Protocol

Medical Services Protocol Updates

Distribution Date: **September 1, 2017**

The following Medical Protocol update includes information on protocols that have undergone a review over the last several months as part of an annual review, or an additional review in order to make changes. The annual review may have resulted in a revision to the guidelines or no changes at all. Two new protocols have been added and none have been archived.

Please note that portions of this protocol update may not pertain to the members to whom you provide care.

Protocol Revision Summary

The effective date of these changes is October 1, 2017 unless otherwise indicated:

Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions

Changes:

- One investigational policy statement addressing treatment of focal articular cartilage lesions with decellularized osteochondral allograft plugs (e.g., Chondrofix) was added;
- One investigational policy statement addressing treatment of focal articular cartilage lesions with reduced osteochondral allograft discs (e.g., ProChondrix, Cartiform) was added.

Genetic and Protein Biomarkers for the Diagnosis and Cancer Risk Assessment of Prostate Cancer

Change:

- Prostate Health Index (PHI) was added as a test, which is considered investigational for the diagnosis of prostate cancer.

Medicare Advantage changes:

- A medically necessary policy statement was added that provides criteria for PCA3 testing;
- Two not medically necessary policy statements were added addressing PCA3 testing when a biopsy is planned and addressing all other indications for PCA3.

Genetic Testing for Alzheimer Disease

Changes:

- A medically necessary policy statement with criteria was added to address targeted genetic testing for a known familial variant in the presenilin genes (PSEN) or amyloid-beta precursor protein (APP) gene associated with autosomal dominant early onset Alzheimer's disease;
- A medically necessary policy statement with criteria was added to address genetic testing for variants in presenilin genes (PSEN) or amyloid-beta precursor protein (APP) gene associated with autosomal dominant Alzheimer's disease;
- The investigational policy statement was adjusted to accommodate the above changes.

Medicare Advantage change:

- A not medically necessary policy statement was added addressing genetic testing for APOE.

Genetic Testing for Duchenne and Becker Muscular Dystrophy
Change:

- An additional criterion was added to the medically necessary policy statement addressing at-risk male offspring to confirm or exclude the need for medical and cardiac surveillance.

Medicare Advantage change:

- One not medically necessary statement was added for genetic testing for DMD gene variants.

Genetic Testing for Mitochondrial Disorders
Changes:

- The criteria for the medically necessary policy statement were simplified to include only that "the testing may eliminate the need for muscle biopsy";
- The investigational policy statement addressing expanded panel testing has been eliminated.

Medicare Advantage Change:

- A not medically necessary policy statement has been added addressing genetic testing for mitochondrial disorders.

Homocysteine Testing in the Screening, Diagnosis, and Management of Cardiovascular Disease
Changes:

- The title was changed to Homocysteine Testing in the Screening, Diagnosis, and Management of Cardiovascular Disease and Venous Thromboembolic Disease;
- The position of the policy statement addressing measurement of plasma levels of homocysteine in the screening, evaluation, and management of patients for cardiovascular disease changed from investigational to not medically necessary;
- An investigational policy statement was added addressing measurement of plasma levels of homocysteine in the screening, evaluation, and management of patients with venous thromboembolism or risk of venous thromboembolism.

Image-Guided Minimally Invasive Lumbar Decompression for Spinal Stenosis
Changes:

- The title was changed to Image-Guided Minimally Invasive Decompression for Spinal Stenosis;
- The investigational policy statement replaced the phrase *lumbar decompression* with the phrase *spinal decompression.*

Interspinous and Interlaminar Stabilization/Distraction Devices (Spacers)
Change:

- One investigational policy statement addressing interspinous distraction devices was clarified by including interlaminar distraction devices, defining the circumstance as a stand-alone procedure and replacing the phrase *neurogenic intermittent claudication* with the phrase *spinal stenosis*.

Medicare Advantage change:

- The medically necessary policy statement has been removed.

Intraoperative Neurophysiologic Monitoring (Sensory-Evoked Potentials, Motor-Evoked Potentials, EEG Monitoring)
Changes:

- The title has changed to Intraoperative Neurophysiologic Monitoring;
- One medically necessary policy statement with criteria was added addressing intraoperative neurophysiologic monitoring of the recurrent laryngeal nerve during high-risk thyroid, parathyroid, and anterior cervical spine surgeries;

- One investigational policy statement was added for situations not meeting the new medically necessary criteria.

Molecular Analysis for Targeted Therapy of Non-Small-Cell Lung Cancer
Change:

- One medically necessary policy statement was added addressing analysis for the T790M mutation in the gene for the EGFR as a technique to predict treatment response to osimertinib (Tagrisso™) in patients who have progressed on or after EGFR-TKI therapy.

Percutaneous Vertebroplasty and Sacroplasty
Change:

- One medically necessary policy statement was added addressing percutaneous vertebroplasty as a treatment for symptomatic osteoporotic vertebral fractures that are less than six weeks in duration and that have led to hospitalization or persist at a level that prevents ambulation.

Spinal Cord Stimulation
Changes:

- There is a change to the medically necessary policy statement so that it now addresses "standard or high-frequency stimulation" instead of "standard (non-high-frequency stimulation)";
- One investigational policy statement was added addressing wireless injectable dorsal root ganglion neurostimulation as a treatment of severe and chronic pain of the trunk or limbs;
- The investigational policy statement addressing high-frequency spinal cord stimulation as the treatment of severe and chronic pain of the trunk or limbs was struck.

Treatment of Tinnitus
Changes:

- A medically necessary policy statement was added providing criteria for psychological coping therapy;
- The investigational policy statement was adjusted to accommodate the new policy statement.

Wearable Cardioverter Defibrillators (effective date is August 1, 2017)
Changes:

- Medically necessary indications have been added to the policy statement addressing use of wearable cardioverter-defibrillators (WCDs) for the prevention of sudden cardiac death;
- The investigational policy statement was adjusted to accommodate new medically necessary criteria;
- Policy guideline information was added addressing re-assessment and compliance.

New Protocols

The effective date of these new protocols is October 1, 2017:

Miscellaneous Genetic and Molecular Diagnostic Tests

- This protocol addresses miscellaneous genetic and molecular diagnostic tests not addressed in separate protocols;
- There is one investigational policy statement which addresses all thirteen tests listed in this protocol;
- This protocol considers this test or procedure investigational. If the physician feels this service is medically necessary, preauthorization is recommended.

Vestibular Function Testing

- There is one medically necessary policy statement with criteria addressing vestibular function testing using electronystagmography and videonystagmography testing batteries, caloric testing, or rotational chair testing;
- There are two not medically necessary policy statements addressing vestibular function testing for the assessment of typical benign paroxysmal positional vertigo that can be diagnosed clinically and repeat vestibular function testing when treatment resolves symptoms;
- There are three investigational policy statements addressing vestibular function testing in all other situations, vestibular evoked myogenic potential tests, and all other laboratory-based vestibular function tests;
- Preauthorization is not required.

Protocols Reviewed Without Change

Previous effective dates indicated remain accurate for the following:

- Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions
- Automated Percutaneous and Percutaneous Endoscopic Discectomy (Formerly Automated Percutaneous and Endoscopic Discectomy)
- Biofeedback as a Treatment of Headache
- Biventricular Pacemakers (Cardiac Resynchronization Therapy) for the Treatment of Heart Failure
- Bronchial Thermoplasty
- Cognitive Rehabilitation
- Computer-Aided Evaluation of Malignancy With Magnetic Resonance Imaging of the Breast
- Cooling Devices Used in the Outpatient Setting
- Corneal Topography/Computer-Assisted Corneal Topography/Photokeratoscopy
- Diagnosis and Medical Management of Obstructive Sleep Apnea Syndrome
- Drug Testing in Pain Management and Substance Abuse Treatment
- Expanded Molecular Panel Testing of Cancers to Identify Targeted Therapies
- Extracorporeal Shock Wave Treatment for Plantar Fasciitis and Other Musculoskeletal Conditions
- Extracranial Carotid Artery Stenting (Formerly Extracranial Carotid Angioplasty/Stenting)
- Fecal Analysis in the Diagnosis of Intestinal Dysbiosis
- Fecal Microbiota Transplantation
- Genetic Testing for Lactase Insufficiency
- Genetic Testing for Li-Fraumeni Syndrome
- Genetic Testing for Lipoprotein(a) Variant(s) as a Decision Aid for Aspirin Treatment
- Genetic Testing for PTEN Hamartoma Tumor Syndrome
- Genetic Testing for Tamoxifen Treatment
- Hematopoietic Cell Transplantation for Acute Lymphoblastic Leukemia
- Hematopoietic Cell Transplantation for Primary Amyloidosis (Formerly Hematopoietic Stem Cell Transplantation for Primary Amyloidosis)
- Hematopoietic Cell Transplantation in the Treatment of Germ Cell Tumors (Formerly Hematopoietic Stem Cell Transplantation in the Treatment of Germ Cell Tumors)
- Hematopoietic Stem Cell Transplantation for Solid Tumors of Childhood
- Hippotherapy
- Ingestible pH and Pressure Capsule
- Keratoprosthesis

- Laboratory Testing for HIV Tropism
- Laboratory Tests for Heart Transplant Rejection
- Magnetic Resonance-Guided Focused Ultrasound
- Microprocessor-Controlled Prostheses for the Lower Limb
- Multigene Expression Assay for Predicting Recurrence in Colon Cancer
- Oncologic Applications of Photodynamic Therapy, Including Barrett Esophagus
- Orthopedic Applications of Stem Cell Therapy (Including Allografts and Bone Substitutes Used With Autologous Bone Marrow)
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- PathFinderTG® Molecular Testing
- Percutaneous Balloon Kyphoplasty and Mechanical Vertebral Augmentation
- Percutaneous Tibial Nerve Stimulation
- Photodynamic Therapy for Choroidal Neovascularization
- Progenitor Cell Therapy for the Treatment of Damaged Myocardium due to Ischemia
- Prophylactic Mastectomy
- Radioembolization for Primary and Metastatic Tumors of the Liver
- Stem Cell Therapy for Peripheral Arterial Disease
- Surgical Treatment of Femoroacetabular Impingement
- Surgical Treatment of Snoring and Obstructive Sleep Apnea Syndrome
- Temporomandibular Joint Dysfunction
- Thermography
- Whole Gland Cryoablation of Prostate Cancer

The above are brief summaries. Please refer to the protocols posted on our provider website for the details of the updated and new protocols that affect your practice. If you need help finding a specific protocol update, please contact Provider Service.