PROVIDENCE Health Plan

Healthcare Services Medical & Pharmacy Policy Alerts

Number 230

December 1, 2018

This is the December 1, 2018 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.

PROVIDENCE Health Plan

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

MEDICAL POLICY COMMITTEE

New Policies or Major Changes

Effective December 1, 2019

Dental Services: Administrative Guideline (All Lines of Business Except Medicare)
MED204
 	
Previously Titled:
 	
Dental Services and Restoration of Head and Facial Structures and Repair of Cleft Palate (All Lines of Business Except Medicare)
	Annual Update
	The intent of this policy is to serve as a guideline for the interpretation of dental versus medical services and to provide clinical scenarios which may fall into each benefit category.
	• Medically necessary dental and/or orthodontic services include those in which the condition being diagnosed and/or treated is not localized to the teeth and/or gums and at least one of the clinical scenarios below is met:
	  ○ Emergent treatment of dental trauma, when the problem is diagnosed and a treatment plan delineated within 72 hours of the trauma.
	  ○ Corrective dental surgery following dental trauma (with additional criteria)
	  ○ Treatment of craniofacial anomalies (with additional criteria)
	  ○ Hospital emergency room treatment of a dental abscess (with additional criteria)
	  ○ Replacement of multiple missing teeth (with additional criteria)
	  ○ Removal of teeth prior to radiation
	  ○ Treatment(s) of osteoradionecrosis
	  ○ Treatment(s) of mandibular or maxillary diseases (e.g., tumors, cysts, infections)
	  ○ Fabricated oral appliance for obstructive sleep apnea
	• Services may encompass dental benefits when the condition being diagnosed and/or treated is localized to the teeth and/or gums and services rendered are not intended to improve loss of function. The policy provides a list of services that may fall under dental benefits.
	• For corrective surgery following dental trauma, the policy now only allows for corrective surgery to treat a craniofacial deformity or restore function.
	• For the treatment of craniofacial anomalies, the services must be required to restore function (in accordance with Oregon House Bill 4128).
	• "Dental or orthodontic procedures that do not correct facial deformities or restore loss of function" are no longer considered not medically necessary because this conflicts with medically necessary dental services, such as removal of teeth prior to radiation therapy.
	• The orthognathic surgery criteria were removed as they are now in the updated Orthognathic Surgery policy.

Dental Services: Administrative Guideline (Medicare Only)	**New Policy** Based on several sources of Medicare guidance, this policy has been created to serve as a guideline for the interpretation of dental versus medical services for Medicare members. – In summary: • Medicare statutorily excludes routine dental services. • Exceptions to the statutory dental exclusion are made "when an otherwise non-covered procedure or service is performed by a dentist as incident to and as an integral part of a Medicare covered procedure". In this instance, the total service performed by the dentist on such an occasion is covered. o Examples provided by Medicare: ▪ Reconstruction of a ridge performed as a result of and at the same time as the surgical removal of a tumor (for other than dental purposes). ▪ The wiring of teeth when done in connection with the reduction of a jaw fracture. ▪ The extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease. ▪ Dental splints for the treatment of a covered medical condition (i.e., dislocated upper/lower jaw joints) ▪ Oral or dental examination performed on an inpatient basis as part of a comprehensive workup prior to renal transplant surgery – Sources of Medicare guidance: • Local Coverage Article (LCA): Routine Dental Services (A52977) • Noridian, Jurisdiction F – Medicare Part B, Dental Services • Medicare General Information, Eligibility, and Entitlement, Publication 100-01, Chapter 5, Section 70.2 • Medicare Benefit Policy Manual, Publication 100-02, Chapter 1, Section 70 • Medicare Benefit Policy Manual, Publication 100-02, Chapter 15, Section 150 • Medicare Benefit Policy Manual, Publication 100-02, Chapter 16, Section 140 • Medicare National Coverage Determinations (NCD) Manual, Publication 100-03, Chapter 1, Part 4, Section 260.6

Effective January 1, 2019

Prostate: Prostatic Urethral Lift **SUR318**	**Annual Update** The medical necessity criteria for the prostatic urethral lift have changed to allow for up to 7 implants.

Effective February 1, 2019

Back: Percutaneous Thermal Intradiscal Treatment for Low Back Pain **(All Lines of Business Except Medicare)** **SUR129**	**Annual Update** The use of percutaneous thermal intradiscal procedure are considered investigational for the treatment of low back pain, including but not limited to the following procedures: • Intradiscal biacuplasty (IDB) • Intradiscal electrothermal therapy (IDET), also known as Intradiscal thermal annuloplasty (IDTA) • Percutaneous intradiscal radiofrequency thermocoagulation (PIRFT) • Percutaneous (or plasma) disc compression (PDD) or coblation • Radiofrequency annuloplasty (RA) • Targeted disc decompression (TDD)
Back: Percutaneous Thermal Intradiscal Treatment for Low Back Pain **(Medicare Only)** **SUR434**	**New Policy** • A new Medicare policy was created based on differences in denial reasoning from the non-Medicare policy (investigational versus not medically necessary). • Based on the National Coverage Determination (NCD) for Thermal Intradiscal Procedures (TIPs) (150.11) and Local Coverage Determination (LCD): Non-Covered Services (35008), Medicare considers percutaneous thermal intradiscal procedures for low back pain to be not medically necessary.
Eye: Blepharoplasty, Blepharoptosis Repair, and Brow Lift **(All Lines of Business Except Medicare)** **SUR216** *Previously: Eye: Blepharoplasty, Blepharoptosis, and Brow Lift*	**Annual Update** Several changes to the policy criteria. These are as follows: 1. Clarified the documentation requirements based on American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS) recommendations. a. Removed references to Goldman III and Humphreys visual field testing. b. Defined functional loss/compromise. c. Added clarification regarding photographic documentation. 2. Added medical necessity requirements ectropion, entropion, and trichiasis. 3. Added medical necessity criterion for the following conditions: nerve palsy, painful and intractable blepharospasm, periorbital sequelae of thyroid disease, trauma, tumor ablative surgery. 4. Removed a note from the criterion which stated: "When the primary problem is related to lateral visual field deficit, superior extent of the lateral visual field less than 20 degrees above the horizontal meridian would be sufficient to justify blepharoplasty." 5. Separated out the medical necessity criteria for blepharoptosis repair and brow lift (brow ptosis repair). These were previously combined in one criterion but now have been split out and revised, as the requirements for each criterion are different. 6. Added medical necessity criteria for blepharoptosis repair in children with ptosis who have or are at risk of amblyopia. 7. Added criteria for when more than one procedure is requested.

Eye: Blepharoplasty, Blepharoptosis Repair, and Brow Lift
(Medicare Only)
SUR435
	New Policy
	Based on coverage difference between Medicare and all other lines of business, a new Medicare policy was created.
	Differences for other lines of business:
	• Medicare allows for upper lid procedures for blepharochalasis and pseudoptosis, whereas all other lines of business do not.
	• Medicare considers lower lid blepharoplasty to be not medically necessary. Appeals may be submitted and will be considered on a case-by-case basis.
	• Slight differences in documentation of functional deficits and photographic requirements for all three procedures.
	  ○ For example, Medicare requires reporting of margin reflex difference (MRD) for all three procedures, whereas all other lines of business only require it for blepharoptosis repair.
	  ○ Formatting difference: Medicare lists all of their documentation and photographic requirements in the Policy Guidelines, while all other lines of business incorporate most of this information right into the criteria.
	• Medicare has some very specific billing requirements regarding requesting two procedures and several restrictions regarding separate payment for various procedures. These have all been included in the Policy Guidelines and Billing Guidelines sections of the policy.
	Codes: Two codes for lower lid blepharoplasty (15820 and 15821) will changed from PAed to not medically necessary.
	NCD/LCD/LCAs:
	Local Coverage Determination (LCD): Blepharoplasty, Eyelid Surgery, and Brow Lift (L36286)
	Local Coverage Determination (LCD): Blepharoplasty, Blepharoptosis and Brow Lift (L34528)
	Local Coverage Determination (LCD): Plastic Surgery (L37020)
	MLN Matters: MM10236 and MM10259

Stem cell Therapy for Orthopedic Applications **MED346**	**New Policy** The previously archived (5/2017) stem cell therapy policy is being reinstated and expanded to address additional uses of stem cells for orthopedic applications. The policy now also addresses the use of bone products containing viable stem cells in addition to stem cells as a stand-alone therapy; both of which are considered investigational. The policy criteria include examples of each type of stem cell therapy.
Surgical Treatments for Lymphedema **SUR433**	**New Policy** • Due to an increase in requests, a new medical policy has been created to address all surgical treatments for lymphedema. • This policy considers all surgical treatments for lymphedema to be investigational, including but not limited to excisional procedures (e.g. liposuction, debulking) and physiologic procedures (e.g., vascularized lymph node transfer, lymphatic bypass techniques, tissue/flap transfer). This investigational stance is based on a lack of well-designed, high quality evidence for the individual surgical procedures proposed to treat lymphedema. • Note: One exception (which is highlighted in the criteria) - Medicare considers liposuction to be cosmetic. So liposuction will be denied as cosmetic for Medicare but investigational for all other lines of business.

No Major Changes

Effective January 1, 2019

Cefaly Device for Treatment of Migraine Headaches **DME181**	**Annual Update** The use of Cefaly for migraine headaches remains investigational.
Surface Electromyography (sEMG) Testing MED349	**Annual Update** Surface Electromyography (sEMG) Testing remains investigational.
Tumor Treatment Fields Therapy for Glioblastoma **DME293**	**Annual Update** • No change to current medical necessity criteria for tumor treatment fields (TTF) therapy for newly-diagnosed patients; criteria updated to include prohibitive contraindications. • No change to investigational stance regarding TTF therapy for patients with recurrent glioblastoma.

Effective February 1, 2019

Prolotherapy MED311	**Annual Update** • There is no change to the current investigational stance for prolotherapy. • The policy now specifically lists out a number of orthopedic/musculoskeletal indications for which prolotherapy has been determined to be investigational, based on the current review of evidence. • The criteria and all language for the use of stem cell therapy for orthopedic applications have been removed as this is now addressed in the updated Stem Cell Therapy for Orthopedic Applications policy (mentioned above).

Archived Policies

Effective January 1, 2019

- Intraoperative Neurophysiological Testing and Monitoring

Vendor Updates

AIM Specialty Health

Effective January 1, 2019

The following codes will be added to AIM's Standard Clinical Appropriateness Review Programs as of 01/01/2019.

For Advanced Imaging:

Terminating Codes

77058	Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral
77059	Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral

New Codes

76391	Magnetic resonance (e.g., vibration) elastography
77046	Magnetic resonance imaging, breast, without contrast material; unilateral
77047	Magnetic resonance imaging, breast, without contrast material; bilateral
77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral
77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral

RBM groupers will be impacted as follows:

Solution	Grouper	CPT Code	CPT Description	Default CPT "1"	New Code
RBM	**29**	77046	Magnetic resonance imaging, breast, without contrast material; unilateral	1	New
RBM	**29**	77048	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral	0	New
RBM	**29**	77047	Magnetic resonance imaging, breast, without contrast material; bilateral	0	New
RBM	**29**	77049	Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; bilateral	0	New

And this is a secondary add on code to grouper 26

RBM	**26**	76391	Magnetic resonance (eg, vibration) elastography	0	New

PHARMACY & THERAPEUTICS COMMITTEE

No Updates