Medical Policy Updates
Effective October 1, 2009

The MVP Quality Improvement Committee (QIC) approved the policies summarized below during the July & August meetings. Some of the benefit interpretation policies may reflect new technology while others clarify existing benefits. All policy updates are listed online in the Benefits Interpretation Manual (BIM). Visit MVP online at www.mvphealthcare.com. Providers can directly access the online BIM through the References section of the Provider portal. The "Current Updates" page lists all policy updates. If you have questions regarding the policies or wish to obtain a paper copy of a policy, contact your Professional Relations representative.

***Healthy Practices* will continue to inform your office about new and updated policies. MVP encourages your office to look at all of the revisions and updates on a regular basis in the Benefit Interpretation Manual (BIM) located on www.mvphealthcare.com in the References section. The update section will list new policies and/or policy revisions at least 30 days prior to their effective date.**

REVISED **Policy Updates Effective October 1, 2009**

The following list of policies was presented to the QIC at the July and August meetings. The policies were recommended for approval without changes. These policies were comprehensively reviewed during 2008. QIC approved the recommendation.

Artificial Intervertebral Discs – Cervical & Lumbar
CT Abdomen, Abdomen/Pelvis, Brain, Cervical/Thoracic/Lumbar Spine, Chest, Extremity, Neck, Pelvis, Sinuses
Hyperbaric Oxygen Therapy (HBO)
Immunizations/Childhood/Adolescent/Adult
Light Therapy for SAD
MRA Brain, Carotid, Kidney, Lower Extremity
MRI Abdomen/Pelvis, Brain, Cervical Thoracic Spine, Chest, Extremity, Hip/Knee, Lumbar Spine, Neck, Pituitary, Shoulder/Wrist, TMJ
Pectus Excavatum
PET Scan Brain, Chest/Cardiac, Whole Body
Prophylactic Mastectomy/Oophorectomy
Wheelchair (Manual)

Policies for Archive

- Age-related Macular Degeneration Treatments
- Optic Nerve and Retinal Imaging

Policy Revisions

Continuous Glucose Monitoring

- Language was changed under the Description to read “CGM may be used either for ambulatory continuous monitoring or long term continuous monitoring.” CGM is indicated for both Type 1 and Type II insulin dependent diabetes.
- Continuous Glucose Monitoring is covered for the Commercial population.
- Only the 72-hour ambulatory monitoring is allowed for Medicare.
- 72 hour ambulatory glucose monitoring does not require prior authorization.
- The Continuous Glucose Monitoring device for home use does require prior authorization.
- There are no age limit restrictions.

Continuous Passive Motion Devices

- An exclusion was added; “use of CPM devices for TMJ is considered investigational”

CT Coronary Artery Disease

- The Medicare Variation Indications have been expanded. Medicare criteria allows the testing in an Emergency Department setting without consideration of other types of stress tests.
- The ACC/AHA guidelines and InterQual® state that doing a traditional stress test would still be a first line test and then if assessment could not be made based on the results progressing to coronary CT is appropriate.

Deep Brain Stimulation – New Policy

- Covered for essential tremor and Parkinson’s that can not be treated by any other means
- Review of the data and the literature does not support Deep Brain Stimulation for Obsessive Compulsive Disorder and is listed under Exclusions.

Electromyography (EMG) & Nerve Conduction Studies (NCS)

- There were no changes to this policy.

Endovascular Procedures

- The policy covers endovascular procedures for repair of AAA for high risk patients who are not candidates for open surgery.

Enteral Therapy (New Hampshire)
Enteral Therapy (Vermont)

- Both VT and NH have individual mandates regarding Enteral Therapy. It was decided to separate the Enteral Therapy policies by state. The policy is compliant with the respective state mandate.

Experimental or Investigative Procedures

- The Medicare compendia section was significantly revised.

Flu Mist 2009-2010

- The policy covers flu mist for the 2009-2010 flu season.

High Frequency Chest Wall Oscillation Devices

- Language was added indicating that coverage will be allowed for members with a diagnosis of a neuromuscular disease.

- The criteria for this policy is based on Medicare and InterQual®.

Home Care Services

- There were no criteria changes were made to the policy.

Home Prothrombin Time Monitoring

- There were no criteria changes were made to the policy.

Hospice Care

- Language was added in the Description section of this policy to clarify the Schenectady palliative care program.

Implantable Cardioverter Defibrillators

- The Indications/Criteria section for Implantable cardioverter defibrillators for members with non-ischemic dilated cardiomyopathy was revised to indicate that members would need to have the condition for >9months prior to treatment.
- Medicare allows coverage for members with the condition for >3 months when enrolled in a clinical trial.

IMRT

- No changes to the criteria for this policy.
- The policy follows NCCN guidelines.
- Policy was sent to MCMC for review by Radiation Oncologists. They supported the plan's perspective; the only proven indications for IMRT are listed in this policy.
- For special circumstances requests will be reviewed on a case by case basis.

Low Vision Aids

- This policy is covered for the Medicaid and Option Family population.
- This service does not require prior authorization.

MRI Breast

- No changes were made to the policy.
- ~~This service does not require prior authorization.~~ **(Prior Authorization is REQUIRED)**

Metal-on-Metal Hip Resurfacing

- There were no criteria changes were made to the policy.

Neuropsychological Testing *(See UM section in this issue regarding Neuropsychological Testing)*

- The policy was changed to reflect the testing requires that a doctorate level psychologist must interpret the test data; however, a qualified technician may perform the test.
- The policy lists the specialties that can order the test.

Oncotype DX Test/Breast Cancer Prognosis

- The policy was revised to include the size of the breast tumor based on the NCCN guidelines for the Oncotype DX test.
- The test requires prior authorization.

Oxygen Therapy for Cluster Headaches

- Under Exclusions; a fourth bullet was added to clarify that the oxygen that would be indicated would be in a tank form, not as an oxygen concentrator.

Prosthetic Devices (Eye & Facial)
Prosthetic Devices (Lower Limb)

- The existing Prosthetic Devices policy was separated into two individual policies.
- Both policies follow Medicare criteria and coverage.
- There was a minor language change in the Medical Record Documentation section in both policies. The language now reads "For coverage for non-standard prosthetic devices, documentation must include detailed information supporting medical necessity".

Radiofrequency Ablation Spinal Pain/Rhizotomy

- This policy covers radiofrequency ablation for facet joint pain and severe cancer pain.
- Exclusions were added for chronic cervical and chronic thoracic pain.

Yttrium-90 Microspheres for Treatment of Liver Cancer – New Policy

- The policy follows NCCN guidelines and package labeling.
- This service requires prior authorization

Please refer to the coding section on the policies to identify any code changes (e.g., new, deleted) or codes no longer requiring prior authorization for a specific policy.