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.

WellFirst Health™

Links to online medical policy documents are provided when they are available. The online Document Library contains current medical policies and, at times, may also include those with future effective dates. Please go to the Document Library for the most up-to-date information regarding our medical policies. 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 August 1, 2022

- Intensity Modulated Radiation Therapy (IMRT) MP9426 – prior authorization is not required

Medical Policies Retired and Prior Authorization Removed

Effective July 1, 2022

- Health and Behavior Assessment Intervention for Stress Management and Relaxation Training MP9375
- Lumbar Discography MP9427
- Pediatric Gait Trainer – MCG Clinical Guidelines

Effective August 1, 2022

- Breast Pumps, Hospital Grade MP9092
- Shingrix, Non-Routine Use MP9549

Medical Policies Prior Authorization Removed

Effective August 1, 2022

- Gastric Pacemaker and Gastric Electrical Stimulation MP9463
- Cranial Orthotic Devices for Plagiocephaly MP9495 (covered service when criteria are met and a benefit of the member's plan)
- Cardioverter-Defibrillator, Wearable (Zoll Life Vest) MP9522

Procedures and Devices – Experimental and Investigational – Non-covered

Services listed for policies in this section are not covered, unless otherwise indicated.

Effective June 1, 2022

Non-covered Medical Procedures and Services MP9415

- Bioimpendance spectroscopy or bioelectric impendance analysis detection of lymphedema (e.g., SOZO, ImpediMed L-Dex)
- Computer based treatment for cognitive behavioral therapy (CBT) for substance abuse disorders (e.g., reSET)
- Electrotherapy stimulation for behavioral health disorders

Effective July 1, 2022

Engineered Products for Wound Healing MP9287

- Noncontact normothermic wound therapy

Genetic Testing for Somatic Tumor Markers MP9486

- Cxbladder urine test for bladder cancer screening or detection
- In vitro chemosensitivity or chemoresistance assays (e.g., ChemoFx Assay, Correct Chemo)
- Affirma Expression Atlas

Lab Testing MP9539

- Covered- Hepatitis C virus (HCV) and FibroTest/ActiTest panels are covered for the assessment of liver fibrosis and/or necroinflammatory activity in members with Hepatitis C virus.
- Non-covered - FibroSure and FibroTest/ActiTest panels for all other indications are considered experimental and investigational.
- Cytotoxic testing for allergy diagnosis
- Covered - Food allergy/intolerance (in vitro) of food allergen specific IgE is covered for members with clinically suspected food allergy. Food allergen specific IgG or IgG4 and serum or saliva IgA tests are considered experimental and investigational.
- Analysis of hair in the clinical setting (e.g., for toxicology, forensic, or evaluation of deficiency related indications)
- Lipoprotein-associated phospholipase A1 Immunoassay (Lp-PLA2) for prediction of risk for coronary artery heart disease or ischemic stroke (e.g., PLAC test)
- Collagen cross links tests as markers of bone turnover (e.g., MicroVue)
- Glycosylated acute phase proteins (GlycA), nuclear magnetic resonance spectroscopy
- Karius test liquid biopsy for infectious disease
- Versiti VWF Propetide Antigen

Effective October 1, 2022

Non-covered Medical Procedures and Services MP9415

- Bronchial thermoplasty for the treatment of asthma
- Cell therapy for treatment of cardiac disease
- Confocal laser endomicroscopy for Barrett's esophagus
- Extracorpeal magnetic stimulation for treatment of urinary incontinence
- Extracorpeal shock wave therapy for musculoskeletal indications and soft tissue injuries
- Gastrointestinal monitoring system
- Intense pulse light treatment for dry eyes
- Laser therapy for nicotine dependence
- Laser therapy for treatment of pain

Procedures and Devices – Experimental and Investigational – Non-covered (continued)

Services listed for policies in this section are not covered, unless otherwise indicated.

- Percutaneous neuromodulation therapy for treatment of pain
- Scoliosis treatment protocols including the VibeForHealth Scoliosis Traction Chair, CLEAR Scoliosis Institute
- Wilderness therapy for outdoor behavioral healthcare

Effective November 1, 2022

Non-covered Medical Procedures and Services MP9415

- Annulous fibrosis repair devices (e.g., Xclose)
- Arthroscopy, shoulder with implantation of subacromial spacer
- Cervicography
- Computerized dynamic posturography
- Corneal hysteresis assessment
- Thoracic electrical bioimpedance for cardiac output measurement

Percutaneous Vertebroplasty/ Kyphoplasty and Sacroplasty MP9429

- Percutaneous sacroplasty

Procedures and Devices Medically Necessary – Covered

Services listed for the policies in this section are covered.

Effective June 1, 2022

Genetic Testing for Somatic Tumor Markers MP9486

- MammaPrint

Effective July 1, 2022

Bariatric Surgery and Weight Management Procedures MP9319

- Medically necessary for the treatment of non-alcoholic fatty liver disease (NAFLD)

New Medical Policies

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

Effective October 1, 2022:

Extracorpeal Photophoresis (Photochemotherapy) MP9558

Extracorpeal photophoresis does not require prior authorization and is considered medically necessary for any of the following: erythrodermic cutaneous T-cell lymphoma; chronic or acute graft-versus-host disease; heart transplantation allograft rejection; heart transplantation rejection prophylaxis; and lung transplantation allograft rejection.

Actigraphy MP9559

Actigraphy is considered medically necessary for the diagnosis of insomnia, hypersomnia, Circadian rhythm disorders and insufficient sleep syndrome. Prior authorization is not required.

Exhaled Breath Tests for Asthma and Other Inflammatory Pulmonary Conditions: Exhaled Nitric Oxide Breath Test and Exhaled Breath Condensate pH Measurement MP9560

Exhaled nitric breath tests do not require prior authorization and are considered medically necessary for the following: diagnosis of eosinophilic airway inflammation; determining the likelihood of steroid responsiveness in members with chronic symptoms suggestive of airway inflammation.

Effective December 1, 2022

Elastography MP9562

Ultrasound transient elastography (e.g., FibroScan) is considered medically necessary for diagnosing and monitoring liver fibrosis in members with chronic liver disease or with psoriasis who are currently receiving therapy with methotrexate. Ultrasound transient elastography is considered experimental and investigational, and therefore not medically necessary for all other liver disease and all non-liver disease indications. Magnetic resonance elastography is considered medically necessary when ultrasound transient elastography is unavailable, contraindicated or results are indeterminate and for known or suspected nonalcoholic fatty liver disease. Prior authorization is not required.

Percutaneous Tibial Nerve Stimulation MP9563

Percutaneous tibial nerve stimulation does not require prior authorization and is considered medically necessary for the treatment of overactive bladder in members 18 years of age and older. Percutaneous nerve stimulation is considered experimental and investigational, and therefore not medically necessary, for all other indications, including but not limited to, neurogenic bladder, fecal incontinence, constipation, chronic pelvic pain, and use in individuals less than 18 years of age.

Eye Movement Desensitization and Reprocessing (EMDR) MP9564

EMDR is considered medically necessary for the treatment of post-traumatic stress disorder. Prior authorization is not required.

Laser Treatments for Chorodial Neovascularization (CNV) Associated with Macular Degeneration MP9565

For members with macular degeneration, conventional focal laser treatment using argon or diode laser is considered medically necessary for the treatment of choroidal neovascularization outside the center of the macula. The following are considered experimental and investigational, and therefore are not medically necessary: transpupillary thermotherapy using a warm infrared diode laser to treat classic or occult CNV; laser photocoagulation of retinal drusen to prevent loss of visual acuity due to possible development of classic or occult CNV. Prior authorization is not required.

Multichannel Intraluminal Esophageal Impedance with pH Monitoring MP9567

Esophageal impedance with pH monitoring for the evaluation of gastroesophageal reflux disease is considered medically necessary in members with atypical symptoms or non-responsive to treatment. Prior authorization is not required.

Chronic Cerebrospinal Venous Insufficiency (CCSVI) in Multiple Sclerosis Diagnosis and Treatment MP9568

The diagnosis and treatment of CCSVI in Multiple Sclerosis, including but not limited to, venous angioplasty, is considered experimental and investigational, and therefore not medically necessary.

Chemiluminescent Testing (ViziLite) for Oral Cancer Screening MP9569

ViziLite for oral cancer screening is considered experimental and investigational, and therefore not medically necessary.

Medical Policy Revisions

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

Effective June 1, 2022
Sacroiliac Joint (SI) Injection and Radiofrequency Ablation (RFA) MP9466

Radiofrequency ablation of the SI joint is not covered. The following are not covered: non-pulsed and pulsed percutaneous RFA/denervation, cooled percutaneous RFA/denervation and laser ablation/denervation.

Effective July 1, 2022
Total Ankle Arthroplasty MP9363

The policy does not apply to those devices that have been granted a Humanitarian Device Exemption by the FDA, which are considered medically necessary when all FDA-required criteria are met. The exemption includes Patient Specific Talus Spacer indicated for avascular necrosis of the ankle joint.

Gastric Pacemaker and Gastric Electrical Stimulation MP9463

The policy does not apply to those devices that have been granted a Humanitarian Device Exemption by the FDA, which are considered medically necessary when all FDA-required criteria are met. Gastric emptying scintigraphy is not required to confirm chronic, intractable nausea and vomiting secondary to gastroparesis. Prior authorization is required.

Electric Tumor Treatment Field (ETTF) MP9474

ETTF requires prior authorization and is considered medical necessary for the treatment of newly diagnosed, histologically confirmed supratentorial glioblastoma following debulking surgery and completion of radiation therapy, in conjunction with chemotherapy (temozolomide).

Effective August 1, 2022
Repairs/Replacement of Durable Medical Equipment (DME)/Supplies MP9106

Reimbursement or repair of any covered item that is damaged and/or destroyed by member carelessness, misuse, abuse, loss or theft is not covered. Repair or replacement of DME/supplies is covered according to the member's Certificate or Summary Plan Description. Prior authorization is required. DME purchases from online retailers are not covered.

Effective September 1, 2022
Bone Growth Stimulator (BGS) MP9076

An electric bone growth stimulator is considered medically necessary for the treatment of long bone fracture nonunion of the appendicular skeleton and failed or high-risk spinal fusion (all regions of the spine). Ultrasonic bone growth stimulation is considered medically necessary for acute fracture or non-union fracture when the medical policy criteria are met. Prior authorization is required.

Cardiac Monitoring Devices and Cardiac Procedures MP9540

External continuous pulmonary fluid monitoring (e.g., Cardio-Pulmonary Stethoscope System) is considered experimental and investigational, and therefore not medically necessary.

Varicose Vein and Venous Insufficiency Treatments of Lower Extremities MP9241

Sclerotherapy is limited to two visits per leg within a six-month period. Radiofrequency/laser ablation therapy is limited to one visit per leg within a six-month period. Additional treatment requires Medical Director review for medically necessity. Prior authorization is required.

Effective October 1, 2022
Cardioverter Defibrillator, Wearable (Zoll Life Vest) MP9522

Claims will deny if the diagnosis billed is not medically necessary. Prior authorization is required.

Transcranial Magnetic Stimulation (TMS) MP9526

A baseline depression score using an evidenced-based validated rating scale is required. The ordering provider is required to be a psychiatrist. Prior authorization is required. (Current Transcranial Magnetic Stimulation (TMS) MP9526, effective through 9/30/2022.)

Effective November 1, 2022
Percutaneous Left Ventricular Assist Device (pVAD) MP9528

The policy does not apply to those devices that have been granted a Humanitarian Device Exemption by the FDA, and are considered medically necessary when all FDA required criteria are met. Percutaneous left ventricular assist device pVAD (e.g., Impella) is considered medically necessary for the following: bridge to recovery, bridge to decision, destination therapy, short-term circulatory support in cardiogenic shock or as an adjunct to percutaneous coronary intervention. Prior authorization is not required. (Current Percutaneous Left Ventricular Assist Device (pVAD) MP9528, effective through 10/31/2022.)

Medical Policy Revisions (continued)

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

Inflammatory Bowel Disease: Serologic Markers and Pharmacogenomic and Metabolic Assessment of Thiopurine Therapy MP9533

Fecal measurement of calprotectin does not require prior authorization and is considered medically necessary for:

- Monitoring/managing disease activity in inflammatory bowel disease
- Differentiating inflammatory bowel diseases
- For distinguishing inflammatory bowel disease from irritable bowel syndrome in individuals with symptoms that have lasted greater than four weeks

Anti-smooth muscle antibodies (ASMA) and centrosomal protein 72 (CEP72) are considered experimental and investigational, and therefore not medically necessary.

Lab Testing MP9539

The following tests are considered experimental and investigational, and therefore not medically necessary: serial dilution endpoint titration for the diagnosis and treatment of airborne allergy and Hydroxychloroquine drug assay.