Medical Policy Updates

Highlights of recent medical policy revisions, as well as any new medical policies approved by WellFirst Health Medical Policy Committee, are listed below. The Medical Policy Committee meetings take place monthly. As always, we appreciate the expertise by medical and surgical specialists during the technology assessment of medical procedures and treatments.

To view WellFirst Health medical policies, visit wellfirstbenefits.com ➤ select the Providers link at the top of the web page ➤ Medical Management. From the Medical Management page, click the Medical policies link located under the WellFirst Health policies section. The document library is updated as the medical policies become effective. For questions regarding any medical policy or if you would like copies of a complete medical policy, please contact our Customer Care Center at **866-514-4194**.

All other WellFirst Health clinical guidelines used by the Health Services Division, such as MCG (formerly known as Milliman) and the American Society of Addiction Medicine, are accessible to the provider upon request. To request the clinical guidelines, contact the Health Services Division at **800-356-7344, ext. 4012**.

Medical policy updates are published alongside our quarterly newsletters. The Summer 2022 Provider News is published on the WellFirst Health Provider news page at wellfirstbenefits.com/providers/news. Please call the Customer Care Center at **866-514-4194** if you have questions about accessing our newsletters

General Information

Coverage of any medical intervention discussed in a WellFirst Health medical policy is subject to the limitations and exclusions outlined in the member's benefit certificate and applicable state and/or federal laws. A verbal request for a prior authorization does not guarantee approval of the prior authorization or the services. After a prior authorization request has been reviewed in the Health Services Division, the requesting provider and member are notified. Note that prior authorization through the WellFirst Health Health Services Division is required for some treatments or procedures.

Prior authorization requirements for self-funded plans (also called ASO plans) may vary. Please refer to the member's Summary Plan Document or call the Customer Care Center number found on the member's card for specific prior authorization requirements.

For radiology, physical medicine (PT/OT) and musculoskeletal surgery prior authorizations, please contact National Imaging Associates (NIA) Magellan.

Radiology

Providers may contact NIA by phone at **866-307-9729**, Monday-Friday from 7 a.m. to 7 p.m. CST or via **RadMDSupport@MagellanHealth.com**. View details about the radiology prior authorization program.

Physical Medicine

Providers can contact NIA by phone at **866-307-9729** Monday-Friday from 7 a.m. to 7 p.m. CST or by email at **RadMDSupport@MagellanHealth.com**. View details about the physical medicine prior authorization program.

Musculoskeletal

Providers can contact NIA by phone at **866-307-9729** Monday-Friday from 7 a.m. to 7 p.m. CST or by email at **RadMDSupport@MagellanHealth.com**. View details about the musculoskeletal prior authorization program.

Newsletters are published on the WellFirst Health Provider news page at wellfirstbenefits.com/Providers/Provider-news. Please call the Customer Care Center at **866-514-4194** if you have questions about accessing the updates.

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Medical Policy Updates

This section includes links to the online medical policy documents when they are available. The online Document Library contains current medical policies and, at times, may also include those with future effective dates. To verify when a policy is or will be in effect, please refer to the effective date listed at the end of policy documents.

Medical Policies Retired

Effective January 1, 2023:

Micra Permanent Leadless Pacemaker MP9518

Effective March 1, 2023:

the following policies have been replaced by new genetic testing medical polices, developed by our contracted vendor Concert Genetics.

Genetic Testing for Hereditary Cardiac Disease and Arrhythmias MP9472

Genetic Testing for Thrombophilia MP9473

Genetic Testing for High-Penetrance Breast and/or Epithelial Ovarian Cancer Susceptibility MP9478

Genetic Testing for Pharmacogenetics MP9479

Genetic Testing for Polyposis MP9482

Genetic Testing for Multiple Endocrine Neoplasia Syndrome, Type 1 and Type 2 MP9483

Genetic Testing for Diffuse Gastric Cancer, Hereditary MP9484

Genetic Testing for Lynch Syndrome MP9487

Genetic Testing for Cowden Syndrome MP9488

Genetic Testing for Chromosomal Microarray Analysis MP9491

Genetic Testing for Neurologic Disorders MP9497

Genetic Testing for Stickler Syndrome MP9504

Genetic Testing for Ehlers-Danlos Syndrome and Ankylosing Spondylitis MP9505

Genetic Testing for Marfan Syndrome MP9506

Maturity Onset Diabetes of the Young Sequencing Panel MP9507

Genetic Testing for Hereditary Cancer Susceptibility MP9521

Genetic Testing for Hereditary Hemorrhagic Telangiectasia MP9524

Genetic Testing for Familial Hypercholesterolemia MP9525

Genetic Testing for Birt-Hogg-Dube Syndrome MP9527

Genetic Testing for Focal Segmental Glomerular Sclerosis MP9543

Whole Exome and Whole Genome Sequencing MP9548

Effective April 1, 2023:

The following policies will be replaced by the new genetic testing medical policies, developed by our contracted vendor Concert Genetics:

Genetic Testing MP9012

Genetic Testing for Somatic Tumor Markers MP9486

Effective May 1, 2023:

Acne MP9023

Transcatheter Pulmonary Valve Implantation (Melody Valve) MP9440

Percutaneous Mitral Valve Repair (MitraClip) MP9500

Medical Policies Prior Authorization Removed

Effective March 1, 2023:

Pectus Excavatum and Pectus Carinatum MP9206

Effective May 1, 2023:

Cardiac Event Monitor Devices and Cardiac Procedures MP9540

Procedures and Devices – Experimental and Investigational – Non-covered

Effective January 1, 2023:

Non-covered Medical Procedures and Services MP9415

- Assistive algorithmic ECG risk-based assessment for cardiac dysfunction
- Cardiac focal ablation utilizing radiation therapy for arrhythmia
- Gastrointestinal monitoring system (e.g., SmartPill, G-tech Wireless Patch System)
- Quantitative pupillometry
- Therapeutic induction of intra-brain hypothermia for the treatment of concussion and all other indications
- Transcutaneous auricular neurostimulation for the treatment of pain associated with opioid withdrawal

Effective February 1, 2023:

Non-covered Medical Procedures and Services MP9415

- Shoulder arthroscopy with implantation of subacromial spacer
- Three-dimensional printed anatomic modeling for surgical planning

Products for Wound Healing MP9287

- Electrical or electromagnetic stimulation for chronic wound healing

Effective April 1, 2023:
Non-covered Medical Procedures and Services MP9415

- Compounded, nebulized intranasal antibiotics/antifungals for the treatment of sinusitis
- Orthotrac pneumatic vest for low back pain
- Vaginal tactile imaging for biochemical mapping
- VivAer airway remodeling for airway obstruction

Effective May 1, 2023:
Lab Testing MP9539

- Testing for neutralizing antibodies to interferon beta in the management of multiple sclerosis

Procedures and Devices – Medically Necessary

Effective March 1, 2023:

- Foot adductus positioning device

New Medical Policy

Services listed for policies in this section may be covered (considered medically necessary) or noncovered (considered experimental and investigational).

Effective March 1, 2023:
Treatment of Obstructive Sleep Apnea (OSA) and Related Conditions with Invasive Treatments and Surgery MP9585

Prior authorization is required for uvulopalatopharyngoplasty and implanted hypoglossal nerve stimulation. The following procedures are considered experimental and investigational, and therefore not medically necessary (not an all-inclusive list): uvulopalatoplasty for sleep disorders, including radio-frequency uvulopalatoplasty and laser assisted uvulopalatoplasty; nasal expiratory positive airway pressure (e.g., Provent®), radiofrequency volumetric tissue reduction and tongue-based suspension surgery.

Rare Disease and System Specialty Specific New Genetic Testing Medical Policies

Effective March 1, 2023, WellFirst Health implemented new genetic testing medical polices for rare diseases and system specific conditions, expanding the Health Plan's coverage of testing for these diseases and conditions. The new medical policies were developed by our contracted vendor Concert Genetics, an industry-leader in genetic testing technology assessment and policy development. As genetic testing has increasingly become the standard of care, the Health Plan is committed to the access and quality of these services for our members. The implementation of these policies is a continuation of the Health Plan's partnership with Concert Genetics.

Providers are strongly encouraged to review applicable policies before ordering a test to understand if prior authorization is required and, even if not, to review criteria that may affect decisions at the time testing is ordered.

The new policies include a list of applicable codes that are available to us through our partnership with Concert Genetics. The submission of accurate and specific codes on claims is critical for services to be payable. Claims will be denied in the absence of an applicable diagnosis and procedure code(s).

Medical Policies for Rare Diseases Genetic Testing

Effective March 1, 2023:

The following are new genetic testing medical policies for rare diseases:

Exome and Genome Sequencing for the Diagnosis of Genetic Disorders MP9586

Prior authorization is required, as described in the medical policy.

Multisystem Inherited Disorders, Intellectual Disability, and Developmental Delay MP9587

Prior authorization is not required.

Medical Policies for System Specialty Specific Genetic Testing

Effective March 1, 2023:

The following are new genetic testing medical policies for system specialty specific conditions. Prior authorization is not required.

Aortopathies and Connective Tissue Disorders MP9588

Cardiac Disorders MP9589

Dermatologic Conditions MP9590

Epilepsy, Neurodegenerative and Neuromuscular Disorders MP9591

Eye Disorders MP9592

Gastroenterologic Disorders (Non-Cancerous) MP9593

Hearing Loss MP9594

Hematologic Conditions (Non-Cancerous) MP9595

Hereditary Cancer Susceptibility MP9596

Immune, Autoimmune, and Rheumatoid Disorders MP9597

Kidney Disorders MP9598

Lung Disorders MP9599

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Metabolic, Endocrine and Mitochondrial Disorders MP9600

Pharmacogenetics MP9602

Skeletal Dysplasia and Rare Bone Disorders MP9603

New Medical Policies for Oncology Genetic Testing

Effective April 1, 2023, WellFirst Health is implementing new medical policies for oncology genetic testing which were developed by our contracted vendor Concert Genetics. Prior authorization is not required; however, an appropriate diagnosis code must be on the claim. Claims will be denied in the absence of a covered diagnosis or procedure code(s) or if the coverage criteria are not met. Policies include Current Procedural Terminology (CPT) codes for informational purposes only, and may be subject to change without notice. Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement.

Algorithmic Testing MP9605

Cancer Screening MP9606

Cytogenetic Testing MP9607

Molecular Analysis of Solid Tumors and Hematologic Malignancies MP9608

Circulating Tumor DNA and Circulating Tumor Cells (Liquid Biopsy) MP9609

Effective April 1, 2023:
General Approach to Genetic Testing MP9610

Genetic Testing Payment Policy MP9584

Information regarding codes and billing for genetic and molecular testing services.

Prior Authorization and Claim Submissions for Genetic Testing

For services requiring prior authorization, providers are to continue submitting prior authorization requests through the WellFirst Health Provider Portal. Providers without portal access may fax the Genetic Testing prior authorization to the phone number on the form. Additionally, providers are to continue submitting claims to the Health Plan in the same way they do currently.

New Medical Policies for Transplantation

Effective April 1, 2023, transplant evaluation, transplantation, or retransplantation requires prior authorization. Refer to the Member Certificate or Summary Plan Description for coverage.

Bone Marrow or Stem Cell (Peripheral or Umbilical Cord) Transplantation MP9611

Heart/Lung Transplantation MP9612

Heart Transplantation (Adult and Pediatric) MP9613

Liver Transplantation MP9614

Lung Transplantation MP9615

Pancreas Transplantation (Pancreas Alone) MP9616

Pancreas-Kidney (SPK, PAK) Transplantation MP9617

Intestinal Transplantation MP9618

Effective May 1, 2023:
Proton Beam Radiation Therapy (PBRT) MP9619

Refer to the medical policy for criteria and documentation requirements. Prior authorization is not required.

Enhanced External Counterpulsation (EECP) MP9620

The use of an FDA approved enhanced external counterpulsation device is considered medically necessary when the member: has disabling chronic stable angina (Grade III or IV); is on maximal medical therapy and disease is not readily amenable to surgical interventions. Prior authorization is not required.

Real-Time Mobile Cardiac Outpatient Telemetry (RT-MCOT) MP9621

RT-MCOT is considered medically necessary if symptoms suggest a potentially significant cardiac event or condition. Prior authorization is not required when ordered in the emergency room.

Quantitative Electroencephalogram (qEEG) and Referenced Electroencephalogram (rEEG) MP9622

Quantitative electroencephalogram (brain mapping) is considered medically necessary for the evaluation of epilepsy; detection of acute, intracranial-surgery related complications; member is symptomatic for possible cerebrovascular disease when neuroimaging and standard EEG analysis remain inconclusive; and evaluation of encephalopathy or dementia when the diagnosis is unresolved. Prior authorization is not required.

Transcatheter Heart Valve Replacement and Repair Procedures MP9623

Transcatheter aortic valve replacement, percutaneous pulmonary valve implantation (Melody valve), or transcatheter mitral valve leaflet repair (MitraClip) using an FDA-approved system according to FDA-approved indications is considered medically necessary. Prior authorization is not required.

Sacral Nerve Stimulation (SNS) MP9624

Sacral nerve stimulation is considered medically necessary for the treatment of: chronic urinary urge incontinence; non-obstructive urinary retention; urge/frequency syndrome and fecal incontinence in adults after a thorough diagnostic work-up. Treatment of fecal incontinence in children is considered experimental and investigational, and therefore not medically necessary.

Transcatheter Closure of Cardiac Defects MP9625

Transcatheter closure of atrial septal defect, ventricular septal defect, patent ductus arteriosus and patent foramen ovale is considered medically necessary if FDA indications are met and an FDA approved device is used. Criteria does not apply to those devices which have been granted a humanitarian device exemption by the FDA. Prior authorization is not required.

Medical Policy Revisions

Services listed for policies in this section may be covered (considered medically necessary) or noncovered (considered experimental and investigational).

Effective January 1, 2023:

Limb Prosthesis MP9103

Robotic (powered) lower body exoskeleton (e.g., ReWalk, C-Brace, Indigo exoskeleton device) is considered experimental and investigational, and therefore not medically necessary.

Traction for Cervical Pain, Home Use MP9302

Ambulatory and gravity assisted traction devices are considered experimental and investigational, and therefore not medically necessary.

Glaucoma Surgery Devices and Minimally Invasive Glaucoma Surgery (MIGS): Microstent Implantation MP9467

Microstent implantation of iStent Trabecular Micro-Bypass, iStent inject, or Hydrus Microstent are considered medically necessary when used according to FDA label indications and policy criteria is met. Prior authorization is not required.

Urethral Bulking Agents for Urinary Incontinence MP9475

FDA approved urethral bulking agents approved for stress incontinence are considered medically necessary when all of the following are met: incontinence is due to sphincter deficiency or congenital abnormalities; failure of at least one conservative treatment; and agent is being used as a second-line treatment. Prior authorization is not required.

Transcranial Magnetic Stimulation (TMS) MP9526

TMS is considered experimental and investigational, and therefore not medically necessary for neurological conditions: epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, history of repetitive or severe head trauma, neurodevelopmental disorders or central nervous system primary or secondary tumors. TMS is also considered experimental and investigational, and therefore not medically necessary for: amyotrophic lateral sclerosis, tinnitus, migraine and fibromyalgia. Prior authorization is required.

Lab Testing MP9539

Salivary hormone testing for aging and/or menopause is considered experimental and investigational, and therefore not medically necessary for all indications, including evaluation of preterm labor, aging, menopause, or to monitor outcomes of hormonal replacement therapy.

Cardiac Monitoring Devices and Cardiac Procedures MP9540

Non-invasive measurement of left ventricular end diastolic pressure (e.g., VeriCor System) is considered experimental and investigational, and therefore not medically necessary.

Effective February 1, 2023:

Blood Coagulation Home Testing Devices MP9263

Home testing devices are considered medically necessary for long-term (more than 6 months) or lifelong oral anticoagulation therapy for: post-heart valve replacement, recurrent DVT and chronic atrial fibrillation. Prior authorization is not required.

Effective March 1, 2023:

Sleep Studies: Unattended (Home) Sleep Studies and Attended Nocturnal Polysomnography (NPSG), Multiple Sleep Latency Testing and Maintenance of Wakefulness Testing MP9132

Unattended sleep studies are limited to one night or day (if shift worker) sleep cycle. The initial supervised (attended) full-channel NPSG for pediatric members (under age 18) performed in a healthcare facility using a Type 1 device, including split-night studies, require prior authorization. One supervised NPSG per lifetime is allowed for adult or pediatric members to evaluate the presence of obstructive sleep apnea for members with a diagnosis of any of the following: neuromuscular disorder which significantly increases risk (e.g Down's Syndrome, Prader Willi, myelomeningocele) or cranial facial anomalies which impair the upper airway, such as those which cause midface hypoplasia, retrognathia or micrognathia.

Treatment of Obstructive Sleep Apnea (OSA) and Related Conditions – CPAP, APAP, BiPAP and Oral Devices MP9239

Home use of Bilevel Positive Airway Pressure (BiPAP) for conditions other than OSA, with or without a backup rate, requires prior authorization and is covered for confirmed sleep-associated hypoventilation. Home use of BiPAP with average volume assured pressure support (AVAPS) requires prior authorization and is considered medically necessary for confirmed severe, chronic hypoventilation due to inadequate breath-to-breath tidal volume maintenance with standard BiPAP.

Clinical Trials (Clinical Trial Participation) MP9447

Coverage of routine patient care costs for a qualified member participating in an approved clinical trial requires prior authorization. In association with an approved clinical trial, routine or standard patient care is covered including all health care services and items and drugs for the treatment of the life-threatening disease that are consistent with the usual and customary standard of care (e.g., professional services, hospital services, laboratory tests, x-rays and other imaging). Services not covered: the investigational item, device, service or drugs that are the subject of the clinical trial; items and services that are provided solely to satisfy data collection and/or analysis needs that are not used in the direct clinical management of the member, (e.g., the cost of data collection and record keeping, research physician and/or clinician time and result analysis costs).

Liver and Other Neoplasm – Chemoembolization and Radioembolization for Hepatic Tumors (TheraSphere or SIR-Spheres) MP9462

Radioembolization for hepatic tumors with intra-hepatic microspheres is considered medically necessary for unresectable metastatic liver tumors from uveal melanoma. Prior authorization is not required.

Gender Reassignment (Gender Affirmation) Procedures MP9465

The policy was retitled. See Member Certificate or Summary Plan Description for additional information regarding services available for coverage. All gender reassignment surgeries require prior authorization.

Neuropsychological Testing MP9493

Testing requires prior authorization and is considered medically necessary for any of the following, where initial assessment or assessment over time is needed (not an all-inclusive list):

- Measurement of cognitive or behavioral deficits related to known or suspected CNS impairment, trauma, or neuropsychiatric disorders
- Establish a treatment plan by measuring functional abilities/impairments in individuals which known or suspected CNS and neuropsychiatric disorders
- Determine the potential impact of substances that may cause cognitive impairment or result in measurable improvement in cognitive function
- Conduct pre-surgical or treatment-related measurement of cognitive function to determine whether one might safely proceed with a medical or surgical procedure that may affect brain function
- Determine through measurement of cognitive abilities when a member's condition impairs their ability to comprehend and participate effectively in treatment regimens
- Design, administer and/or monitor outcomes of cognitive rehabilitation procedures
- Measure cognitive or functional deficits in children and adolescents based on inability to develop expected knowledge, skills or abilities as required to adapt to cognitive, social, emotional or physical demands
- Evaluate primary symptoms of impaired attention and concentration that may occur in neurological and psychiatric conditions

Effective May 1, 2023:

Plastic and Reconstructive Surgery MP9022

Skin resurfacing or procedures to improve the appearance of the skin (including dermabrasion, chemical peel, collagen injection, cryotherapy, or chemical exfoliation) are considered not medically necessary.

The following procedures require prior authorization:

- Scar revision treatments to improve or restore normal bodily function. Revision is incidental to or follows surgery resulting from injury, sickness or other disease of the skin.
- Initial or repeat panniculectomy
- Initial or repeat abdominoplasty
- Rhinoplasty when performed with or without septoplasty
- Otoplasty including congenital ear deformity
- Liposuction for the treatment of lymphedema or lipedema

Hyperbaric (HBO) and Topical Oxygen Therapy MP9055

Policy was retitled. Prior authorization is not required. The Undersea and Hyperbaric Medicine Society criteria are used. Topical oxygen therapy is considered experimental and investigational, and therefore not medically necessary.

Spinal Cord or Dorsal Column Stimulation and Dorsal Root Ganglion Stimulation MP9430

Spinal cord or dorsal column stimulation permanent placement requires prior authorization. A trial or removal without intended reoperation or reimplantation does not require prior authorization. Trials are required to be at least three days with a pain reduction of 50% or more. A psychiatric/psychological evaluation is required within twelve months of the procedure.

Magnetic Esophageal Ring for the Treatment of Gastroesophageal Reflux Disease (GERD) (LINX) Reflux Management System MP9471

LINX is considered medically necessary for members with: abnormal pH study or endoscopy has identified Los Angeles Classification System Grade A or B esophagitis, GERD is refractory (failed proton pump inhibitor therapy) and other nonsurgical treatments have been trialed and failed. Prior authorization is required.

Cardiac Event Monitors and Cardiac Procedures MP9540

The following cardiac monitors are considered medically necessary for the detection of cardiac arrhythmias: Holter monitor, patch cardiac rhythm monitor (ZIO Patch) and external loop recorder/external intermittent cardiac event monitor. An implantable loop cardiac recorder is considered medically necessary for unexplained symptoms suggestive of cardiac arrhythmias, post-cardiac ablation monitoring, history of cryptogenic stroke or transient ischemic attack. Prior authorization is not required.