PROVIDENCE Health Plan

PROVIDENCE Health Assurance

Healthcare Services Medical & Pharmacy Policy Alerts

Number 271

June 1, 2022

This is the June 1, 2022 issue of the Providence Health Plans, Providence Health Assurance and Providence Plan Partners, Medical and Pharmacy Policy Alert to our providers. The focus of this update is to communicate to providers' new or revised Medical or Pharmacy policy changes. The Health Plan has a standard process to review all Medical & Pharmacy Policies annually. Policies will be available for review on ProvLink and via the PHP website at: https://healthplans.providence.org/providers/provider-support/medical-policy-pharmacy-policy-and-provider-information/

The Provider Alert, Prior Authorization Requirements, and Medical policies are all available on ProvLink and through the link above.

NOTE: For Oregon Medicaid requests, services which do not require prior authorization will process against the Prioritized List. To determine which services require prior-authorization, please see the current PHP prior authorization list here.

MEDICAL POLICY COMMITTEE

MEDICAL

ALL LINES OF BUSINESS EXCEPT MEDICARE

Effective 7/1/2022

Biofeedback and Neurofeedback (All Lines of Business Except Medicare) **MP270**	**Policy Updates:** • No change to criteria. **Codes/PA:** • No change to overall configuration but added clarification that any **denied** diagnosis code must be in the **primary** position of the biofeedback line item in order to warrant a denial for the line item. If an approved diagnosis code is in the primary position and a denied diagnosis code is in any other position, the biofeedback code can adjudicate normally. **OHP:** No impact - no changes to existing PA requirements.
Chemoresistance and Chemosensitivity Assays (All Lines of Business Except Medicare) **MP121**	**Policy Updates:** Add 2 investigational assays as examples of chemoresistance tests: • 3D Predict Ovarian Doublet Panel by KIYATEC • 3D Predict Ovarian PARP Panel by KIYATEC **Codes/PA:** • Add new 7/1/2022 codes, 0324U and 0325U, to policy, configuring to deny as investigational. • Add code 0564T, already denying as investigational on the Investigational and Non-Covered Medical Technologies (All Lines of Business Except Medicare) policy **OHP:** No impact - no changes to existing PA requirements.

Colorectal Cancer Screening (All Lines of Business Except Medicare) **MP106**	**Policy Updates:** • Changing scope to all lines of business except Medicare • Add criterion III: Screening colonoscopies may be medically necessary as a follow up screening after a positive fecal immunochemical test or fecal DNA test. **Codes/PA:** • No changes to codes or PA for Commercial. For Medicare, no changes to codes or PA. Certain tests that are **not** currently allowed as Preventive and are not covered by Medicare will remain non-covered and will be addressed by the *Genetic and Molecular Testing (Medicare Only)* policy instead. **OHP:** No impact- no changes to existing PA requirements.
Genetic Testing: Hereditary Breast and Ovarian Cancer (All Lines of Business Except Medicare) **MP143**	**Policy Updates:** • Update criterion II (genetic testing for members with a personal history of cancer) based on the V 2.2022 NCCN guidelines for Genetic/Familial High-Risk Assessment for Breast, Ovarian, and Pancreatic Cancer. See policy draft for specific changes. Criteria liberalized to allow for testing for triple-negative breast cancer at any age and for treatment decisions for metastatic breast cancer and high-risk, HER-2 negative breast cancer. **Codes/PA:** • No changes to codes/PA **OHP:** No impact- no changes to existing PA requirements.

Effective 8/1/2022

Orthotic Foot Devices and Therapeutic Shoes (All Lines of Business Except Medicare) **MP90**	**Policy Updates:** • Policy criteria updates, but changes to the intent only (i.e. reordering). Policy is based primarily on CMS guidance documents. **Codes/PA:** • L3000-L3170, L3300-L3450, L3465-L3520, and L3550-L3595 incorrectly deny as not a paid benefit. Codes will now pay when medical necessity criteria are met and deny as not medically necessary otherwise • One code (L3265, Plastazote sandal, each) incorrectly denies as cosmetic. CRF needed to allow this code to pay without review. **OHP:** New coding configurations for this policy do not apply to OHP. OHP will continue to follow guidance based on the Prioritized List and the Oregon Administrative Rules

Archive

Effective 7/1/2022

Fecal Microbiota Transplantation **MP126**	**Policy Updates:** Archive policy and **remove PA** from CPT code due to low utilization. **Codes/PA:** Remove PA from G0455. 44705 will deny per coding policy beginning 6/1/2022. **OHP:** Archive applies - zero claims history for OHP.

MEDICARE

Effective 7/1/2022

Chemosensitivity and Chemoresistance Assays (CSRAs) (Medicare Only) **MP329**	**Policy Update:** • New Medicare Advantage medical policy. Separating Commercial from Medicare when Medicare guidance or policies are available. Continue to use Medicare policies when available and Commercial policies in the absence of Medicare guidance. There is a slight variation with the title from Commercial due to terminology and acronyms used by various Medicare contractors. **Codes/PA:** Summary of coding and configuration is as follows: • **No changes:** 0083U, 0564T, 86849, 87999, 88299, 89240 *(CPT codes 0083U and 0564T will be removed from the Medicare IMT policy and addressed by this policy, but no change to code configuration or edits. IMT policy will be presented with this change when the Q3 2022 code updates are presented.)* • **Change E/I denial to NMN denial:** 0248U, 81535, 81536 • **New codes eff. 7/1/2022:** 0324U, 0325U
Genetic and Molecular Testing (Medicare Only) **MP317**	**Policy Update:** Interim update to consolidate other Medicare genetic testing into this policy. The consolidated policies with this update are: • *Genetic Testing: Hereditary Breast and Ovarian Cancer (Medicare Only)* • *Non-Small Cell Lung Cancer: Molecular Testing for Targeted Therapy (Medicare Only)* **Codes/PA:**

<table>
<tr><td></td><td>Transferred codes from above archived policies to this policy that weren't already included in this policy. Coding configuration changes include the following:
Added 0009U to PA section of GMT policy, but no change to PA configuration.
Added 0288U to PA section of GMT policy, removing NMN denial and adding PA.
Added 0137U to Not Covered section of GMT policy, but no change to NMN configuration per LCA.
Removed codes 88235-88291 from policy. While they are at times requested with genetic testing services, they do not require formal review themselves and are currently allowed with no edits.
Added codes for non-covered colorectal cancer screening and pre-screening tests that are not part of Preventive Benefits to this policy (tests are called out by name currently, but codes are not included). These codes are: 0091U (change E/I denial to NMN denial) and G0327 (no change to configuration).</td></tr>
<tr><td>Biofeedback and Neurofeedback (Medicare Only)

MP515</td><td>Policy Updates:
No change to criteria.
Codes/PA:
No change to overall configuration but added clarification that any denied diagnosis code must be in the primary position of the biofeedback line item in order to warrant a denial for the line item. If an approved diagnosis code is in the primary position and a denied diagnosis code is in any other position, the biofeedback code can adjudicate normally.</td></tr>
<tr><td>Blood Counts (Medicare Only)

MP209</td><td>Policy Updates:
No criteria changes, continue to base coverage or non-coverage on Medicare national coverage determination (NCD).
Codes/PA:
No change to CPT/HCPCS codes in policy, but there is an update to the diagnosis code list, based on the Medicare April 2022 NCD implementation update. Additional diagnosis codes are being added to the pair-to-deny list, while some codes are being removed. These changes are effective retroactively back to 10/1/2021.
<table>
<tr><th>Remove from list of denied codes:</th><th>Add to list of denied codes (these Dx codes replace the above codes):</th></tr>
<tr><td>Z590
Z594
Z598</td><td>Z5900
Z5901
Z5902
Z5941
Z5948</td></tr>
</table></td></tr>
</table>

	Z59811 Z59812 Z59819 Z5989
Complementary and Alternative Medicine (CAM) Treatments (Medicare Only) **MP327**	**Policy Updates:** • With the archival of the *Lyme Disease* policy effective 7/1/2022, non-antimicrobial alternative therapies for Lyme disease were moved to the Commercial CAM policy. This policy update is being made to the Medicare CAM policy to align with those changes. Since no specific Medicare guidance for non-antimicrobial alternative therapies for Lyme disease, continue to use Commercial criteria (no change from Lyme Disease policy criteria). **Codes/PA:** • Add codes 99601, 99602, and S9494-S9504 to this policy, but no changes to code configuration.
Fecal Incontinence Treatments (Medicare Only) **MP228**	**Policy Updates:** • Remove use of Commercial criteria for PTNS, replaced with available LCA • For vaginal insert for fecal incontinence (FI), Commercial criteria will be used instead of LCA, added the rationale why. • Updated "Billing Guidelines" due to above changes and included codes 0587T-0590T with note about CPT 64566. Also clarified that biofeedback codes are configured to deny when reported with FI diagnosis codes. **Codes/PA:** Summary of coding and configuration changes: • Removed E/I denial edit from A4563 and L8605 and added NMN denial edit. • Revised dx code configuration for CPT 64566 to match the PTNS LCA. • Added codes 0587T-0590T to this policy and also revised their code configuration to match the PTNS LCA. • Since the Eclipse system is a vaginal insert, it may not be reported with unlisted anus procedure code. Therefore, added CPT 58999 for unlisted female genital procedure (no change to configuration, still an unlisted code).
Urinary Incontinence Treatments (Medicare Only) **MP231**	**Policy Updates:** • Consistent with fecal incontinence policy changes, updated "Billing Guidelines" based on LCA for PTNS. This policy was already using the correct LCA, so no criteria changes were required. **Codes/PA:** Summary of coding and configuration changes: • Removed E/I denial edit from A4563 and L8605 and added NMN denial edit. • Removed PA from codes 0587T-0590T and revised their code configuration to match the PTNS LCA. • Revised dx code configuration for CPT 64566 to match the PTNS LCA.

	• For HCPCS code E0740, the criteria is based on NCD, which states coverage is available so removed NMN denial edit and added PA (zero claims or PA in past two years, so no significant impact)
Respiratory Viral Panels (Medicare Only) **MP255**	**Policy Updates:** • Update to criteria. The LCD specific to *respiratory* viral panels is being retired, but the information found in this LCD is being transferred to a new LCD, which will be effective 6/2/2022. This new LCD is much more extensive than just respiratory testing, so at next annual review of this policy, a more thorough review will be done to determine if additional steps need taken about this policy, due to the change in scope of the LCD. **Codes/PA:** Summary of coding and configuration changes: • CPT codes 87631, 87636, 87637, 0240U and 0241U: Update diagnosis code configuration to match the new LCD. • CPT codes 87632, 87633, 0115U, 0202U, 0223U, and 0225U: Remove NMN denial and add new diagnosis code and place of service (POS) configuration.

Effective 8/1/22

Orthotic Foot Devices and Orthopedic Shoes (Medicare Only) **MP298**	**Policy Updates:** • Rearranged services in the criteria table and added a "HCPCS" column. • Moved local coverage articles (LCAs) to the "Billing Guidelines" section. • Added "Policy Guidelines" section with additional information about Medicare's overall position on these devices. • Reformatted the "Billing Guidelines" section. • Rearranged "Cross References" and added updated MP numbers • Removed duplicate citations from the "References" section, added new citations. **Codes/PA:** Summary of code changes: • Added HCPCS code A9270 to the policy, based on LCA A52501; however, no change to configuration (continue to deny member liability). • HCPCS codes L3215, L3216, L3217, L3219, L3221, and L3222 were moved from the "No PA Required" section to the "Not Covered" section of the code table and add NMN denial. • Also update L3252, L3253 and L3260 to deny x07 (not covered benefit) per Medicare, consistent with L3265 (which already denies in this manner). However, there is large volume on this set of codes, especially L3260. Hold on these codes for now.

	• Other codes for replacement components, inserts or modifications were re-arranged or re-ordered in the "No PA Required" section, but no changes to configuration.

Archive

Effective 7/1/2022

Genetic Testing: Hereditary Breast and Ovarian Cancer (Medicare Only) **MP144**	**Policy Updates:** • Archive this Medicare Only policy. This policy addresses several tests, both single gene and panel test types. The codes for the single gene BRCA1 & BRCA2 testing are already addressed in the *Genetic and Molecular Diagnostics (Medicare Only)* policy, so added a potentially covered single gene test table to the policy. Specific proprietary tests currently addressed in this policy that are not already in the *Genetic and Molecular Diagnostics (Medicare Only)* will be moved to the overarching GT policy, following current format. Added additional "Quick Links" to areas around the policy document for faster navigation. **Codes/PA:** • Tests will be addressed by the *Genetic and Molecular Diagnostics (Medicare Only)* policy. This 7/1/2022 policy version also includes new Q3 2022 Code updates. See separate CRW for any code configuration changes.
Non-Small Cell Lung Cancer: Molecular Testing for Targeted Therapy (Medicare Only) **MP193**	**Policy Updates:** • Archive this Medicare Only policy. This policy addresses several tests, both single gene and panel test types. The codes for the single gene EGFR and KRAS testing are already addressed in the *Genetic and Molecular Diagnostics (Medicare Only)* policy, so added a potentially covered single gene test table to the policy. Specific proprietary tests currently addressed in this policy that are not already in the *Genetic and Molecular Diagnostics (Medicare Only)* will be moved to the overarching GT policy, following current format. Added additional "Quick Links" to areas around the policy document for faster navigation. **Codes/PA:** • Tests will be addressed by the *Genetic and Molecular Diagnostics (Medicare Only)* policy. This 7/1/2022 policy version also includes new Q3 2022 Code updates. See separate CRW for any code configuration changes.

REIMBURSEMENT

Effective 6/1/2022

Inpatient Hospital Readmissions **RP1**	**Type of Update:** New Reimbursement Policy **Policy Updates:** ● New reimbursement policy addressing both unplanned and planned inpatient hospital readmissions. ● **Per the recommendation of RCGA and legal, the policy will only apply to participating and contracted facilities and will not apply to Medicaid/OHP.** ○ **Phase II will explore OON facilities and application to OHP.** ● The criteria, first-and-foremost, are in-line with all relevant Medicare claims processing and benefit manuals. However, the Medicare language is rather vague, so supplemental review criteria were added based on the plan survey and an UpToDate® review on Hospital Readmissions. ● The policy first defines the criteria for readmission review. If readmission review criteria are met, either the unplanned or planned readmission criteria would then be applied. ○ Criteria note added that even if the readmission is beyond 30 days it is still subject to MD review (RCGA confirmed that we have the ability to review any inpatient readmission, regardless of time period between admissions). ● Current medical management policy states Leave of Absence (ie Planned Readmission) for Medicare is null/void if the time between discharge and readmission is greater than 60 days. ○ After consultation with RCGA, it was determined that we have the ability to review both planned and unplanned readmissions at any point in time (not just those that occur within 30 days or those that extend beyond 60 days). Thus, this language was removed, and the criteria note mentioned above was added. ● Current medical management policies, which will now be archived: 54.0 (HCS Facility Readmissions) **Reimbursement Methodology:** ● Unplanned readmission—when criteria are met, the second inpatient stay is not reimbursable. ● Planned readmission—when criteria are met, the initial and subsequent admissions will be combined into a single DRG payment. **Major Differences from Current Policy & Process:** ● Current policy does not differentiate between planned and unplanned readmission ● Today, we combine the two DRGs even if it's an unplanned readmission. ● Plan to develop a proactive method for pending claims (vs maybe/maybe not catching them in CCR review)
Facility Routine Supplies and Services	**Type of Update:** New Reimbursement Policy

RP2	**Policy Updates:** • Creation of a new reimbursement policy around facility routine supplies and services that will be used to review IP claims not captured by the Optum high dollar review ($30-$99K claims) • The policy criteria outline supplies and services which are not separately reimbursable because they are considered incidental to the facility charge. • The policy is in-line with all relevant Medicare guidance around routine items or services and supplies billed in error. • Because the Medicare guidance is rather vague, extensive policy guidelines have been added to give examples of supplies and services which are not separately reimbursable. • Current medical management policies, which will now be archived: (maybe) 82.0—need to review with reimbursement team and Stephanie Asher. **Reimbursement Methodology:** Supplies or services which meet policy criteria will be considered not separately reimbursable.

VENDOR UPDATES

Clinical Alert – CT Contrast Shortage

Radiology Program

AIM has been made aware of a possible temporary iodinated contrast shortage, specifically involving GE Healthcare's iodinated contrast media (Omnipaque™) stemming from a manufacturing facility lockdown in Shanghai, China. Iodinated contrast is used to provide enhancement of organs, tissues, and blood vessels for CT scans. GE estimates an 80 percent reduction in the supply of Omnipaque for about 6–8 weeks.

The Greater New York Hospital Association recently published potential conservation strategies for providers and imaging facilities to consider (https://www.gnyha.org/news/ge-contrast-media-shortageand-conservation-strategies/), including evaluating imaging requests and protocols for appropriate use of contrast media.

What is AIM doing to address the contrast shortage?

AIM management focuses on the appropriateness of the modality. We leave decisions about whether to

perform that modality with or without contrast to the radiologist/rendering provider.
For indications that cannot be adequately imaged by non-contrast CT, alternative advanced imaging modalities may be appropriate. Many AIM guideline indications have allowances for MRI and/or PET/CT "when CT cannot be performed or is non-diagnostic," which would include scenarios such as this when contrast CT cannot be performed (and non-contrast CT is expected to be non-diagnostic).
Requests for alternative imaging made under such circumstances should include this detail (eg "iodinated contrast for CT is not available") in the submitted prior authorization request, either by peer-topeer discussion or via the free text entry option for online web portal requests.

AIM Imaging Guidelines (Vascular, Spine, Extremity)	Effective **June 12th** are updates to the following:
	• **Vascular Imaging Guidelines**
	  ○ Liberalizations
	  ▪ *Carotid revascularization:* Screening – new indications post neck irradiation for incidental carotid calcification
	  ▪ Subacute stroke/TIA: allow CTA/MRA Neck without previously prerequisite US in alignment with 2021 AHA/ASA guidelines.
	  ▪ Chronic stroke/TIA: New Carotid US indication given potential for intervention; CTA/MRA Neck allowed for chronic posterior circulation stroke/TIA.
	  ▪ Removal of CXR requirement added last cycle given lower threshold for elevated D-dimer scenarios, thrombosis related to COVID infection, etc.
	
	Effective **September 11th** are updates to the following:
	• **Vascular Imaging Guidelines**
	  ○ Liberalizations
	  ▪ *Pulsatile tinnitus:* Allow optional CTA/MRA Neck evaluation.
	  ▪ *Carotid revascularization:* Surveillance - alignment with SVS guideline for annual imaging post-revascularization after first year (reduced frequency for residual severe stenosis by prior GL; no change for mild-moderate residual stenosis; expansive when no residual stenosis).
	  ▪ Allow either CTA or MRA chest for thoracic dissection (surveillance sometimes done w/ MR).
	  ▪ Addition of optional pelvic imaging for possible iliac vessel involvement – prior content gap.
	  ▪ Screening: addition of femoral aneurysm to listed lower extremity sites predisposing to AAA (content gap).
	  ▪ New indication for Arterial US surveillance for repaired popliteal artery aneurysm (in alignment with 2021 SVS guidelines).
	  ○ Restrictions

	▪ Management: alignment with SVS guidelines for post- endovascular repair only, repeat imaging in 12 months after baseline. ▪ Surveillance: alignment with SVS guidelines for annual surveillance post endovascular repair. ▪ Imaging study corrected to include optional added pelvic imaging (not only pelvic vein imaging). ▪ Diagnosis: suspected PAD without physiologic testing (including exercise testing) not indicated. ▪ Diagnosis: suspected PAD without physiologic testing (including exercise testing) not indicated (added scenarios aligned with PAD upper extremity). • **Spine Imaging Guidelines** o Liberalizations ▪ *General prerequisites for spine imaging*: Allow exception to specified durations of conservative management in rare cases. o Restrictions ▪ *Cervical injury*: Clarified that post-traumatic neurologic deficit refers specifically to a finding on exam ▪ *Thoracic or lumbar injury*: Clarified that "neurologic deficit" refers to an exam finding rather than a subjectively reported symptom. ▪ *Perioperative and periprocedural imaging*: added requirement for initial evaluation with radiographs. • **Extremity Imaging Guidelines** o Liberalizations ▪ *General prerequisites for extremity imaging* Allow exception to specified durations of conservative management in rare cases. ▪ Added indication for evaluation of supracondylar fracture. ▪ Added CT as an alternative to MRI for tibial plateau fracture. o Restrictions ▪ Standardized conservative management to 6 weeks (previously 4 weeks for acute rotator cuff tear). ▪ Modified language to clarify intent – total shoulder arthroplasty should not require advanced imaging. ▪ Excluded robotic-assisted hip arthroplasty as robotic-assisted surgery in general does not provide net benefit over conventional arthroplasty.

PROVIDENCE Health Plan

PROVIDENCE Health Assurance

Here's what's new from the following policy committees:

Pharmacy & Therapeutics (P&T) Committee

Go-Live Date: Monday, August 01, 2022, unless otherwise noted

Special Updates:

Self-Administered Drug Exclusions

- Some medications are injected into the body (IM and SC) by either a healthcare provider or directly by the patient or their caregiver
- There are benefits to requiring self-administration of some of these drugs including lower drug costs, lower administrative costs, convenience for patients, and on-going patient support through our specialty pharmacy providers. These types of drugs are added to a self-administered drug (SAD) exclusion list.
- A drug in the corresponding line of business SADs Exclusion List will be covered under the medical benefit for the initial 60-day treatment period to allow for proper healthcare provider training of self-administration and monitoring for adverse events. After the 60-day initial period, the drug will not be covered under the medical benefit ("incident-to" a healthcare provider visit), unless approved for on-going coverage.
- Effective 8/1/2022 the following drugs will be added to the SADs exclusion list:
    - Stelara® syringe
    - Orencia® syringe and auto-injector
    - Fasenra® syringe and auto-injector (Pen)
    - Nucala® syringe and auto-injector
    - Actemra® syringe and auto-injector
    - Benlysta® subcutaneous administration with syringe and auto-injector

Infusion therapy Site of Care

- Drugs have been added to the Infusion therapy Site of Care policy
- Effective 8/1/2022, the following drugs will be required to be administered at an approved site of care unless and authorization has been granted for continued administration at an unapproved site of care:
    - Immune gamma globulin products (Asceniv®, Hyqvia®, Panzyga®, Cutaquig®)
    - Enzyme replacement therapies (Fabrazyme®, Lumizyme®, Nexviazyme®, Elaprase®, Mepsevii®, Vimizim®, Aldurazyme®)

        - For new starts only on enzyme replacement therapies- a longer transition time will be allowed to an approved site of care due to concerns for anaphylactic reactions
    - Denosumab (Prolia®, Xgeva®)
    - Radicava®
    - Onpattro®
    - Alpha-1 protenase inhibitos (Aralast NP®, Prolastin®, Zemaira®)
    - Tepezza®
- The most up-to-date list of approved site-of-care facilities/providers can be found at: https://www.providencehealthplan.com/-/media/providence/website/pdfs/providers/medical-policy-and-provider-information/pharmacy-policy/approved-site-of-care-facility-list.pdf