



# Medical Policy Update

Effective June 1, 2009

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*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](http://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

## **Policy Changes Effective June 1, 2009**

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

- Blepharoplasty/Browlift/Ptosis Repair
- Breast Implantation
- Breast Reduction Surgery
- Breast Surgery for Gynecomastia
- Cochlear Implants & Osseointegrated Devices
- Hyperhidrosis Treatment
- Infertility
- Injection Procedures for the Management of Chronic Spinal Pain
- Laser Treatment for Port Wine Stains
- Mifepristone
- Phototherapeutic Keratectomy/Refractive Surgery
- Prolotherapy
- Prostatic Brachytherapy
- Speech Generating Devices
- XSTOP Interspinous Process Decompression System

## **Policy Updates Effective June 1, 2009:**

### **Bone Density Study for Osteoporosis**

- There were no changes made to the existing criteria.
- The policy follows Medicare and NIH coverage criteria.
- There is a frequency limit of once every two years.

### **Brachytherapy for Breast Cancer**

- There were no changes made to the existing criteria.
- Brachytherapy must be done as an adjunct to whole breast radiation.

- Criteria are consistent with NCCN guidelines.

### **Cryoablation Breast Tumors**

- This policy is a non-coverage policy.
- The procedure is not supported in the medical literature and is considered investigational and not medically necessary.

### **Eating Disorders – Policy for Archive**

- Policy to be Archived and the Behavioral Health Team will be utilizing InterQual criteria exclusively.

### **EEG & Anesthesia Monitoring**

- The policy originally addressed anesthesia awareness which is non-covered for general surgery.
- The policy was expanded to include Electroencephalogram (EEG) intra-operative monitoring for these indications carotid artery surgery and electrocorticography when used to record EEG during surgery involving an exposed cerebral cortex.

### **Hyaluronic Acid Derivatives**

- A Medicare Variation was added allowing coverage of viscosupplementation for osteoarthritis of the knee or shoulder when ordered and administered by an orthopedist, rheumatologist, or physiatrist and when criteria are met.
- There is no FDA support for viscosupplementation of the shoulder, therefore coverage for the shoulder is not allowed for Commercial members.

### **Negative Pressure Wound Therapy Pumps - New**

- This policy will replace the Wound Care policy that is scheduled for archive.
- Language related to Negative Pressure Wound Therapy Pumps was extracted and this new policy was developed.

### **Nesiritide Infusion for Heart Failure**

- No criteria changes were made to this policy.
- Coverage is strictly limited to the inpatient setting with acute decompensated CHF and is based on FDA labeling and Medicare criteria.
- Coverage is not allowed in the out patient setting.

### **Stereotactic Radiosurgery (Brain)**

- Technology is limited to specialists in neurosurgery and radiation oncology.
- Criteria is based upon the NCCN guidelines and references from Wake Forest University Baptist Medical Center defining the size of tumors treated as < 3 cm in diameter.
- Multiple or recurrent metastasis with four (4) or more lesions are excluded.
- In review of the literature, it was found that there is nothing to support that one method of stereotactic radiosurgery is superior to another. Therefore, the robotic component does not qualify for additional reimbursement.

### **TMD New York/New Hampshire**

- The Policy Description section was revised.

### **TMD Vermont**

- The Policy Description section was revised.
- The Indications/Criteria section was revised to define Non Surgical & Surgical Treatments.
- Under the Exclusions/Limitations section
  - Diagnostic Arthroscopy was deleted
  - Low Level Light Therapy was added under exclusions.

### **Varicose Vein of the Lower Extremities (Surgical Treatment)**

- The Indications/Criteria section was updated
  - Vein diameter defined “must be greater than 3 mm.”
  - Evidence from a Duplex Scan deleted under the documentation requirements.
  - “Photographs may be requested” was added.
  - Interventional Radiologists were added to the Specialists that may perform the procedure.

### **Wound Care Treatment – Policy for Archive**

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.