Policy Updates November 2017

- Medical Policies

CareSource™

AT CARESOURCE, WE LISTEN TO OUR HEALTH PARTNERS, AND WE STREAMLINE OUR BUSINESS PRACTICES TO MAKE IT EASIER FOR YOU TO WORK WITH US.

We have worked to create a predictable cycle for releasing medical and reimbursement policies, so you know what to expect. Check back each month for a consolidated network notification of medical and reimbursement policy updates from CareSource.

HOW TO USE THIS NETWORK NOTIFICATION:

- Reference the Table of Contents and click on the policy title to navigate to the corresponding policy summary.
- The summary will indicate the effective date and impacted plans for each policy.
- Within the summary, click on the hyperlinked policy title to open the webpage with the full policy.

FIND OUR POLICIES ONLINE

To access all CareSource policies, visit CareSource.com and click “Health Partner Policies” under Provider Resources.

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POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLANS	SUMMARY	IMPACT
Debridement Services	Medical	12/15/17	Medicaid	The Debridement Services policy was created to provide health partners with medical necessity and policy rationale information consistent with the most up-to-date evidence-based medical literature regarding debridement services.	• No Prior Authorization • Osteomyelitis o Debridement for osteomyelitis is covered for chronic osteomyelitis and osteomyelitis associated with an open wound. • Chronic Foot Ulcer Management o Debridement of diabetic foot ulcers more frequently than once every seven (7) days, for longer than three (3) consecutive calendar months, is not indicative of an effective plan of treatment. Should a patient require more debridement services per wound than noted above, the medical record must include careful documentation reflecting neuropathic, vascular, metabolic, or other co-morbid conditions. o Removing a collar of callus (hyperkeratotic tissue) around an ulcer is not considered debridement of skin or necrotic tissue. • Limitations of Coverage o Debridement services are not covered in the absence of necrotic, devitalized, fibrotic, or other tissue or foreign matter present that would interfere with the normal wound healing process and must be documented in the medical record. o Removal of devitalized tissue from wound(s), non - selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care and is not addressed in this policy. o Anesthesia services are not separately reimbursable for these services.

POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLANS	SUMMARY	IMPACT
Facet Medial Branch Nerve Blocks	Medical	12/17/17	Medicaid	The Facet Medial Branch Nerve Blocks policy was created to provide health partners with medical necessity and policy rationale information consistent with the most up-to-date evidence based medical literature facet medial branch nerve block services.	• A prior authorization is required for each facet medial branch nerve block injection for pain management. • Facet Medial Branch Nerve Block Injections are indicated when **ALL of the following** criteria are met: o Spine pain is predominantly axial and non-radiating and located in the cervical, thoracic, or lumbar spine. If pain is pseudo-radicular, the contemporaneous medical record must display documentation of this according to the criteria outlined in this policy. o Relevant imaging studies of the painful spinal region were completed within 36 months prior to the date of this request. • CareSource will consider a Facet Medial Branch Nerve Block Injection medically necessary for evaluation of predominantly non-radiating pain that is unresponsive to a well-managed course of conservative therapy when the following criteria exist: o A thorough history and physical exam documenting cause of the pain if known, duration of symptoms, severity, exacerbating factors, abnormal physical and diagnostic findings and prior conservative treatment measures. If pain is pseudoradicular, the contemporaneous medical record must so state this finding o Documentation of associated medical and psychological disorders o Diagnostic studies including x-rays and MRIs where appropriate that have confirmed the diagnosis of facet arthropathy or degenerative disease of the spine.

POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLANS	SUMMARY	IMPACT
Hepatitis Panel	Medical	12/17/17	Medicaid	Primary mode of transmission, whether the illness is acute or chronic, and vaccine availability vary between the different types of viral hepatitis. Chronic hepatitis can lead to liver cirrhosis, liver failure, liver cancer, and ultimately, death.	• Does not require prior authorization for medically necessary hepatitis panel tests • Specifies the following circumstances to be medically necessary for hepatitis panel testing: o To detect viral hepatitis infection when there are abnormal liver function test results, with or without signs or symptoms of hepatitis o Prior to and subsequent to liver transplantation • Specifies the components of the Hepatitis Panel o Hepatitis A antibody (HAAb), IgM Antibody o Hepatitis B core antibody (HBcAb), IgM Antibody o Hepatitis B surface antigen (HBsAg) o Hepatitis C antibody If required, providers must submit their prior authorization number, their claim form, as well as appropriate HCPCS and/or CPT codes along with appropriate modifiers in accordance with CMS. Claims not meeting the necessary criteria as described in the policy document will be denied.

POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLANS	SUMMARY	IMPACT
Sleep Studies	Medical	12/17/17	Medicaid	SBD is characterized by apnea, breathing that has stopped, and/or hypopnea, shallow breathing. Apneic episodes can last from seconds to minutes and can occur up to hundreds of times over the course of a night's sleep. The number of apnea or hypopnea episodes are determined during a sleep study and is known as the Apnea-Hypopnea Index (AHI). An AHI of less than 5 is normal while 5 to 15 indicates mild sleep apnea; 15 to 30 indicates moderate sleep apnea; and more than 30 is considered severe sleep apnea.	• Does not require prior authorization for a medically necessary sleep study. • Specifies that a patient must have symptoms of the following conditions in order for a sleep study to be considered medically necessary: o Narcolepsy o Parasomnias o Sleep apnea • Specifies other criteria regarding referral, diagnostic testing, and confirmation of diagnosis • Specifies the minimum components that a polysomnography is defined to include, without limitation

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Thyroid Testing	Medical	12/17/17	Medicaid	The Thyroid Testing policy was created to provide health partners with medical necessity and policy rationale information consistent with the most up-to-date evidence based medical literature regarding thyroid testing services.	• Members who are clinically stable, performed up to 2 times per year • Members who have symptoms consistent with hyperthyroidism • Members who are asymptomatic and 60 years of age or older, performed every 5 years • Members who are asymptomatic but are considered high risk due to the following: o Family or personal history of thyroid disease. This should be limited to a one-time screening. o Family or personal history of Type I Diabetes or other autoimmune disorder. This should be limited to a one-time screening. o Member who is prescribed medications that may interfere with thyroid function.

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Transthoracic Echocardiogram	Medical	12/17/17	Medicaid	The Transthoracic Echocardiogram policy was created to provide health partners with medical necessity and policy rationale information consistent with the most up-to-date evidence based medical literature regarding transthoracic echocardiogram services.	• CareSource does not require a prior authorization for a transthoracic echocardiogram (TTE). • Transthoracic echocardiography may be indicated for 1 or more of the following: o Acute thromboembolic event o Aortic dissection o Ascending aortic aneurysm, known, or history of aortic dissection o Atrial fibrillation o Cardiac Shunt o Cardiovascular evaluation in acute setting o Chest pain, pediatric o Congenital heart disease o Endocarditis, known or suspected o Heart failure, cardiomyopathy, or left ventricular dysfunction, known or suspected o Heart murmur o Hypertension o Pericardial disease o Preoperative or preprocedural planning needed o Prosthetic heart valve o Pulmonary embolism o Pulmonary hypertension, cor pulmonale, or unexplained dyspnea o Syncope o Thoracic aortic aneurysm o Thoracic aortic aneurysm in patient with bicuspid aortic valve o Valvular heart disease

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Trigger Point Injections	Medical	12/17/17	Medicaid	The Trigger Point Injections policy was created to provide health partners with medical necessity and policy rationale information consistent with the most up-to-date evidence based medical literature regarding trigger point injection services.	• Trigger-point injections of anesthetic and/or corticosteroid for back pain, neck pain, or myofascial pain syndrome will be considered as medically necessary when pain has persisted despite appropriate medical management and **ALL** of the following criteria are met: o Conservative therapies such as bed rest, exercises, heating or cooling modalities, and pharmacotherapies such as non-steroidal anti-inflammatory drugs, muscle relaxants, non-narcotic analgesics, have been tried and failed. o Trigger points have been identified by palpation. o Injections for (initial) diagnosis and pain stabilization are given no less than one week apart, and preferably two weeks apart. o Injections for (subsequent) treatment of the same anatomic site(s) are given two months or longer apart, as long as at least 50% relief is obtained for six weeks, and initial and subsequent injections provided total to no more than 8 dates of service for trigger point injections per calendar year per patient. • The injections for treatment are not used in isolation, but are provided as part of a comprehensive pain management program, including **2 or more** of the following: o Physical therapy sessions o Chiropractor visits o Exercise program o Non-narcotic medications