“What’s New” Medical Policy Updates May 2017

Listed below are the recent changes made to policies within the Geisinger Health Plan Medical Policy Portfolio during the month of April that will become effective June 15, 2017 (unless otherwise specified). The Plan uses medical policies as guidelines for coverage decisions made within the insured individuals written benefit documents. Coverage may vary by line of business and providers and members are encouraged to verify benefit questions regarding eligibility before applying the terms of the policy.

MP81 Chelation Therapy - REVISED – (Revised Language; Added Exclusion)

Guideline for utilization of chelation therapy
Chelation therapy will be considered medically necessary when the member’s laboratory values meet or exceed the following levels:
Arsenic:
- 24 hr urine greater than 50 mcg/L or greater than 100 mcg/24 hr. collection.

Lead
- Whole blood greater than 45 mcg/dl (pediatric and adult)
- Whole blood greater than 25 mcg/dl (pediatric)

EXCLUSIONS:
Chelation therapy for the treatment of toxicity from dental amalgam fillings is considered experimental, investigational or Unproven and is NOT COVERED. There is insufficient evidence to confirm an association between amalgam fillings and systemic symptoms and disorders.

MP97 Genetic Testing for BRCA - REVISED – (Revised Language, Indications, Exclusions)

Individuals Members without a personal history of breast cancer, ovarian cancer/fallopian tube/primary peritoneal cancer, or pancreatic adenocarcinoma, but with a known mutation in a cancer susceptibility gene within the family, or with a family history of any of the following:

First or second-degree blood relative with a history of breast cancer diagnosed at 45 years or younger
5. First or second-degree blood relative with a history of male breast cancer

EXCLUSIONS:
- Genetic testing for BRCA1 or BRCA2 mutations on those less than 18 years of age is considered experimental, investigational, and unproven.
- Testing of unaffected family members in the absence of a known BRCA1 or BRCA2 mutation in the family is considered not medically necessary.
- Testing of unaffected individuals with no significant family history of cancer or no known genetic mutations in the family is considered not medically necessary.
- Genetic testing to assess the risk breast or prostate cancer in men without breast cancer is considered experimental, investigational, and unproven.
- The use of BRCA Analysis Rearrangement Test (BART) for the purpose of screening in the general population is considered experimental, investigational, and unproven.
- The use of CHECK2 testing is considered experimental, investigational, and unproven.

MP212 Non-Contact low-frequency Ultrasound Management (MIST Therapy) - REVISED – (Added CMS Limitation)

LIMITATIONS FOR MEDICARE BUSINESS SEGMENT ONLY:
Per CMS, low frequency, non-contact, non-thermal ultrasound (MIST Therapy) must be provided 2-3 times per week to be considered "reasonable and necessary."

Observable, documented improvements in the wound(s) should be evident after 2 weeks or 6 treatments. Improvements would include documented reduction in pain, necrotic tissue, or wound size or improved granulation tissue.

Medicare will cover up to 6 weeks or 18 treatments with documented improvements of pain reduction, reduction in wound size, improved and increased granulation tissue, or reduction in necrotic tissue. Continued treatments beyond 18 sessions per episode of treatment will be considered only upon individual consideration.

MP293 Intrathecal Infusion Pump - REVISED – (Combined MP298 w/ MP 293)

DESCRIPTION:
An implantable infusion pump that is intended to provide long-term, continuous or intermittent infusion of pain medication or anti-spasmodic medication for the treatment of severe and chronic pain.

Intrathecal Infusion Pump

INDICATIONS: Requires Prior Medical Director or designee Authorization

The intrathecal infusion pump is used as a last resort to treat chronic intractable pain. An intrathecal infusion pump for administration of opioid medication for long term use is considered medically necessary when all of the following criteria are met:

1. For the treatment of severe, chronic, intractable and disabling pain with one of the following diagnoses:
   a. Advanced primary or metastatic carcinoma
   b. CRPS Type I or Type II refractory to other treatments
   c. Postherpetic neuralgia
   d. Failed back surgery
   e. Phantom limb pain
   f. Arachnoiditis
   g. Spinal cord myopathy/myelopathy
   h. Complex/severe vertebral compression fractures

   And

2. An evaluation must be done by a multi-disciplinary team, which must include a psychological evaluation that states there are no behavioral health contraindications, and

3. Documented failure or contraindication to physical therapy or chiropractic care. There must be documentation of a minimum of 4 weeks of physical therapy or chiropractic care at least 2 times per week for the four weeks (minimum of 8 visits) within one year of the request for injections. The therapy MUST be associated with the body area that will be treated with the requested injections. A home exercise program is not an adequate substitute for formal physical therapy or chiropractic care. If the provider indicates the member cannot do physical therapy or chiropractic care due to pain, the provider must submit documentation from an evaluating physical therapist or chiropractor dated within 4 weeks of the request indicating the member cannot tolerate therapy services. Please note that one visit for injection to allow the member to attend therapy is not considered medically necessary. Please also note that completion of less than the minimum number of therapy or chiropractor visits due to non-compliance is not an acceptable alternative to this requirement in the absence of documentation the member was unable to tolerate therapy services, and
4. Documented failure or contraindication to pharmacologic therapy. There must be documentation of the use of at least three (3) classes of medications from the following list of medication classes must be submitted for review: NSAIDs, opiates, non-opioid analgesics, anti-epileptic medications used for treatment of chronic pain, antidepressant medications used for treatment of chronic pain, ASA or ASA derivatives, muscle relaxants, steroids, such as prednisone or Medrol or documented contraindication to each of these drug classes; and
5. Documented failure or contraindication to nerve blocks/epidural injections; and
6. Documented failure or contraindication to surgical intervention; and
7. A preliminary trial of opioid administration via intrathecal/epidural catheter or via epidural injections with opioids with a noted reduction of at least 50% of the pain symptoms with minimal side effects. NOTE: The preliminary trial also requires prior authorization and must meet criteria 1, 2 and 3.

CONTRAINDICATIONS:
1. Severe spinal stenosis with intraspinal obstruction
2. Physical addiction to opioid medications
3. Infection
4. Pain that is primarily psychogenic in nature

EXCLUSIONS:
The Plan does NOT provide coverage for intrathecal infusion pump for any other indication not listed because it is considered experimental, investigational or unproven.

Intrathecal Infusion Pump for Administration of Anti-Spasmodic Agents

DESCRIPTION:
An implantable infusion pump that is intended to provide long-term, continuous or intermittent anti-spasmodic infusion. Baclofen is used as a skeletal muscle relaxant to relieve spasticity of the spine or cerebral region.

MP298 Intrathecal Infusion Pump for Anti-Spasmodic Medications – RETIRED (See MP293)

MP315 Esophageal Sphincter Augmentation - NEW POLICY

DESCRIPTION: LINX is an FDA-approved magnetic sphincter augmentation device composed of a series of magnets set in titanium casing and connected by titanium wires laparoscopically implanted to augment lower esophageal function in patients with gastroesophageal reflux disease refractory to nonsurgical medical therapy and maximized pharmacologic therapy. The magnetic sphincter augmentation device is an alternative to Nissen fundoplication which is an irreversible creation of a non-physiologic sphincter that prohibits belching and vomiting.

INDICATIONS: REQUIRES PRIOR AUTHORIZATION BY A PLAN MEDICAL DIRECTOR OR DESIGNEE
Magnetic esophageal sphincter augmentation is considered medically necessary when all of the following criteria are met:

- The member has medical record documentation of a diagnosis of GERD; and
- Medical record documentation that disease is refractory to:
  - Documented reasonable attempts at weight loss if BMI ≥30
  - Diet modification
  - maximized PPI treatment
• Disease requires long-term therapy; and
• Pre-operative manometry has eliminated the diagnosis of achalasia or scleroderma-like esophagus; and
• Ambulatory pH monitoring has been completed in members without evidence of erosive esophagitis

EXCLUSIONS:
This service is currently considered to be non-covered for Medicaid business segment.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

The following policies have been reviewed with no change to the policy section. Additional references or background information was added to support the current policy.

MP37 Home Phlebotomy Program
MP39 Home Uterine Monitoring
MP44 Aquatic Therapy
MP46 Progressive Stretch Devices
MP62 TMLR
MP76 HH/DME Hyperbilirubinemia
MP127 Prolotherapy
MP133 Meniscal Allograft
MP165 Treatment of Vestibular Disorders
MP198 Pulse Oximetry for Pediatric Home Use
MP263 Minimally Invasive Lumbar Decompression (MILD)