

Distribution Date: December 2, 2013

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. Seven new protocols have been added and two have been archived.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 January 1, 2014 unless otherwise indicated:

#### **Autografts and Allografts in the Treatment of Focal Articular Cartilage Lesions**

Investigational statement for autologous and allogeneic minced cartilage added and “Osteochondral” removed from the title.

#### **Autologous Chondrocyte Implantation for Focal Articular Cartilage Lesions**

Statement on minced cartilage removed (and placed in above protocol) and “Other Cell-Based Treatments” removed from the title.

#### **Automated Percutaneous and Endoscopic Discectomy**

Investigational statements clarified to read “back pain and/or radiculopathy” in place of “back pain”.

#### **Cryosurgical Ablation of Miscellaneous Solid Tumors Other Than Liver, Prostate, or Dermatologic Tumors**

Metastasis added to the investigational statement to read: “...or other solid tumors or metastasis outside the liver and prostate....”

#### **Diagnosis and Management of Idiopathic Environmental Intolerance (i.e., Multiple Chemical Sensitivities)**

In the second policy statement on treatment, changes made for clarification, including “including but not limited to”; also the statement on intracellular micronutrient testing was made more concise.

#### **Enhanced External Counterpulsation (EECP)**

Removed “for Chronic Stable Angina or Congestive Heart Failure” from the title.  
Clarified that the protocol addresses *outpatient* treatment.

#### **Gene Expression Testing to Predict Coronary Artery Disease**

Added:

- Population that the Corus CAD™ test is marketed for: stable, nondiabetic patients.
- Medical necessity criteria for Medicare Advantage.

#### **General Approach to Genetic Testing**

This replaces the Genetic Testing for Inherited Disorders protocol and expands the content to not only carrier

testing (hereditary) but also to diagnostic, prognostic, and gene variant, but excludes cytogenetic testing (karotyping), biochemical testing, and molecular testing for infectious disease.

Medicare Advantage policy statement limits coverage to members personally afflicted with a disease.

#### **Genetic Testing for FMR1 mutations (including Fragile X Syndrome)**

Added statement to Protocol: "Genetic testing for FMR1 mutations is considered investigational for all other patient populations."

#### **Hematopoietic Stem-Cell Transplantation for Plasma Cell Dyscrasias, Including Multiple Myeloma and POEMS Syndrome**

POEMS syndrome added to the title and addressed in the criteria statements: medically necessary for autologous HSCT for disseminated disease; investigational for allogeneic and tandem HSCT.

#### **Intensity-Modulated Radiation Therapy (IMRT): Cancer of the Head and Neck or Thyroid**

Added: "if criteria are not met, IMRT is considered not medically necessary".

#### **Meniscal Allografts and Other Meniscus Implants**

Title and investigational statement changed so that "other" meniscal materials are addressed.

#### **Myoelectric Prosthetic Components for the Upper Limb**

Title change: the word "components" was added.

#### **Non-BRCA Breast Cancer Risk Assessment (e.g., OncoVue)**

BREVA Gen™ added to the investigational statement, as well as "e.g." preceding OncoVue® in the title.

#### **Open and Thoracoscopic Approaches to Treat Atrial Fibrillation (Maze and Related Procedures)**

Added investigational statements for hybrid ablation and off pump maze procedures.

#### **Orthognathic Surgery**

Minor edits made to the verbiage.

#### **Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux**

Contraindications added in a Policy Guidelines Section.

#### **Preimplantation Genetic Testing**

Changes made to the medical necessity statements:

- Parent with documented history of aneuploidy in a previous pregnancy removed as example of reason for evaluating an embryo at elevated risk of chromosomal abnormality;
- "otherwise fertile" couples changed to couples "not known to be infertile";
- "structural" was added to "chromosomal abnormality" for clarification; and
- "e.g., unbalanced translocation" was removed because it was repetitive.

Reminder: Most of our business does not cover preimplantation genetic testing because it is an adjunct to in vitro fertilization.

#### **Radiofrequency Ablation of Miscellaneous Solid Tumors Excluding Liver Tumors**

Thyroid was added to the investigational statement.

**Reduction Mammoplasty**

Medicare Advantage medical necessity criteria added.

**Sacral Nerve Neuromodulation/Stimulation**

The length of a successful percutaneous test was changed from at least two weeks to at least one week; policy statements for fecal incontinence now follow same format as urinary incontinence addressing trial stimulations and permanent implantation separately.

**Temporomandibular Joint Dysfunction**

Added: Joint vibration analysis added as an investigational diagnostic procedure.

Added for Medicare Advantage: Cervical traction as a potential medically necessary treatment.

Removed: Low-level laser therapy, which is addressed in the separate Low-Level Laser Therapy Protocol.

Corrected: Intra-oral “reversible” prosthetic devices to intra-oral “removable” prosthetic devices.

**Wireless Capsule Endoscopy as a Diagnostic Technique in Disorders of the Small Bowel, Esophagus, and Colon**

Additions to the investigational policy statements: Ulcerative colitis, acute GI bleeding (also including as an initial test), and Lynch Syndrome.

**Wireless Pressure Sensors in Endovascular Aneurysm Repair**

This remains of no proven value (investigational) and a Benefit Application Section was added to indicate that no separate fee will be made.

**New Protocols**

The effective date of these new protocols is January 1, 2014.

**Endometrial Ablation**

- Medically necessary for women with menorrhagia who are not candidates for, or who have been unresponsive to, hormone therapy and would otherwise be considered candidates for hysterectomy, investigational if those criteria are not met.
- Preauthorization is not required.

**Esophageal pH Monitoring**

- Investigational for catheter-based impedance-pH monitoring, and medically necessary for esophageal pH monitoring using a wireless or catheter-based system, as well as medical necessity criteria for 24-hour catheter-based monitoring.
- Separate Medicare Advantage section indicating twenty-four hour ambulatory pH monitoring as medically necessary for patients who are suspected of having gastric reflux, but only if the patient presents diagnostic problems associated with atypical symptoms or the patient's symptoms are suggestive of reflux, but conventional tests have not confirmed the presence of reflux.
- Preauthorization is not required but recommended for the investigational indication if the physician feels it is medically necessary, despite this protocol indicating it is investigational.

**General Approach to Evaluating the Utility of Genetic Panels**

- Includes general medical necessity guidelines; includes asterisks to clearly indicate tests that are covered in a separate protocol. (A “Refer to Protocol”).
- Separate Medicare Advantage statement included due to Medicare not paying for screening in the absence of a problem.
- Preauthorization is required.

**Genetic Cancer Susceptibility Panels Using Next Generation Sequencing**

- Investigational; includes laboratory tests BreastNext, OvaNext, ColNext, and CancerNext.
- Preauthorization is not required but recommended if the physician feels it is medically necessary, despite this protocol indicating it is investigational.

**Genetic Testing for Statin-Induced Myopathy**

- Not medically necessary.
- Preauthorization is not required but recommended if the physician feels it is medically necessary, despite this protocol indicating it is not medically necessary.

**Genetic Testing for the Diagnosis of Inherited Peripheral Neuropathies**

- Investigational.
- Preauthorization is not required but recommended if the physician feels it is medically necessary, despite this protocol indicating it is investigational.

**Photodynamic Therapy for Choroidal Neovascularization**

- Medically necessary indications as well as potential investigational uses.
- Separate Medicare Advantage criteria statement with medically necessary indications and non-covered limitations.
- Preauthorization is not required.

**Medical Protocols Reviewed Without Change**

Previous effective dates indicated remain accurate for the following:

- Blepharoplasty
- Biofeedback as a Treatment of Urinary Incontinence in Adults
- Continuous Passive Motion (CPM) in the Home Setting
- Decompression of the Intervertebral Disc Using Laser Energy (Laser Discectomy) or Radiofrequency Coblation (Nucleoplasty)
- DNA-Based Testing for Adolescent Idiopathic Scoliosis
- Facet Arthroplasty
- Fecal Analysis in the Diagnosis of Intestinal Dysbiosis
- Genetic Testing for Alpha-1 Antitrypsin Deficiency
- Genetic Testing for Hereditary Hemochromatosis
- Genetic Testing for Inherited Thrombophilia
- Genetic Testing for Rett Syndrome
- Hematopoietic Stem-Cell Transplantation for Waldenstrom Macroglobulinemia
- Intradialytic Parenteral Nutrition
- Keratoprosthesis
- KIF6 Genotyping for Predicting Cardiovascular Risk and/or Effectiveness of Statin Therapy
- Lung Volume Reduction Surgery for Severe Emphysema
- Neurofeedback
- Novel Lipid Risk Factors in Risk Assessment and Management of Cardiovascular Disease
- Occlusion of Uterine Arteries Using Transcatheter Embolization
- Percutaneous Intradiscal Electrothermal (IDET) Annuloplasty and Percutaneous Intradiscal Radiofrequency Annuloplasty

- Prolotherapy
- Radiofrequency Ablation of Primary or Metastatic Liver Tumors
- Stereotactic Radiosurgery and Stereotactic Body Radiation Therapy
- Total Ankle Replacement
- Transcutaneous Electrical Nerve Stimulation (TENS)
- Transmyocardial Revascularization
- Treatment of Tinnitus
- Urinary Tumor Markers for Bladder Cancer
- Use of Common Genetic Variants to Predict Risk of Nonfamilial Breast Cancer

### Deleted Protocols

Effective immediately, the following protocol is archived:

- Analysis of Proteomic Patterns for Early Detection of Cancer

Effective January 1, 2014, the following protocol is archived:

- Routine Services for Qualifying Clinical Trials

**The above are brief summaries.** Please refer to the protocols posted on the provider website, for the details of updated protocols and new protocols that affect your practice. If you need assistance obtaining specific protocol updates, please contact Provider Service.