing" section from the criteria, as the "Comprehensive Genomic Profiling" LCDs have been retired in lieu of the new NCD. 4. Added new coverage criteria for the Guardant 360 plasma-based comprehensive genomic profiling (CGP) test, based on new LCDs allowing for coverage. Therefore, this test has been removed from the list of investigational tests in criterion IX.. Test description and evidence from the LCDs have also been added to the policy for this test. 5. Removed the criteria, codes, description, and reference to the LCD and two LCAs regarding circulating tumor cell assays. These assays and the Medicare LCD are already addressed in the Circulating Tumor Cell Assays medical policy. **NCD/LCD/LCAs:** • National Coverage Determination (NCD) for Next Generation Sequencing (NGS) (90.2) • Local Coverage Determinations (LCDs) L37651 and L37671: MolDX: Guardant360® Plasma-Based Comprehensive Genomic Profiling in Non-Small Cell Lung Cancer (NSCLC)

Vestibular Function Testing **MED368** *Previously Titled: Vestibular Autorotation Testing*	**Annual Update** No change to criteria designating VAT as not medically necessary. Investigational criteria added to address the use of vestibular evoked myogenic potential (VEMP) for the diagnosis of any indication, including but not limited to, Meniere disease (MD). Policy name changed from "Vestibular Autorotation Test (VAT)" to "Vestibular Function Testing" per addition of VEMP to criteria. **Codes/PA:** No changes.

Effective May 1, 2019

Hyperbaric Oxygen Therapy (All Lines of Business Except Medicare) **MED252** **&** **Hyperbaric Oxygen Therapy (Medicare Only)** **MED420**	**Interim Update** Added a note to the top of the policy criteria to indicate that hyperbaric oxygen therapy performed concurrently with negative pressure wound therapy is not covered.
Negative Pressure Wound Therapy **DME377**	**Interim Update** Added a note to the top of the policy criteria to indicate that negative pressure wound therapy performed concurrently with hyperbaric oxygen therapy is not covered.

Effective June 1, 2019

Back: Discography **SUR121**	**Annual Update** No change to criteria designating discography as investigational for all indications.
Investigational and Non-Covered Medical Technologies (All Lines of Business Except Medicare) **MED288**	**Interim Update** Added six codes for paravertebral facet (zygapophyseal) joint injections. These codes will auto-deny investigational. **Codes/PA:** No PA, all codes will deny investigational. • 0213T-0218T
Investigational and Non-	**Interim Update** • Updated policy based on 1/1/19 updated of the Noridan Non-Covered Services LCD (linked).

Covered Medical Technologies (Medicare Only) **MED393**	• The old CPT code for the SpaceOAR (0438T) was terminated and thus removed from the non-covered services LCD. The 0438T code was replaced with the 55874 code, which was not added to the non-covered services LCD and is not addressed in any other Medicare guidance. Therefore, we will follow commercial criteria (investigational) in accordance with our hierarchy. So this code has been moved from the "Not Medically Necessary" section to the "Investigational" section of the policy.
Sleep Disorder Treatment: Oral Appliance Therapy (All Lines of Business Except Medicare) **DME411**	**Interim Update:** • Removed the positive airway pressure (PAP) trial/failure requirement for mild obstructive sleep apnea (OSA). • Criteria have been added (I.B.1.b. and I.C.1.b.) to require consult with a sleep specialist to ensure the PAP trial was adequate and all treatment options were discussed prior to OAT for moderate and severe OSA patients. • A note has been added to indicate that positive airway pressure (PAP) therapy would be considered a duplicative service and not covered in mild OSA if member chose oral appliance therapy.

Vendor Updates

Providence Health Plan is pleased to announce its partnership with eviCore healthcare to provide Physical and Occupational Therapy benefits management services for members enrolled in select Commercial Plans.

Beginning June 1st, 2019, providers may request medical necessity review through eviCore healthcare for dates of service June 1st, 2019 and thereafter. For additional information, including eviCore's clinical guidelines and a complete list of services requiring medical necessity review, please visit: https://www.eviCore.com/healthplan/PHP or call the eviCore Client Provider Operations department at (800) 646-0418 (Option #4).

PHARMACY & THERAPEUTICS COMMITTEE

NO UPDATES