Medical Policy Updates

Highlights of recent medical policy revisions, as well as any new medical policies approved by Dean Health Plan's 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 all of Dean Health Plan's medical policies, visit deancare.com. From the home page, hover over **For Providers** located on the top, right of the screen and click **Medical Management**. Under Dean Health Plan Policies, click **Medical Policies**. For questions regarding any medical policy or if you would like copies of a complete medical policy, please contact our Customer Care Center at **800-279-1301**.

All other Dean Health Plan 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**.

The medical policy updates in this document are published alongside our quarterly newsletters on the Dean Health Plan Provider news page at deancare.com/providers/news. Please call the Customer Care Center at **800-279-1301** if you have questions about accessing our newsletters.

General Information

Coverage of any medical intervention discussed in a Dean Health Plan 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 Dean Health Plan 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.

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 September 1, 2022

Intrathecal Pump Implantation MP9278

Effective February 1, 2023

Breast Surgery MP9026

See new policies:

- **Breast Implant Removal, Revision, or Reimplantation MP9580**
- **Male Gynecomastia Surgery MP9581**
- **Female Breast Reduction Surgery – Reduction Mammoplasty MP9582**

Laser Treatment for Psoriasis MP9399

- See revised policy **Light Treatment and Laser Therapies for Benign Dermatologic Conditions MP9057**
- **Medicare Advantage Light Treatment and Laser Therapies for Benign Dermatologic Conditions MP9057** This policy is specific to Medicare Advantage.

Breast Reconstruction Surgery MP9476

See new policies:

- **Breast Implant Removal, Revision, or Reimplantation MP9580**
- **Male Gynecomastia Surgery MP9581**
- **Female Breast Reduction Surgery – Reduction Mammoplasty MP9582**

Genetic Testing for Reproductive Carrier Screening and Prenatal Care MP9477

See new policies:

- **Genetic Testing: Non-Invasive Prenatal Screening (NIPS) MP9573**
- **Genetic Testing: Preimplantation MP9574**
- **Genetic Testing: Prenatal and Preconception Carrier Screening MP9575**
- **Genetic Testing: Prenatal Diagnosis (Amniocentesis, CVS, or PUBS) and Pregnancy Loss MP9576**

Medical Policies Retired and Prior Authorization Removed

Effective December 1, 2022

- **Light Treatment and Laser Therapies for Benign Dermatologic Conditions MP9057**
- **Light Treatment and Laser Therapies for Benign Dermatologic Conditions MP9057** — This policy is specific to Medicare Advantage.
- Laser Treatment for Psoriasis MP9399

Procedures and Devices – Experimental and Investigational – Non-covered

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

Effective September 1, 2022

Non-covered Medical Procedures and Services MP9415

- Endoscopic implantation of Plexiglas microspheres
- Epidural lysis of adhesions (e.g., Racz Epidural Catheter)
- Interferential current stimulation (e.g., Dynatron STS)
- Quantitative sensory testing

Effective October 1, 2022

Non-covered Medical Procedures and Services MP9415

- Volara System Oscillation and Lung Expansion

Products for Wound Healing MP9287

- Negative pressure wound therapy with installation

Effective November 1, 2022

- Non-covered Medical Procedures and Services MP9415
  Electric cell-signaling treatment (e.g., neoGEN System)

New Medical Policies

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

Effective December 1, 2022

Functional Electrical Stimulation (FES) Therapy, Functional Neuromuscular Electrical Stimulation (NMES) Rehabilitation Therapy, and Lower Limb Activity-Based Locomotor Exercise (ABLE) Training MP9566

FES and NMES using stationary equipment is considered medically necessary when used as one component of a comprehensive facility-based program and supervised by a skilled provider (e.g., occupational or physical therapist). Prior authorization is not required.

Pelvic Vein Embolization MP9572

Pelvic vein embolization for the treatment of pelvic vein congestion syndrome/chronic pelvic pain is considered experimental and investigational, and therefore not medically necessary.

Effective January 1, 2023

Cognitive Rehabilitation/ Remediation MP9561

Cognitive rehabilitation/remediation is considered medically necessary following focal traumatic brain injury when there is a reasonable expectation of achieving measurable improvement. Cognitive rehabilitation/remediation for coma stimulation or cognitive decline resulting from progression of a chronic disease is considered experimental and investigational, and therefore not medically necessary. Prior authorization is not required.

Outpatient and Inpatient Electroconvulsive Therapy (ECT) MP9570

ECT is considered medically necessary to treat severe, treatment-resistance depression, and may be useful in treating individuals with bipolar disorder and schizophrenia that has not responded to other treatments. Prior authorization is not required.

Cell Therapy for the Treatment of Cardiac Disease MP9578

Cell therapy treatment is considered experimental and investigational, and therefore not medically necessary for cardiac disease.

Neurofeedback/Biofeedback for Behavioral and Substance Use Disorders MP9579

Neurofeedback or biofeedback (with or without EEG guidance) is considered not medically necessary, and therefore not covered for treating any behavioral or substance use disorders including but not limited to: ADHD, depression, anxiety, OCD, PTSD, alcohol/drug abuse and autism spectrum disorder.

Effective February 1, 2023

New Prenatal Genetic Testing Medical Policies

In November 2022, Dean Health Plan introduced new prenatal genetic testing medical polices, developed by our contracted vendor Concert Genetics, an industry-leader in genetic testing technology assessment and policy development.

- **Genetic Testing: Non-Invasive Prenatal Screening (NIPS) MP9573 —** Other common names: non-invasive prenatal testing (NIPT), cell-free DNA testing (cfDNA) and cell-free fetal DNA testing. Prior authorization is required, as described in the medical policy.
- **Genetic Testing: Preimplantation MP9574 —** Prior authorization is dependent on applicable laws and provisions per state as outlined in the member benefit certificate or summary plan description. Prenatal cell-free DNA screening tests coverage criteria.
- **Genetic Testing: Prenatal and Preconception Carrier Screening MP9575 —** Coverage criteria for prenatal cell-free DNA screening tests. Prior authorization is required, as described in the medical policy.
- **Genetic Testing: Prenatal Diagnosis (Amniocentesis, CVS, or PUBS) and Pregnancy Loss MP9576 —** Prior authorization is required, as described in the medical policy. Coverage criteria related to prenatal and pregnancy loss diagnostic genetic testing intended to diagnose genetic conditions following amniocentesis, chorionic villus sampling or pregnancy loss

  Member required to have genetic counseling by and testing ordered by:
  - Board-certified medical geneticist
  - Maternal-fetal medicine specialist/perinatologist
  - Board-certified OBGYN
  - Board-certified genetic counselor
  - Advanced practice practitioner in genetics or maternal-fetal medicine/perinatology

Also, effective February 1, 2023

Breast Implant Removal, Revision or Reimplantation MP9580

Unilateral or bilateral breast implant removal when associated with breast reconstruction following mastectomy and the procedure is coded as such does not require prior authorization. If criteria is met for implant removal unilaterally, then removal of the other breast implant is covered if both are removed at the same time.

Male Gynecomastia Surgery MP9581

Prior authorization is not required for unilateral or bilateral breast reduction when it is associated with breast reconstruction following mastectomy. For pubertal (adolescent) onset, gynecomastia must have been present for at least two years and classified as Grade II, III, or IV per the American Society of Plastic Surgeons (ASPS). For post pubertal-onset, gynecomastia must have been present for at least one year and classified as Grade III or IV per the ASPS. Photographs are required.

Female Breast Reduction Surgery – Reduction Mammoplasty MP9582

Unilateral or bilateral breast reduction when it is associated with breast reconstruction following a mastectomy, and the procedure will be coded as such, does not require prior authorization. Breast reduction for women aged 18 years and older or for whom growth is complete (e.g., breast size stable over one year) requires prior authorization. Women 40 years of age or older are required to have a mammogram negative for cancer within one year prior to planned surgery.

Genetic Testing – Payment Policy MP9584

Payment policy applies to genetic and molecular testing services and codes billed from the following sections of the CPT/HCPCS manual: molecular pathology; genomic sequencing procedures and other molecular and multianalyte assays and multianalyte assays with algorithmic analyses and proprietary laboratory analyses (PLA) codes.

Medical Policy Revisions

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

Effective September 1, 2022

Varicose Vein and Venous Insufficiency Treatment of Lower Extremities MP9241

Duplex ultrasonography is required within the last six months. Prior authorization is required.

Effective December 1, 2022

Bone Anchored Hearing Aid System (BAHS) MP9018

BAHS initial percutaneous or subcutaneous surgery does not require prior authorization. BAHS are considered medically necessary for the treatment of bilateral or unilateral conductive or mixed conductive and sensorineural hearing loss for the following:

- Bilateral or unilateral hearing loss of greater than 20 dBHL
- Pure-tone average bone conduction hearing threshold less than or equal to level appropriate for model to be implanted
- Middle or external ear pathology, if present, is not amenable to surgical reconstruction
- Trial of air conduction hearing aid failed or is not appropriate

Surgical and Minimally Invasive Treatments for Benign Prostatic Hypertrophy/Hyperplasia (BPH) MP9361

Treatment is considered medically necessary for benign prostate hypertrophy (BPH) with documented urinary outflow obstruction. Prior authorization is not required. The following procedures are considered medically necessary:

- Transurethral microwave thermotherapy (TUMT)
- Transuretheral needle ablation (TUNA) also known as radiofrequency thermotherapy or radiofrequency needle ablation (RFNA)
- Transuretheral incision of the prostate (TUIP)
- Transuretheral electrovaporization of the prostate (TUVP)
- Laser prostatectomy
- Laser based procedures including contact laser ablation of the prostate (CLAP), holmium laser procedures of the prostate (e.g., HoLAP, Holep, HoLRP and thulium laser procedures of the prostate) (ThuLEP)
- Prostatic uretheral lift (e.g., UroLift System)
- Transuretheral resection of the prostate (TURP)
- Transuretheral laser coagulation therapies, including non-contact visual laser ablation of the prostate (VLAP)
- Prostatic stent insertion endouretheral prosthesis (uretheral stent) (e.g., UroLume)
- Water vapor thermal therapy (e.g., Rezum System)

Facet Joint Injections and Percutaneous Denervation Procedures (Radiofrequency and Laser Ablation) for Facet Mediated Joint Pain MP9448

Prior authorization is required. Initial intra-articular diagnostic facet joint injections/medial branch nerve blocks are considered medically necessary when:

- Diagnostic blocks are needed to confirm or validate facet joint as source of chronic pain
- Member is a candidate for facet neurotomy
- Limited to no more than three levels per side of each spinal region per the initial and/or confirmatory diagnostic session(s)

Initial radiofrequency ablation/ neurotomy of the facet joint/facet neurotomy is medically necessary when:

- Severe, non-radiating radicular chronic spinal (cervical, thoracic or lumbar) pain for at least three months duration
- Documented failure of three months or more of nonoperative management
- Two positive diagnostic blocks (facet joint injection or medial branch nerve blocks) that have achieved 80% pain relief from baseline pain scores
- Imaging studies and physical examination have ruled out other causes of spinal pain

Repeat radiofrequency joint denervation/neurotomy at the same facet joint level is considered medically necessary when all of the following are met:

- Pain relief of at least 50% lasting a minimum of 12 weeks
- Procedure is performed at a minimum of six months following the prior denervation/ablation (maximum of two times over a twelve-month period per side and facet joint level)
- Severe pain limiting activities of daily living for at least three months despite conservative treatments
- Repeat RFA treatment procedure is limited to three levels per side of each spinal region in a six-month period

Liver and Other Neoplasm – Chemoembolization and Radioembolization for Hepatic Tumors MP9462

Coverage for radioembolization is based on the FDA approval as a Humanitarian Device Exemption. Prior authorization is not required. Radioembolization with intra-hepatic microsphere is considered medically necessary for:

- Unresectable metastatic liver tumors from neuroendocrine tumors
- Unresectable primary hepatocellular carcinoma
- Unresectable metastatic liver tumors from primary colorectal cancer
- Unresectable primary intra-hepatic cholangiocarcinoma
- Unresectable primary hepatocellular carcinoma as a bridge to liver transplantation

Corneal Cross-Linking (CXL) MP9470

Conventional and accelerated CXL is considered medically necessary for the treatment of keratoconus or corneal ectasia. Prior authorization is not required. CXL is considered experimental and investigational, and therefore not medically necessary for either of the following:

- When performed concurrently with refractive eye surgery procedures such as LASIK or when combined with intrastromal corneal ring segments
- Transepithelial and partial epithelium-off CXL

Bone, Cartilage, Ligament Graft Substitutes and Blood Derived Biologics for Orthopedic Applications MP9545

The following stem cell and cellular bone matrix products for orthopedic applications, are considered experimental and investigational, and therefore not medically necessary:

- Allograft bone graft substitutes containing stem cells, or allograft or synthetic bone graft substitutes that must be combined with autologous blood or bone marrow
- Synthetic ceramic-based or bioactive glass bone substitutes or fillers

The following autologous blood-derived products are considered experimental and investigational, and therefore not medically necessary:

- Platelet-rich plasma
- Autologous conditioned serum injections
- Autologous whole blood injections for tendonopathies and other indications

Effective January 1, 2023

Responsive Cortical Stimulation MP9496

Prior authorization is not required. Treatment is considered medically necessary for members age 18 and older with localized focal epilepsy who:

- Have undergone diagnostic testing that localized no more than two epileptogenic foci
- Currently have an average of at least three or more disabling seizures per month
- Seizures are refractory to two or more antiepileptic medications

Effective February 1, 2023

Plastic and Reconstructive Surgery MP9022

Prior authorization is not required for breast reconstruction for congenital anomalies (e.g., Poland syndrome, congenital tubular, constricted or absence of breast). Breast procedures following mastectomy and lumpectomy that result in significant deformity in order to produce a symmetrical appearance does not require prior authorization.

- **Plastic and Reconstructive Surgery MP9022 —** This policy is specific to Medicare Advantage.

Light Treatment and Laser Therapies for Benign Dermatologic Conditions MP9057

Prior authorization is not required for phototherapy, photochemotherapy, photodynamic therapy, laser therapy (e.g., excimer or pulsed dye laser) and intense pulse light therapy. Refer to the medical policy for criteria. Commercial tanning beds do not qualify as an office trial, and are considered not medically necessary, and therefore are not covered.

- **Light Treatment and Laser Therapies for Benign Dermatologic Conditions MP9057** — This policy is specific to Medicare Advantage.

Genetic Testing for Somatic Tumor Markers MP9486

Thyroid nodule gene expression testing (e.g., ThyraMir) is considered medically necessary. The following tumor profile tests are considered experimental and investigational, and therefore not medically necessary: lung cancer algorithmic tests (e.g., Biodsix); Barrett's esophagus risk stratification testing (e.g., Tissue Cypher Barrett's Esophagus Assay) and ductal carcinoma in situ risk stratification testing (e.g., PreludeDx).