Protocol

Medical Services Protocol Updates

Distribution Date: **December 1, 2015**

The following Medical Protocol update includes information on protocols that have undergone a review over the last several months for 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. Five new protocols have been added and one has been archived.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 January 1, 2016:

Bariatric Surgery

Medicare Advantage changes:

- Clarification in a medically necessary policy statement for those *who suffer from type II diabetes or life-threatening cardiopulmonary problems such as severe sleep apnea or obesity-related heart disease* to *who suffer from type II diabetes or other comorbidities related to obesity;*
- The medically necessary policy statement related to revisional surgeries was removed.

Chelation Therapy for Off-Label Uses

Change:

- One indication was removed from the investigational policy statement (hypoglycemia).

Computed Tomography Perfusion Imaging of the Brain

Changes:

- A new medically necessary indication was added to select patients with anterior large-vessel stroke for mechanical embolectomy;
- The investigational policy statement was reworded to accommodate the new medically necessary indication;
- Preauthorization is required.

Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency in Multiple Sclerosis

Change:

- Designation in policy statement changed from investigational to not medically necessary.

Diagnosis and Treatment of Sacroiliac Joint Pain

Medicare Advantage change:

- A policy statement was added indicating that radiofrequency ablation is investigational for treatment of sacroiliac joint pain whether performed using traditional, cooled, or pulsed radiofrequency.

Endoscopic Radiofrequency Ablation or Cryoablation for Barrett Esophagus
Change:

- An investigational policy statement was changed to include the clarification *when the above criteria are not met, including but not limited to Barrett's esophagus (*in the absence of dysplasia).

Endovascular Procedures for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)
Changes:

- A new policy statement indicates that the use of endovascular mechanical embolectomy with a device with FDA approval for the treatment of acute ischemic stroke may be considered medically necessary when meeting criteria;
- The investigational policy statement regarding endovascular interventions in the treatment of acute stroke was reworded to accommodate the new medically necessary policy statement.

Facet Joint Denervation
Medicare Advantage change:

- Detail was added to both the medically necessary and investigational policy statements.

General Approach to Evaluating the Utility of Genetic Panels
Change:

- The medically necessary policy statement was extensively reworded.

General Approach to Genetic Testing
Changes:

- Criteria in the medically necessary statement were revised;
- The *Policy Guideline Section* was extensively revised and corresponds with new language in the policy statement.

Genetic Testing for Cardiac Ion Channelopathies
Changes:

- The medically necessary and investigational policy statements for Long QT Syndrome and Catecholaminergic Polymorphic Ventricular Tachycardia were reworded for clarity;
- Under Brugada syndrome, medically necessary policy statements were added for diagnostic genetic testing and for testing of an asymptomatic individual with a known familial mutation. The corresponding investigational policy statement was adjusted to correlate with this change;
- Under Short QT Syndrome, a medically necessary policy statement was added for testing of an asymptomatic individual with a known familial mutation. The investigational policy statement was adjusted to correlate with this change.

Genetic Testing, Including Chromosomal Microarray Analysis and Next-Generation Sequencing Panels, for the Evaluation of Developmental Delay/Intellectual Disability, Autism Spectrum Disorder, and/or Congenital Anomalies
Changes:

- The policy statement for chromosomal microarray analysis (CMA) was changed so that this testing is medically necessary as first-line testing when criteria are met;
- The not medically necessary policy statement for CMA was removed;
- The investigational policy statement for CMA was reworded;

- An indication (congenital anomalies) was added to the investigational policy statement for panel testing with next generation sequencing.

Hyperbaric Oxygen Therapy
Change:

- Fibromyalgia and mental illness (i.e., post-traumatic stress disorder, and generalized anxiety disorder or depression) were added as indications under the investigational policy statement.

Implantable Cardioverter Defibrillator (ICD)
Changes:

- Indications for cardiac ion channelopathies were added in both pediatric and adult medically necessary policy statements;
- An indication was added under the pediatric medically necessary policy statement for hypertrophic cardiomyopathy;
- Medically necessary indications were added for the use of a subcutaneous ICD. The associated investigational policy statement was reworded to accommodate this change.

In Vitro Chemoresistance and Chemosensitivity Assays
Change:

- The policy statement was clarified with the addition of two specific assays which are considered investigational (the ChemoFx assay and the CorrectChemo assay).

Medicare Advantage change:

- The Medicare Advantage medically necessary and investigational policy statements have been removed.

Open and Thoracoscopic Approaches to Treat Atrial Fibrillation (Maze and Related Procedures)
Changes:

- The title was changed to Open and Thoracoscopic Approaches to Treat Atrial Fibrillation and Atrial Flutter (Maze and Related Procedures);
- The medically necessary policy statement was clarified by specifying the maze/modified maze procedure must be performed with concomitant cardiac surgery;
- A policy statement was added to address the use of the maze/modified maze procedure when performed on a non-beating heart during cardiopulmonary bypass without concomitant cardiac surgery as not medically necessary.

Plasma Exchange
Change:

- One indication (neuromyelitis optica [NMO]) was added to the investigational policy statement.

Plugs for Fistula Repair
Changes:

- The title was changed to Plugs for Anal Fistula Repair;
- The policy statement was clarified to indicate biosynthetic fistula plugs are considered investigational for the repair of *anal* fistulas.

Sacral Nerve Neuromodulation/Stimulation
Medicare Advantage change:

- A Medicare Advantage section was added to clarify two fine points of difference between general

business and the Medicare NCD regarding members being refractory to conventional therapy and the need to demonstrate improvement through trial stimulation.

Temporomandibular Joint Dysfunction
Change:

- Physical therapy was removed from the list of non-surgical treatments that are investigational.

Transcranial Magnetic Stimulation as a Treatment of Depression and Other Psychiatric/Neurologic Disorders
Medicare Advantage Changes:

- An indication for the medically necessary statement was added to specify that treatment must be delivered by an FDA approved/cleared device and used as specified in the manufacturers user manual;
- An indication was added in the policy statement to specify that this treatment is not medically necessary for persons with conductive, ferromagnetic or other magnetic-sensitive metals implanted in their head which are non-removable and within 30 cm of the transcranial magnetic stimulation coil.

Transcutaneous Electrical Nerve Stimulation
Medicare Advantage changes:

- The medically necessary criteria for use of a conductive garment were changed by deleting two indications;
- The reference to clinical trials for use in chronic low back pain was removed, as there is no current coverage for clinical trials in this area, and a not medically necessary statement for this application was added.

Treatment of Hyperhidrosis
Changes:

- Table 1, for use as a reference to the medically necessary policy statement regarding treatment of primary hyperhidrosis, was clarified by replacing the phrase “pharmacologic management” with specific medications and indications for use;
- A second medically necessary policy statement was clarified by specifying severe *secondary* gustatory hyperhidrosis as the subject;
- The not medically necessary policy statement was clarified by adding the phrase *any of the above* medical complications.

New Protocols

The effective date of these new protocols is January 1, 2016:

Detection of Circulating Tumor Cells in the Management of Patients With Cancer

- This procedure is considered investigational;
- Preauthorization is not required but recommended if, despite this protocol position, the physician feels the service is medically necessary.

Genetic Testing for CHEK2 Mutations for Breast Cancer

- Genetic testing for CHEK2 mutations is considered investigational;
- Preauthorization is not required but recommended if, despite this protocol position, the physician feels the service is medically necessary.

Panniculectomy and Abdominoplasty

- There is one policy statement with medically necessary criteria for panniculectomy;
- Three not medically necessary policy statements address panniculectomy, abdominoplasty, and diastasis recti repair;
- Preauthorization is required.

Percutaneous Left Atrial Appendage Closure Devices for Stroke Prevention in Atrial Fibrillation

- There is one medically necessary policy statement for the use of an FDA-approved left atrial appendage closure device;
- There are two investigational policy statements;
- Preauthorization is required.

Tumor-Treatment Fields Therapy for Glioblastoma

- Tumor-treatment fields therapy to treat glioblastoma is considered investigational;
- Preauthorization is not required but recommended if, despite this protocol position, the physician feels the service is medically necessary.

Protocols Reviewed Without Change

Previous effective dates indicated remain accurate for the following:

- Allogeneic Hematopoietic Stem-Cell Transplantation for Genetic Diseases and Acquired Anemias
- Ambulance (Emergency)
- Aqueous Shunts and Stents for Glaucoma
- Assays of Genetic Expression in Tumor Tissue as a Technique to Determine Prognosis in Patients With Breast Cancer
- Balloon Ostial Dilation for Treatment of Chronic Sinusitis
- Biofeedback as a Treatment of Urinary Incontinence in Adults
- Blepharoplasty
- Cardiac Rehabilitation in the Outpatient Setting
- Carrier Testing for Genetic Diseases
- Chromosomal Microarray Testing for the Evaluation of Early Pregnancy Loss and Intrauterine Fetal Demise
- Closure Devices for Patent Foramen Ovale and Atrial Septal Defects
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure
- Continuous Passive Motion in the Home Setting
- Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors
- Decompression of the Intervertebral Disc Using Laser Energy (Laser Discectomy) or Radiofrequency Coblation (Nucleoplasty)
- Diagnosis and Management of Idiopathic Environmental Intolerance (i.e., Multiple Chemical Sensitivities) *title was changed* to Diagnosis and Management of Idiopathic Environmental Intolerance and Intracellular Micronutrient Analysis
- DNA-Based Testing for Adolescent Idiopathic Scoliosis
- Dopamine Transporter Imaging With Single-Photon Emission Computed Tomography
- Electrostimulation and Electromagnetic Therapy for Treating Wounds
- Endometrial Ablation
- Endothelial Keratoplasty
- Endovascular Grafts for Abdominal Aortic Aneurysms

- Extracorporeal Photopheresis
- Facet Arthroplasty
- Gastric Electrical Stimulation
- Genetic Cancer Susceptibility Panels Using Next-Generation Sequencing
- Genetic Testing for Alpha-1 Antitrypsin Deficiency
- Genetic Testing for Familial Cutaneous Malignant Melanoma
- Genetic Testing for FMR1 Mutations (Including Fragile X Syndrome)
- Genetic Testing for Hereditary Hearing Loss
- Genetic Testing for Hereditary Hemochromatosis
- Genetic Testing for Inherited Thrombophilia
- Genetic Testing for Rett Syndrome
- Genetic Testing for Statin-Induced Myopathy
- Genetic Testing for the Diagnosis of Inherited Peripheral Neuropathies
- Genetic Testing of CADASIL Syndrome
- Hematopoietic Stem-Cell Transplantation for Autoimmune Diseases
- Hematopoietic Stem Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma and POEMS Syndrome
- Hip Resurfacing
- Implantation of Intrastromal Corneal Ring Segments
- Interspinous Fixation (Fusion) Devices
- Intradialytic Parenteral Nutrition
- Isolated Small Bowel Transplant
- Kidney Transplant
- Lipid Apheresis
- Lung Volume Reduction Surgery for Severe Emphysema
- Magnetoencephalography/Magnetic Source Imaging
- Measurement of Serum Antibodies to Infliximab and Adalimumab
- Meniscal Allografts and Other Meniscal Implants
- Neurofeedback
- Occlusion of Uterine Arteries Using Transcatheter Embolization
- Orthognathic Surgery
- Percutaneous Intradiscal Electrothermal Annuloplasty and Percutaneous Intradiscal Radiofrequency Annuloplasty
- Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux
- Pharmacogenomic and Metabolite Markers for Patients Treated With Thiopurines
- Photodynamic Therapy for Choroidal Neovascularization
- Placental and Umbilical Cord Blood as a Source of Stem Cells
- Pneumatic Compression Pumps for Treatment of Lymphedema and Venous Ulcers
- Preimplantation Genetic Testing
- Prolotherapy
- Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors
- Radiofrequency Ablation of Primary or Metastatic Liver Tumors
- Radioimmunoscintigraphy Imaging (Monoclonal Antibody Imaging) With Indium-111 Capromab Pendetide (ProstaScint®) for Prostate Cancer
- Reconstructive Breast Surgery/Management of Breast Implants
- Saturation Biopsy for Diagnosis and Staging of Prostate Cancer

- Semi-Implantable and Fully Implantable Middle Ear Hearing Aids
- Subtalar Arthroereisis
- Surgical Treatment of Bilateral Gynecomastia
- Transanal Radiofrequency Treatment of Fecal Incontinence
- Transmyocardial Revascularization
- Treatment of Tinnitus
- Urinary Tumor Markers for Bladder Cancer
- Use of Common Genetic Variants (Single Nucleotide Polymorphisms) to Predict Risk of Nonfamilial Breast Cancer
- Vagus Nerve Stimulation
- Viscocanalostomy and Canaloplasty
- Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus, and Colon
- Wireless Pressure Sensors in Endovascular Aneurysm Repair

Deleted Protocol

Effective immediately, the following protocol is archived:

- Vertebral Fracture Assessment With Densitometry

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.