PREVEA360 health plan℠

ProviderNews

Medical Policy Update

Fall 2016

Highlights of recent medical policy revisions as well as any new medical policies approved by Prevea360 Health Plan's Medical Policy Committee are shown below. The Medical Policy Committee meetings take place monthly. We appreciate contributions by specialists during the technology assessment of medical procedures and treatments.

To view all Prevea360 Health Plan medical policies, go to our Medical Management page at prevea360.com. This page is updated as the medical policies become effective. If you have questions regarding any medical policy or would like copies of a complete medical policy, please contact our Customer Care Center at 877.233.7555. All other Prevea360 Health Plan clinical guidelines used by the Quality and Care Management Division, such as MCG (formerly known as Milliman Care Guidelines) and the American Society of Addiction Medicine are accessible to the provider upon request. To request clinical guidelines, contact the Customer Care Center at 877.233.7555.

Coverage of any medical intervention discussed in a Prevea360 Health Plan medical policy is subject to the limitations and exclusions outlined in the Member Certificate. A verbal request for a referral does not guarantee authorization of the referral or the services. After a written referral request has been reviewed in the Quality and Care Management Division, a printed 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. or by email at RadMDSupport@MagellanHealth.com.

Details about the radiology prior authorization program can be found online at http://www.prevea360.com/For-Providers/Patient-Care/Radiology-Prior-Authorization.aspx

Medical Policy Updates:

Prophylactic Mastectomy (MP9449) Section 5.0 indicates prophylactic mastectomies are covered for women without a personal history of breast cancer when they have a known BRCA1, BRCA2, PTEN, or P53 mutation confirmed by genetic testing.

Sleep Studies: Attended Polysomnography and Portable Polysomnography Tests, Multiple Sleep Latency Testing and Maintenance of Wakefulness Testing (MP9132) Effective December 1, 2016, prior authorization is required for both supervised polysomnograms, and portable or home sleep study tests. Both studies may be considered medically necessary when ordered by a pulmonologist, neurologist, psychiatrist, otolaryngologist, a physician board certified in sleep medicine or their advanced practitioners; and documentation submitted by the provider indicates criteria were met. Multiple Sleep Latency Tests (MSLT) and Maintenance of Wakefulness Tests (MWT) were added to MP9132.

Artificial Intervertebral Discs (MP9364) Artificial cervical disc systems may be approved for single-level or contiguous two level disc disease for specific indications.

Transport of Patients (MP9137) Air ambulance transport is considered medically appropriate for life threatening emergencies; when ground ambulance transport would compromise the patient's condition or when the patient requires transport to a hospital; or from one hospital to another because the first hospital does not have the required services and/or facilities to treat the patient. Air ambulance must be provided to the closest, most appropriate facility to render the required services and/or facilities to treat the patient. Any ground or air ambulance transportation for patient convenience or for non-clinical (social) reasons is not a covered benefit.

Phototherapy for Skin Conditions, Including Home Ultraviolet Light (UVB) (MP9057)An in-home UVB light unit may be considered medically appropriate if a Dermatologist has documented improvement with the use of UV treatments in the physician's office or clinic. The patient must be capable of operating the home phototherapy unit and staying within the prescribed periods of exposure. The UVB light unit is also expected to be used frequently (e.g., 3 times/week) on a long term basis. Please refer to the medical policy for medical criteria.

Lymphedema Compression Devices (MP9119) Multi-chamber programmable also known as gradient pressure lymphedema pumps are considered not medically necessary for the treatment of lymphedema. Treatment for lymphedema extending onto the chest, trunk and /or abdomen with a pneumatic compression device is considered experimental and investigational.

Breast Pumps, (MP9092) Prevea360 Health Plan covers the purchase of one manual breast pump (HCPCS code E0602) or one personal-use electric breast pump (HCPCS code E0603) per birth. This benefit does not require prior authorization and may be requested up to four weeks prior to the member's estimated delivery date.

Continuous Glucose Monitoring (MP9091)
An initial 4 week continuous glucose monitoring trial may be appropriate for children under the age of 8 with Type 1 diabetes mellitus. For use beyond the initial 4 week trial period proof of near-daily use of the device is required.
Prior authorization may be approved if the medical record indicates all of the following:
The member requires an intensive insulin regimen such as 3 or more insulin injections per day, or use of continuous subcutaneous insulin infusion pump.
Documentation must indicate there is consistent monitoring of the patient's blood glucose 3 or more times per day and either the member and/or family are motivated to use the device on a near-daily basis

High Flow Oxygen Durable Medical Equipment (DME)
Home high flow oxygen, (up to 15 liters per minute), for the treatment of cluster headaches requires a prior authorization. The ICD-10-CM diagnosis codes for cluster headaches. (G44.001, G44.009, G44.011, G44.019, G44.021, and G44.029) will require prior authorization.

New Medical Policies

Liver and Other Neoplasm – Chemoembolization (CE) and Intra-Hepatic Microspheres (TheraSphere) (MP9462) Chemoembolization (CE) and Intra-Hepatic Microspheres (TheraSphere) will require prior authorization. Refer to the medical policy for medically appropriate indications.

Gastric Pacemaker and Gastric Electrical Stimulation (MP9463) Gastric pacing (pacemaker) or gastric electrical stimulation is considered medically necessary for the treatment of chronic, intractable (drug refractory) nausea and vomiting secondary to gastroparesis due to diabetic or idiopathic etiology. Prior authorization is required. The coverage decision was based on the Food and Drug Administration (FDA) approval as a Humanitarian Device Exemption.

Measurement of Serum Levels and Antibodies to REMICADE (infliximab) and HUMIRA (adalimumab) (MP9464) Prior authorization is required and testing must be ordered by a board certified gastroenterologist experienced in the treatment of inflammatory bowel disease. The testing must be performed by an approved lab provider. Therapeutic drug monitoring is medically necessary to guide adjustments to therapy for a member who has lost response to treatment.

Refractive and Therapeutic Keratoplasty (MP9461) The correction of surgically induced astigmatism with a corneal relaxing incision (including limbal relaxing incisions) or corneal wedge resection is considered medically necessary if the member had previous corneal transplant (penetrating keratoplasty) within the past 60 months or cataract surgery within the last 36 months. Therapeutic procedures may also be approved if section 2.0 criteria are met. Procedures on the eye that are primarily refractive in nature

or that are primarily to compensate for the native refractive error of the eye are considered not medically necessary. The medical policy indicates types of procedures which are considered not medically necessary.

Review and Assessment of New Technologies and Services

Non-Covered Medical Procedures and Services (MP9415) The Medical Directors reviewed the following services or procedures: Dynamic musculoskeletal ultrasound for all indications, including screening, diagnosis and/or monitoring of low back pain or other neuromusculoskeletal conditions. Magnetic Resonance Imaging (MRI) transrectal ultrasonography (TRUS) fusion guided biopsy for the diagnosis of prostate cancer. Hormone salivary testing for the screening, diagnosis, and/or monitoring of aging and menopause. These are all considered experimental/investigational, and are therefore non-covered.