Medical Policy Update – March 1, 2015

Please review the following new or revised medical policy/coverage criteria.

- Clinic groups whose staff members do not have internet access may request a paper version of revised and new policies by calling 1.888.467.0774.
- Providers may also ask to speak with a Medical Director if they have a question about a utilization management decision.
- For general policy and process questions, call 1.888.467.0774 or email medicalpolicy@healthpartners.com

Medical Service	Comments/Changes
Spinal Cord Stimulator (SCS)	x Revised to clarify intent of coverage by removing radicular pain limitation and clarifying regional pain syndrome to complex regional pain syndrome, including upper and lower extremity pain. x Continues to require prior authorization x Effective 8/25/14
Investigational Services – Category III T Codes	x Effective immediately: x 0054T, 0055T, 0248T no longer require prior authorization. x 0319T – 0328T have been retired and removed from this policy. x 0376T is covered without prior authorization. 0340T – 0391T are new Category III T codes effective 7 &1/1/15; prior authorization is required.
Feeding/Oral Function Therapy, Pediatric	x Policy revised with minor clarification, effective immediately. x Criterion added to the section defining the presence of feeding/oral function problems: "Definite differences are documented in standardized sensory testing in the area of oral sensory processing, or oral sensory sensitivity."
Speech Therapy, Habilitative Physical & Occupational Therapy – Outpatient Habilitative	x Policy revised with minor clarifications that are not content changes but more accurately defining how the policy has been administered, effective immediately. x Clarifies feeding/oral therapy swallowing problems are addressed in a unique policy. x Clarification of other criteria to make the policy more effective in the current habilitative therapy milieu. x Adding one criterion as not covered: "Therapy to improve speech for a second language."

	current habilitative therapy milieu. x Adds “Recreation therapy” as not covered.
Colorectal Cancer (CRC) Screening with Stool Based DNA Testing (Cologuard®)	x New policy effective immediately. x Cologuard® is not covered because it is considered investigational.
Mole, Nevus, Lipoma or Skin Lesion Removal	x Policy revised effective immediately. x Policy title revised to include lipoma. x Adds criteria – “Removal of lipoma(s) will generally be covered if any of the following medical conditions are present as documented by the physician in the medical records x Changes in consistency; or x Suspicion of malignancy, or x Documentation of a functional limitation related to the lipoma location. x No prior authorization required.
Pharmacy Policies	Comments/Changes
Alemtuzumab (Lemtrada)	x New policy. x Requires prior authorization. x Effective 5/1/2015.
Natalizumab (Tysabri)	x Revised policy. x Use is allowed prior to other therapies in rapidly declining multiple sclerosis.

(continued)

Pharmacy Policies, cont.	Comments/Changes
Blinatumomab (Blincyto)	x