PREVEA360 health plan℠

ProviderNews

Medical Policy Update

Spring 2018

Below are highlights of recent medical policy revisions, as well as any new medical policies approved by Preva360 Health Plan's Medical Policy Committee, which meets monthly. We appreciate contributions by specialists during the technology assessment of medical procedures and treatments.

To view all of Preva360 Health Plan's medical policies, visit our management page on prevea360.com. We update our website as the medical policies become effective.

For questions regarding any medical policy, or if you would like copies of a complete medical policy, contact our Customer Care Center at 877.230.7555. All other Prevea360 Health Plan clinical guidelines used by the Quality and Care Management Division, such as MCG (formerly known as Milliman) and the American Society of Addiction Medicine, are accessible to providers upon request. To request the clinical guidelines, contact the Customer Care Center.

Coverage of any medical intervention discussed in a Prevea360 Health Plan medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate. A verbal request for a referral does not guarantee authorization of the referral or the services. After a referral request has been reviewed in the Quality and Care Management Division, a notification is sent to the requesting provider and member. Note that prior authorization through the Prevea360 Health Plan Quality and Care

Management Division may be required for some treatments or procedures.

For imaging prior authorizations, please contact National Imaging Associates (NIA). Providers can contact NIA by phone at 866.307.9729 Monday-Friday from 7:00 a.m. to 7:00 p.m. CST or by email at RadMDSupport@MagellanHealth.com. Details about the radiology prior authorization program can be found on prevea360.com.

New Medical Policies

Genetic Testing for Marfan Syndrome MP9506
Effective January 1, 2018, FBN1 gene testing requires prior authorization. Pre and post-test genetic counseling is required.

Genetic Testing for Stickler Syndrome MP9504
Effective February 1, 2018, genetic sequencing panel requires prior authorization. Pre and post-test genetic counseling is required.

Genetic Testing for Thoracic Aortic Aneurysm and Non-syndromic Aortic Dissection MP9053
Effective January 1, 2018, diagnosis or screening for nonsyndromic familial thoracic aneurysm and aortic dissection requires prior authorization. Pre and post-genetic counseling is required.

Micra Permanent Leadless Pacemaker MP9518
Prevea360 Health Plan will provide coverage for leadless pacemakers when procedures are performed as part of an approved CMS study and medical policy criteria are met. Prior authorization is required.

The following medical policies do not require prior authorization.
A claim may be denied without a medically necessary diagnosis. These policies are effective on April 1, 2018.

Diagnostic, Therapeutic and Surveillance Colonoscopy MP9510
Screening colonoscopies are covered under Preventive Services and not addressed in this medical policy. Colonoscopies, sigmoidoscopy, or proctosigmoidoscopy performed for diagnostic, therapeutic or surveillance do not require prior authorization, but must meet the clinical criteria listed in the policy.

Echocardiogram MP9513
Transthoracic (TTE), transesophageal (TEE), or fetal echocardiography is considered medically necessary for appropriate clinical scenarios.

Endometrial Biopsy MP9509
Endometrial biopsy is considered medically necessary when needed as part of the diagnostic evaluation in the appropriate clinical scenario.

General Anesthesia for Gastro Intestinal (GI) Endoscopy MP9519
General anesthesia may be considered medically necessary for upper or lower GI endoscopic procedures. Documentation by the endoscopist or anesthesiology provider must indicate risk factors or significant medical conditions.

Nasal Endoscopy (Outpatient) MP9514
A diagnostic nasal endoscopy is considered medically necessary in the appropriate clinical scenario for the evaluation and visualization of the nasal anatomy when there are symptoms suggestive of nasal or sinus origin and physical examination does not provide sufficient clinical information to establish a diagnosis.

Upper Endoscopy (EGD) Esophagogastroduodenoscopy MP9517
EGD is considered medically necessary for high-risk screening, diagnosis, surveillance, or treatment when performed in the appropriate clinical scenario for the listed indications.

Medical Policy Changes

Genetic Testing for Neurological Disorders MP9497
Effective January 1, 2018, Occulopharyneal Muscular Dystrophy (OPMD) – PABPN1 gene testing is considered experimental/investigational and therefore is not covered.

Genetic Testing for Lynch Syndrome MP9487
Effective January 1, 2018, multigene hereditary cancer panels that accompany Lynch syndrome genes are considered experimental/investigational.

Non-Covered Durable Medical Equipment (DME) MP9347
Prevea360 Health Plan does not cover effective January 1, 2018, automatic external defibrillators (Code E0617) and crutch substitute-lower limb platforms.

Orthosis: Ankle (AFO), Knee Ankle (KAFO), or Knee (KO) MP9085
Effective January 1, 2018, requests to repair orthotics are considered appropriate at 3-year intervals unless there is an anatomical change or the orthotic is non-functional (wear and tear).

Pectus Excavatum and Pectus Carinatum Treatment MP9206
Effective December 1, 2017, pectus carinatum treatment with orthotic compression bracing and surgical treatment criteria was added. Pectus Excavatum braces may be considered medically necessary and the reference to the brace being non- covered was

removed from Non-covered Durable Medical Equipment/Supplies MP9347.

Plastic and Reconstructive Surgery MP9022
Effective January 1, 2018, liposuction for lipedema/tumescent lymph sparing is considered not medically necessary and therefore is not covered.

Skin Substitutes for Wound Healing MP9287
Effective December 1, 2017, EpiFix® an amniotic allograft, may be considered medically necessary if the member has tried and failed standard wound therapy, Apligraf®, and Dermagraft®. Prior authorization is required for all skin substitutes and may be considered medically necessary for either diabetic or venous insufficiency ulcers.

Transport of Members (Ambulance) MP9137
Effective February 1, 2018, if a member is being transported from an acute inpatient care setting to another acute inpatient care setting, a prior authorization is not required. Examples include transfers between acute care hospitals, long-term acute care, inpatient hospice, skilled nursing, or inpatient rehabilitation.

A prior authorization for transport is not required when a member requires services (e.g., dialysis, medical imaging and radiation therapy) that are not available in the inpatient facility, and there is a planned return to the inpatient hospital.

The following medical policies are being retired. NIA prior authorizes these procedures.

- PET for Malignancy MP9240
- PET for Neurological Applications MP9260
- Breast Imaging MP9269
- CT GI Endoscopy MP9316

Technology Assessments

Non-Covered Medical Procedures MP9415
The Medical Policy Committee reviewed the following treatments, procedures, or services and has determined that these services are not covered:

- Myocardial strain imaging all indications
- Hydrodissection therapy for pain management
- Iontophoresis for indications other than hyperhidrosis
- Salivary hormone testing for aging and/or menopause added examples (e.g., DHEA, estradiol, estrogen, melatonin, progesterone, testosterone, or cortisol)
- Thermosensor ShuntCheck
- Computer-aided detection related to breast imaging