

# *Policy Updates* November 2017

- Reimbursement Policies
- Medical Policies



## 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 on “Health Partner Policies” under the “Provider Resources” menu.

### CLAIMS AND APPEALS

As indicated in the applicable Health Partner Manual, if you do not agree with the decision of a processed claim, you will have 365 days from the date of service or discharge to file an appeal. Please submit your appeal through the Provider Portal or in writing. For detailed instructions, please consult your applicable Health Partner Manual.

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POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLANS	SUMMARY	IMPACT
Breast Imaging – <a href="#">OH MPP PY-0076</a>	REIMBURSEMENT	11/01/2017	OHIO MARKETPLACE	The Breast Imaging Ohio Marketplace Plans reimbursement policy will reimburse participating providers for medically necessary breast imaging services according to Ohio Evidence of Coverage (EOC) criteria. Reimbursement policies are designed to assist you when submitting claims to CareSource.	<ul style="list-style-type: none"> <li>• CareSource does not require prior authorization for screening and diagnostic mammograms.</li> <li>• CareSource follows the Evidence of Coverage (EOC) document criteria for mammography. For further information, please refer to: <a href="https://www.caresource.com/documents/mp-2017-oh-eoc/">https://www.caresource.com/documents/mp-2017-oh-eoc/</a></li> <li>• CareSource considers diagnostic mammography medically necessary for men and women with signs and symptoms of breast disease or a history of breast malignancy.</li> <li>• The total benefit for a screening mammogram shall not exceed one hundred thirty percent (130%) of the Medicare reimbursement rate in the State of Ohio for screening mammograms. If there is more than one Medicare reimbursement rate in the State of Ohio for screening mammograms or a component of a screening mammogram, the reimbursement limit shall be one hundred thirty percent (130%) of the lowest Medicare reimbursement rate in the State.</li> </ul>

POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLANS	SUMMARY	IMPACT
Breast Reduction Surgery – <a href="#">OH MCD MM-0020</a>	MEDICAL	11/01/2017	OH MEDICAID	<p>As one of the conditions of breast reduction surgery, breast size must interfere with activities of daily living. The policy now includes a time component for this condition of at least 1 year. Additionally, as part of this same condition, at least one indication, as specified in the policy, must be observed. This requirement was modified such that a minimum of two indications must be observed.</p> <p>The portion of the policy that addresses failure to relieve symptoms with nonsurgical treatment was removed as the provisions were redundant with another part of the policy.</p>	<p>Breast size interferes with activities of daily living for at least one year, as indicated by two or more of the following:</p> <ul style="list-style-type: none"> <li>• Arm numbness consistent with brachial plexus compression syndrome</li> <li>• Cervical pain</li> <li>• Chronic breast pain</li> <li>• Headaches</li> <li>• Nipple position greater than 21 cm below suprasternal notch</li> <li>• Persistent redness and erythema (intertrigo) below breasts</li> <li>• Restriction of physical activity</li> <li>• Severe bra strap grooving or ulceration of shoulder</li> <li>• Shoulder pain</li> <li>• Thoracic kyphosis</li> <li>• Upper or lower back pain</li> </ul> <p>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.</p> <p>Claims not meeting the necessary criteria as described in the policy document will be denied.</p>

POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLANS	SUMMARY	IMPACT
Gastroesophageal Reflux Disease (GERD) Treatment – <a href="#">OH MCD MM-0055</a>	MEDICAL	11/01/2017	OH MEDICAID	The Society of American Gastrointestinal and Endoscopic Surgeons (SAGES) updated their published clinical guidelines from 2013 regarding endoluminal treatments for GERD.	<p>In March of 2017, SAGES issued an update to their clinical guidelines regarding endoluminal treatments for GERD, stating:</p> <ul style="list-style-type: none"> <li>“Based on existing evidence, TIF can be performed with an acceptable safety risk in appropriately selected patients. The procedure leads to better control of GERD symptoms compared with PPI treatment in the short term (6 months), but appears to lose effectiveness during longer term follow-up and is associated with moderate patient satisfaction scores. Objective GERD measures improve similarly after TIF 2.0 compared with PPI. No comparative, controlled trials exist between TIF and surgical fundoplication, but preliminary evidence suggests that the latter can be used safely after TIF failure.”</li> <li>“Based on existing evidence, Stretta significantly improves health related quality of life score, heartburn scores, the incidence of esophagitis, and esophageal acid exposure in patients with GERD, but does not increase lower esophageal sphincter basal pressure. In addition, it decreases the use of PPI by approximately 50%. The effectiveness of the procedure diminishes some over time, but persistent effects have been described up to 10 years after the procedure in appropriately selected patients with GERD. Stretta is more effective than PPI, but less so than fundoplication. Stretta is safe in adults and has a short learning curve.”</li> </ul> <p style="text-align: right;">(continued)</p>

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Gastroesophageal Reflux (GERD) Treatment – <a href="#">OH MCD MM-0055</a>	MEDICAL	11/01/2017	OH MEDICAID		<p style="text-align: right;">(continued)</p> <p>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.</p> <p>Claims not meeting the necessary criteria as described in the policy document will be denied.</p>

POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLANS	SUMMARY	IMPACT
Nutritional Supplements – <a href="#">OH MCD MM-0024</a>	MEDICAL	11/01/17	OH MEDICAID	Oral or enteral nutrition may be considered medically necessary when the diet consists of 50 percent or more of enteral nutrition for age, under specified conditions.	<ul style="list-style-type: none"> <li>Occupational and physical therapy are reimbursed based on the Medicaid fee schedule.</li> <li>Reimbursement is based off appropriate CPT/ICD-10 matching.</li> <li>Participating providers may provide 30 visits a calendar year (Jan.1 – Dec. 31) without prior authorization. After 30 visits require a prior authorization.</li> <li>Non-participating providers always require a prior authorization.</li> <li>When applicable, 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.</li> <li>Claims not meeting the necessary criteria as described in the policy document will be denied.</li> </ul>



POLICY NAME	POLICY TYPE	EFFECTIVE DATE	PLANS	SUMMARY	IMPACT
Occupational and Physical Therapy – <a href="#">OH MCD PY-0030</a>	REIMBURSEMENT	11/01/17	OH MEDICAID	The occupational and physical therapy payment policy will reimburse providers for medically necessary therapy through criteria based on the Ohio Administrative Code.	Occupational and physical therapy are reimbursed based on the Medicaid fee schedule <ul style="list-style-type: none"> <li>• Reimbursement is based off appropriate CPT/ICD-10 matching.</li> <li>• Participating providers may provide 30 visits a calendar year (Jan.1 – Dec. 31) without prior authorization. After 30 visits require a prior authorization.</li> <li>• Non-participating providers always require a prior authorization.</li> <li>• When applicable, 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.</li> <li>• Claims not meeting the necessary criteria as described in the policy document will be denied.</li> </ul>

POLICY NAME & NUMBER	POLICY TYPE	EFFECTIVE DATE	PLANS	SUMMARY	IMPACT
Occupational and Physical Therapy – <a href="#">OH MA PY-0297</a>	Reimbursement	11/01/2017	OH MEDICARE ADVANTAGE	The Occupational and Physical Therapy payment policy will reimburse providers for medically necessary therapy through criteria based on the LCD L34049 Ohio Administrative Code.	<ul style="list-style-type: none"> <li>• Ohio Medicare Advantage:</li> <li>• Occupational and physical therapy are reimbursed based on the Medicare fee schedule</li> <li>• Reimbursement is based off appropriate CPT/ICD-10 matching</li> <li>• Participating providers may provide 30 visits a calendar year (Jan.1 – Dec. 31) without prior authorization.</li> <li>• When applicable, 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</li> <li>• Claims not meeting the necessary criteria as described in the policy document will be denied.</li> <li>• CareSource may request documentation to validate medical necessity.</li> </ul>

POLICY NAME & NUMBER	POLICY TYPE	EFFECTIVE DATE	PLANS	SUMMARY	IMPACT
Positive Airway Pressure (CPAP) – <a href="#">OH MCD PY-0313</a>	REIMBURSEMENT	11/01/2017	OH MEDICAID	The Positive Airway Pressure Devices for Pulmonary Disorders payment policy will reimburse providers for medically necessary CPAP or BiPAP devices through criteria based on MCG guidelines. Providers must periodically monitor the use of the machine and compliance must be maintained for reimbursement.	<ul style="list-style-type: none"> <li>• Positive airway pressure devices for pulmonary disorders are reimbursed based on the Medicaid fee schedule.</li> <li>• CPAP and BiPAP devices are a 10 month rent-to-purchase. BiPAP (E00471) is a continuous rental and never caps as a purchase. CPAP and BiPAP devices do not require a prior authorization for the first 3 months rental.</li> <li>• Prior authorization is required for months 4 to 10 of the rental period.</li> <li>• Non-participating providers require a prior authorization.</li> <li>• 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.</li> <li>• Claims not meeting the necessary criteria as described in the policy document will be denied.</li> </ul>

POLICY NAME & NUMBER	POLICY TYPE	EFFECTIVE DATE	SUMMARY	IMPACT
Speech-Language Pathology – <a href="#">OH MCD PY-0175</a>	REIMBURSEMENT	11/01/2017	The speech-language pathology payment policy will reimburse providers for medically necessary therapy through criteria based on the Ohio Administrative Code.	<ul style="list-style-type: none"> <li>• Speech-language pathology services are reimbursed based on the Medicaid fee schedule.</li> <li>• Reimbursement is based off appropriate CPT/ICD-10 matching.</li> <li>• Participating providers may provide 30 visits a calendar year (Jan.1 – Dec. 31) without prior authorization. After 30 visits require a prior authorization.</li> <li>• Non-participating providers always require a prior authorization.</li> <li>• When applicable, 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.</li> <li>• Claims not meeting the necessary criteria as described in the policy document will be denied.</li> </ul>
POLICY NAME & NUMBER	POLICY TYPE	EFFECTIVE DATE	SUMMARY	IMPACT
Speech – Language Pathology – <a href="#">OH MA PY-0180</a>	REIMBURSEMENT	11/01/2017	The speech-language pathology payment policy will reimburse providers for medically necessary therapy through criteria based on the LCD L34046.	<ul style="list-style-type: none"> <li>• Speech-language pathology services are reimbursed based on the Medicare fee schedule</li> <li>• Reimbursement is based off appropriate CPT/ICD-10 matching</li> <li>• Speech-language pathology services do not require a prior authorization</li> <li>• Claims not meeting the necessary criteria as described in the policy document will be denied.</li> <li>• CareSource may request documentation to support medical necessity.</li> </ul>