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.

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 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 April 1, 2023:

Continuous Glucose Monitoring MP9091

Pectus Excavatum and Pectus Carinatum Treatment MP9206

Back or Spinal Orthosis: Lumbosacral or Thoracolumbosacral MP9261

Stereotactic Body Radiotherapy MP9459

Refractive and Therapeutic Keratoplasty MP9461

Effective May 1, 2023:

High Flow Oxygen for Cluster Headaches

Risk Reducing (Prophylactic) Mastectomy MP9449

Effective July, 2023:

Port Wine Stain Laser Treatment MP9207

Effective January 1, 2024:

Therapeutic Contact Lens MP9201

Medical Policies Prior Authorization Removed

Effective May 1, 2023:

Electric Tumor Treatment Field (Optune) MP9474

Effective June 1, 2023:

Neuropsychological Testing MP9493

Self-funded ASO plans may require prior authorization. Refer to the member's Summary Plan Description for specific prior authorization requirements.

Implantable Deep Brain Stimulation MP9331

Effective July 1, 2023:

- Genetic Testing: Preimplantation Genetic Testing MP9574
- Genetic Testing: Prenatal Diagnosis and Pregnancy Loss MP9576
- Genetic Testing: Exome and Genome Sequencing for the Diagnosis of Genetic Disorders MP9586

Procedures and Devices – Experimental and Investigational – Non-covered

Effective March 1, 2023:

Non-covered Medical Procedures and Services MP9415

- Transcutaneous electric nerve stimulator (e.g., IB-Stim)

Effective June 1, 2023:

- Sensory and auditory integration therapies for all indications
- Stem cell therapy for peripheral artery disease and all other indications
- Surgical interruption of pelvic nerve pathways for treatment of pelvic pain (e.g., presacral neurectomy, uterosacral nerve ablation) and all other indications
- Tidal knee lavage for osteoarthritis and all other indications

Effective July 1, 2023:

- Absorbable nasal implants for the treatment of nasal valve collapse (e.g., Latera)

Procedures and Devices – Medically Necessary

Effective March 1, 2023:

- Transcatheter intracardiac shunt creation by stent placement for congenital anomalies

New Medical Policy

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

Effective June 1, 2023:

Wireless Capsule Endoscopy and Capsule Technology to Verify Patency Prior to Capsule Endoscopy MP9626

Considered medically necessary as a diagnostic imaging tool for: occult gastrointestinal bleeding in evaluation of obscure small bowel bleeding or iron deficiency anemia

in members who have undergone upper gastrointestinal endoscopy (GI) and colonoscopy when testing has failed to reveal a source of bleeding; Crohn's disease for diagnostic and/or reevaluation in symptomatic members (known or suspected disease) who have undergone upper GI endoscopy or colonoscopy and testing failed to reveal the source of symptoms; small bowel neoplasm in evaluation of suspected, but undiagnosed, small bowel neoplasm, in members symptomatic for a neoplasm, and when the diagnosis has not been confirmed by upper GI endoscopy, colonoscopy, radiologic procedures, and nuclear imaging; GI polyposis syndromes for surveillance of the small bowel with hereditary small bowel polyposis syndromes including familial adenomatous polyposis and Peutz-Jeghers syndrome. Prior authorization is not required.

Therapeutic Apheresis – Plasmapheresis, Plasma Exchange MP9627

Criteria does not apply to devices which have been granted a humanitarian device exemption by the FDA. Prior authorization is not required.

Endoscopic Radiofrequency Ablation for Barrett's Esophagus MP9628

Considered medically necessary for Barrett's esophagus with high-grade dysplasia or low-grade dysplasia. Prior authorization is not required.

Scanning Laser Technologies for Retina and Optic Nerve Imaging MP9629

Considered medically necessary for disease assessment. Prior authorization is not required.

Magnetoencephalography and Magnetic Source Imaging MP9630

Considered medically necessary for localization of epileptic lesion foci for members being considered for surgery and mapping of eloquent cortex prior to excision of cerebral lesions such as tumors or epileptic foci in the proximity of any functional area. Prior authorization is not required.

Chronic Rhinitis: Cryoablation, Radiofrequency Ablation, and Laser Ablation Office-Based MP9631

Cryoablation for chronic rhinitis (e.g., ClariFix), radiofrequency ablation (e.g., RhinAer™), and laser ablation are considered experimental and investigational, and therefore not medically necessary.

Single Photon Emission Computed Tomography (SPECT) for Attention Deficit Hyperactivity Disorder MP9633

SPECT for screening, diagnosis, or evaluation of attention deficit hyperactivity disorder is considered experimental and investigational, and therefore not medically necessary.

Electromagnetic Navigation Bronchoscopy MP9634

Prior authorization is not required.

Effective July 1, 2023

Air Ambulance, Non-Emergent MP9632

Considered medically necessary when ground ambulance transport cannot be provided because it poses a threat or seriously endangers the member's health. Coverage is based on the member's medical condition and geographic location. Non-emergent air ambulance transport is considered medically necessary when all of the following criteria are met: transport is provided by a licensed professional air ambulance, attending physician orders air ambulance transport, member is clinically stable and requires skilled care or medical monitoring. Non-emergent air ambulance transport is covered from the hospital where the member was first admitted to the nearest hospital, when care for the member's condition is not available at the first hospital, and from the hospital to nearest post-acute level of care. Prior authorization is required for non-emergent air ambulance transport. Emergent air ambulance transport does not require prior authorization.

Effective August 1, 2023

Implanted Hypoglossal Nerve Stimulation for the Treatment of Obstructive Sleep Apnea (OSA) MP9636

Considered medically necessary when all of the following criteria are met: device to be implanted is FDA-approved, member is age 18 or older, apnea-hypopnea index or respiratory disturbance index greater than or equal to 15 and less than or equal to 65, documented history of failed CPAP trial of at least 8 weeks or member unable to tolerate CPAP, and other non-surgical options have been considered and excluded. Prior authorization is required.

Myoelectric Upper Limb Prosthetic and Orthotics MP9637

Considered medically necessary when all of the following criteria are met: member has an amputation or missing limb at the wrist or above, standard body-powered prosthetic devices cannot be used or are insufficient to meet the member's functional needs to perform activities of daily living, and the remaining arm musculature has sufficient microvolt threshold. See policy for additional criteria. Prior authorization is required.

Microprocessor Controlled Knee Prostheses, With or Without Polycentric, Three-Dimensional Endoskeleton Hip Joint System MP9638

Considered medically necessary when member meets all of the following criteria: sustained a trans-femoral or knee disarticulation amputation, has reached skeletal maturity, displays functional ambulation level 3 or above, displays adequate cognitive ability to master gait sequencing or care requirements of the higher level of technology, has a need for daily long distance ambulation at variable rates (greater than 400 yards), or has a need for regular ambulation on uneven terrain or for regular use on stairs. See medical policy for additional criteria. Prior authorization is 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:

Genetic Testing: Non-Invasive Prenatal Screening MP9573

Testing to predict twin zygosity is considered experimental and investigational, and therefore not medically necessary. Prior authorization is not required.

Effective April 1, 2023:

Treatment of Obstructive Sleep Apnea and Related Conditions CPAP, APAP, BiPAP and Oral Devices MP9239

Device rental applies to obstructive sleep apnea, but does not apply to any other diagnoses. Prior authorization is required.

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

Allogenic transplantation is considered medically necessary for blastic plasmacytoid dendritic cell neoplasm, Fucosidosis, mixed myelodysplastic/ myeloproliferative neoplasms, and primary/secondary myelofibrosis related conditions. Prior authorization is required.

Heart Transplantation MP9613

Transplantation is considered medically necessary when member meets the American Heart Association Stage D criteria (objective evidence of severe cardiovascular disease, severe limitations, and displays symptoms at rest). Prior authorization is required.

Lung Transplantation MP9615

Transplantation is considered medically necessary for acute respiratory distress syndrome including COVID-19-associated ARDS. Prior authorization is required.

Pancreas Transplantation (Pancreas Alone) MP9616

Considered medically necessary when the member has labile insulin-dependent diabetes mellitus with documented life-threatening hypoglycemic unawareness despite optimal medical management. Prior authorization is required.

Effective May 1, 2023:

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

In lab (attended) sleep studies are not required to be ordered by a pulmonologist, neurologist, psychiatrist, otolaryngologist, or a physician certified in sleep medicine or their advanced practitioners.

Therapeutic Contact Lens MP9201

Therapeutic contact lenses are considered medically necessary for the treatment of diseases of the ocular surface. Prior authorization is not required. Policy reinstated as of May 1, 2023.

Clinical Trials (Clinical Trial Participation) MP9447

Study approved or funded by Value in Cancer Care Consortium no longer required. Prior authorization is required.

Minimally Invasive Glaucoma Surgery (MIGS) MP9467

Policy does not apply to external filtration surgeries (e.g., trabeculectomy or tube shunt devices EX-PRESS®). Prior authorization is not required.

Effective June 1, 2023:

Vagus Nerve Stimulation, Implantable MP9232

Considered medically necessary for members with epilepsy. Prior authorization is required.

Implantable Deep Brain Stimulation (DBS) MP9331

Considered medically necessary for: thalamic stimulation for suppression of tremor in the upper extremity for members diagnosed with essential tremor or Parkinsonian tremor which are uncontrolled with medication and tremor constitutes a significant disability, stimulation of internal globus pallidus or subthalamic nucleus as an adjunctive therapy in reducing symptoms of advanced levodopa-responsive, Parkinson's disease that is uncontrolled with medication, or intractable primary dystonia. Policy criteria does not apply to devices which have been granted a humanitarian device exemption by the FDA. Prior authorization is not required.

Corneal Cross-Linking (CXL) MP9470

Conventional and accelerated corneal cross-linking is considered experimental and investigational, and therefore not medically necessary when performed concurrently with other procedures, also known as CXL-plus or photorefractive keratectomy or phakic intraocular lens implantation.

Neuropsychological Testing MP9493

Considered not medically necessary for baseline testing in asymptomatic persons at risk for sport-related concussions and used alone for evaluation of concussions. Non-covered conditions: headaches (including migraines), history of myocardial infarction, and intermittent explosive disorders. Prior authorization is not required.

Effective July 1, 2023:

Light Treatment and Laser Therapies for Benign Dermatologic Conditions MP9057

Considered medically necessary for the treatment of port wine stain, including Sturge-Weber syndrome. Prior authorization is not required.

Effective August 1, 2023:

Outpatient Enteral Nutrition MP9069

Digestive enzyme cartridge, RELiZORB, is non-covered. Synthetic or semi-synthetic enteral feedings are considered medically necessary when all criteria are met: enteral feedings are the member's sole source of nutrition; member has a functional intestinal tract and there is non-function or disease of the pharynx, esophagus, or stomach preventing nutrients from reaching the small intestine; central nervous system disease leading to sufficient interference with the neuromuscular coordination of chewing and swallowing such that a risk of aspiration exists; and a naso-gastric, jejunostomy, or gastrotomy tube is in place for administering feedings. Prior authorization is required.

Limb Prosthesis MP9103

Microprocessor controlled knee prostheses and myoelectric upper limb prosthetics policies were removed and new policies created. Prior authorization is required.

Mechanical Circulatory Support Devices MP9528

Total artificial heart is considered medically necessary when used as a bridge to heart transplantation in members with biventricular heart failure who have failed optimal medical therapy, are at risk of imminent of death, and the member is a heart transplant candidate. Prior authorization is not required.

Lab Testing MP9539

Hepatitis C Virus (HCV) FibroSure® and FibroTest-ActiTest panels are considered medically necessary for the assessment of liver fibrosis and/or necroinflammatory activity in members with hepatitis C virus (HCV). FibroSure® and FibroTest/ActiTest are considered experimental and investigational, and therefore not medically necessary for members with any other type of Hepatitis or other indication.

Genetic Testing Medical Policies

The following summary is intended to provide a high-level overview of policy changes. For additional details (e.g., CPT codes, criteria, test names, rationale, definitions and references) refer to the specific policy. Codes are included 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. Claims will deny in the absence of an appropriate diagnosis or procedure code and/or if the coverage criteria is not met. Prior authorization is not required.

Effective July 1, 2023:

General Approach to Genetic Testing

General Approach to Genetic Testing MP9610

Targeted mutation analysis for a known familial variant for a genetic condition is considered medically necessary when the condition is adult-onset and member is 18 years of age or older.

Prenatal Genetic Testing Policies

Non-Invasive Prenatal Screening (NIPS) MP9573

NIPS to predict twin zygosity is considered experimental and investigational, and therefore not medically necessary. Maternal serum screening for aneuploidy Penta screen is considered medically necessary.

Prenatal and Preconception Carrier Screening MP9575

Criteria added for SMN1 sequencing and/or deletion/duplication analysis.

Prenatal Diagnosis (via Amniocentesis CVS or PUBS) and Pregnancy Loss MP9576

Noonan Spectrum Disorders/RASopathies criteria expanded and gene list revised to include more tests available.

Effective July 1, 2023:

Rare Disease Genetic Testing Policies

Whole Exome and Genome Sequencing for the Diagnosis of Genetic Disorders MP9586

Standard exome sequencing coverage expanded to include members with unexplained epilepsy.

Multisystem Inherited Disorders, Intellectual Disability, and Developmental Delay MP9587

FMR1 repeat and methylation analysis criteria expanded for females undergoing testing.

Effective July 1, 2023:

System Specialty Specific Genetic Testing Policies

Aortopathies and Connective Tissue Disorders MP9588

Loeys-Dietz syndrome clinical features changed from “all” to “at least two.” Coverage added for familial thoracic aortic aneurysm and dissection multigene panel. Vascular Ehlers-Danlos Syndrome added testing of a member who has a close relative with a clinical diagnosis.

Cardiac Disorders MP9589

Coverage added for comprehensive arrhythmia and cardiomyopathy panels. Criteria clarified for multigene panel testing for: comprehensive cardiomyopathy, hypertrophic cardiomyopathy, dilated cardiomyopathy, arrhythmogenic right ventricular cardiomyopathy, Long QT Syndrome, Brugada Syndrome, and SCNSA variant analysis.

Dermatologic Conditions MP9590

Criteria revised for multigene panels for congenital ichthyosis and epidermolysis bullosa.

Epilepsy, Neurodegenerative and Neuromuscular Disorders MP9591

PSEN1, PSEN2, and APP sequencing and/or deletion/duplication analysis or multigene panel includes members with a personal and/or family history of dementia. FXN repeat analysis is considered medically necessary for any member with either a biological sibling with Friedriech's ataxia or cerebellar ataxia for whom non-genetic causes have been ruled out. PMP22 sequencing and/or deletion/duplication or multigene panel criteria to include evidence of previous nerve palsy added. Parkinson's disease testing is considered medically necessary for an affected member or member with a family history of disease.

Gastroenterologic Disorders (Non-Cancerous) MP9593

Member has a first or second degree relative with pancreatitis removed from hereditary pancreatitis multigene panel criteria. HFE sequencing and/or deletion/duplication analysis family history added.

Hematologic Conditions (Non-Cancerous) MP9595

Factor V Leiden and prothrombin variant analysis for inherited thrombophilia criteria clarified.

Hereditary Cancer Susceptibility Syndromes MP9596

Criteria expanded: SMAD4 and BMPR1A sequencing and deletion/duplication analysis to include member with a personal history of cancer, SMAO4 or BMPR1A pathogenic or likely pathogenic variant detected by tumor profiling, and germline analysis not done; TP53 sequencing and/or deletion/duplication analysis to include member diagnosed with pediatric hypodiploid acute lymphoblastic leukemia; SMA04 and/or BMPR1A sequencing and/or deletion/duplication analysis include personal history of cancer and pathogenic or likely pathogenic variant was detected by tumor profiling and germline analysis was not done yet. Per NCCN Guidelines age for personal history of breast cancer changed from 45 years of age or younger to 50 years of age and younger for hereditary breast cancer susceptibility panels, BRCA1/BRCA2 sequencing and/or deletion/duplication analysis, PALB2 sequencing and deletion/duplication analysis.

Immune, Autoimmune, and Rheumatoid Disorders MP9597

Criteria added for known familial variant analysis for immune, autoimmune, and rheumatoid disorders.

Kidney Disorders MP9598

PKHD1 is not associated with autosomal dominant polycystic kidney disease. Comprehensive kidney disease panel criteria expanded to include cystic renal disease and congenital nephropathy.

Lung Disorders MP9599

SERP/NA1 common variant analysis or sequencing and/or or deletion/duplication analysis criteria clarified.

Metabolic, Endocrine, and Mitochondrial Disorders MP9600

Maturity-onset Diabetes of the Young Panel testing criteria expanded. Testing for other multisystem inherited disorders: maple syrup urine disease, glycogen storage disease type 1, mucolipidosis IV, urea cycle disorders including ornithine transcarbamylase deficiency added.

Pharmacogenetics MP9602

CYP2D6, CYP4R2, and VKORC1 variant analysis indications specified.

Effective July 1, 2023

Oncology Genetic Testing Policies

Algorithmic Testing MP9605

Menopausal status clarified for breast cancer treatment and prognostic algorithmic testing.

Cancer Screening MP9606

FIT-DNA (stool DNA test) criteria revised.

WellFirst Health™

Cytogenetic Testing MP9607

Tumor Specific PD-L1 protein analysis fusion and PMLIRARA gene arrangement criteria clarified.

Molecular Analysis of Solid Tumors and Hematologic Malignancies MP9608

Acute myeloid leukemia added to tumor specific IDH1, IDH2, and TP53 variant analysis. Tumor mutational burden testicular cancer specified as nonseminoma type. Criteria added for tumor type diagnostic solid molecular profiling panel repeat testing.

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

Comprehensive molecular profiling panel tests via circulating tumor DNA coverage added for advanced (stage III or higher) cutaneous melanoma. Considered medically necessary: melanoma focused panel test via circulating tumor DNA; and BRAF and KRAS variant analysis via circulating tumor DNA.