UnitedHealthcare®
Oxford

October 2014

# policy update bulletin

## Medical & Administrative Policy Updates

**UnitedHealthcare respects the expertise of the physicians, health care professionals, and their staff who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost-effective care, and to support practice staff with a simple and predictable administrative experience. The Policy Update Bulletin was developed to share important information regarding Oxford® Medical and Administrative Policy updates.***

***Where information in this bulletin conflicts with applicable state and/or federal law, Oxford® follows such applicable federal and/or state law**

## Oxford® Medical and Administrative Policy Updates

# Overview

This bulletin provides complete details on Oxford® Medical and Administrative Policy updates. The appearance of a service or procedure in this bulletin indicates only that Oxford® has recently adopted a new policy and/or updated, revised, replaced or retired an existing policy; it does not imply that Oxford® provides coverage for the service or procedure. In the event of an inconsistency or conflict between the information provided in this bulletin and the posted policy, the provisions of the posted policy will prevail. Note that most benefit plan documents exclude from benefit coverage health services identified as investigational or unproven/not medically necessary. Physicians and other health care professionals may not seek or collect payment from a member for services not covered by the applicable benefit plan unless first obtaining the member's written consent, acknowledging that the service is not covered by the benefit plan and that they will be billed directly for the service.

A complete library of Oxford® Medical and Administrative Policies is available at **OxfordHealth.com** > *Providers > Tools & Resources > Medical Information > Medical and Administrative Policies.*

### Tips for using the Policy Update Bulletin:

- From the table of contents, click the policy title to be directed to the corresponding policy update summary.
- From the policy updates table, click the policy title to view a complete copy of a new, updated, or revised policy.

### Policy Update Classifications

**New**

New clinical coverage criteria and/or documentation review requirements have been adopted for a service, procedure, test, or device

**Updated**

An existing policy has been reviewed and changes have not been made to the clinical coverage criteria or documentation review requirements; however, items such as the clinical evidence, FDA information, and/or list(s) of applicable codes may have been updated

**Revised**

An existing policy has been reviewed and revisions have been made to the clinical coverage criteria and/or documentation review requirements

**Replaced**

An existing policy has been replaced with a new or different policy

**Retired**

The procedural codes and/or services previously outlined in the policy are no longer being managed or are considered to be proven/medically necessary and are therefore not excluded as unproven/not medically necessary services, unless coverage guidelines or criteria are otherwise documented in another policy

Note: The absence of a policy does not automatically indicate or imply coverage. As always, coverage for a service or procedure must be determined in accordance with the member's benefit plan and any applicable federal or state regulatory requirements. Additionally, UnitedHealthcare reserves the right to review the clinical evidence supporting the safety and effectiveness of a medical technology prior to rendering a coverage determination.

# In This Issue

## Clinical Policy Updates

Page

### NEW



### UPDATED



### REVISED

## In This Issue

## In This Issue



## Administrative Policy Updates



## Reimbursement Policy Updates

# Clinical Policy Updates

| NEW | | |
|---|---|---|
| **Policy Title** | **Effective Date** | **Coverage Rationale** |
| Human Menopausal Gonadotropins (hMG) Used in the Treatment of Infertility | Nov. 1, 2014 | Coverage for human menopausal gonadotropin (hMG) therapy is subject to both *benefit availability* **and** *clinical criteria*.<br><br>It is important to note that *in addition* to the above benefit considerations, clinical criteria below *must also be met*.<br><br>**Note:** For Members **with** benefit coverage availability for hMG agents, those Members currently on a course of therapy will be allowed to remain on therapy.<br><br>• **Connecticut Plans and Products**: Coverage is provided under the general benefits package (i.e., medical).<br><br>• **New Jersey Group Plans**: Coverage is provided under a Member's prescription drug rider, if available, subject to applicable cost share. For those Members without a prescription drug rider, coverage is provided under the general benefits package (i.e., medical), subject to one office visit copayment per 30 day supply.<br><br>• **New York Large Group Plans**: Coverage is provided under a Member's prescription drug rider, subject to applicable cost share, when used in the setting of comprehensive level (mid-level) fertility enhancement techniques such as ovulation induction.<br><br>**Note**: The advanced infertility services benefit must **also** be available when an hMG agent is used in the setting of an advanced reproductive technique (ART) such as in vitro fertilization (IVF) or gamete intrafallopian transfer (GIFT).<br><br>• **New York Small Group Plans**: Coverage is provided under a Member's prescription drug rider, subject to applicable cost share, when used in the setting of comprehensive level (mid-level) fertility enhancement techniques such as ovulation induction.<br><br>**Note**: Coverage for an hMG agent is excluded when used in the setting of an advanced reproductive technique (ART) such as in vitro fertilization (IVF) or gamete intrafallopian transfer (GIFT).<br><br>• Infertility drugs including hMG agents are **excluded** from coverage for the following plans and products:<br><br>o New Jersey Individual<br>o New York Individual<br>o Healthy New York Individual and Group<br><br>• Self-funded groups are not required to adopt the guidelines outlined within this policy, but may elect the same or similar guidelines. Consult with individual group benefit administrators or benefit documentation to determine the availability and structure of coverage.<br><br>• Religious employers are permitted to exclude coverage for treatments that are contrary to their bona fide religious tenets. Refer to the Member's specific certificate of coverage, summary of benefits, and/or health benefit plan documentation for details.<br><br>For Members **with** benefit coverage availability for hMG agents, clinical criteria below *must also be met*. |

# Clinical Policy Updates

| NEW | | |
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| **Policy Title** | **Effective Date** | **Coverage Rationale** |
| Human Menopausal Gonadotropins (hMG) Used in the Treatment of Infertility *(continued)* | Nov. 1, 2014 | All human menopausal gonadotropin (hMG) agents currently available on the U.S. market are considered to be therapeutically equivalent.<br><br>The clinically appropriate dosing for hMG agents when used in an ART cycle without an FSH product is 450 IU/day or less for not more than 14 days of treatment. When used as part of a mixed stimulation protocol (hMG + FSH) or when used alone for ovulation induction or controlled ovarian stimulation the clinically appropriate maximum dosing for hMG agents is 150 IU/day. Exceeding this daily dose and duration of treatment has not been proven to be efficacious in terms of pregnancy outcome.<br><br>The clinical criteria applied to coverage of an hMG agent are determined primarily by active legislation of the state in which a Member's plan or product is underwritten.<br><br>• **Connecticut Plans and Products**: The Member must be under the care of a board certified reproductive endocrinologist (or urologist, for male patients) and have been unable to conceive/produce conception/sustain a successful pregnancy during a one-year period.<br><br>In addition to the above, the following criteria apply to selection of an hMG agent in the patient for whom the therapy is prescribed:<br><br>○ **MENOPUR® (menotropins for injection) for subcutaneous use:**<br>**Female:** MENOPUR® (menotropins for injection) is a gonadotropin indicated for:<br><br>▪ Development of multiple follicles and pregnancy in ovulatory women as part of an Assisted Reproductive Technology (ART) cycle<br><br>**Non-FDA Approved Indications**<br><br>**1. Ovulation Induction**<br><br>a. **Menopur** has been used for the treatment of ovulation induction in patients with polycystic ovary syndrome who failed on clomiphene. The ovulation rate compared to Gonal-f was non-inferior, at rates of 85.7% and 85.5% respectively. In other studies, rates of ovulation of 95% and pregnancy rates of 58% to 72% are demonstrated. Because of its high cost, higher incidence of serious side effects, and difficult of administration menotropins are usually reserved to treat patients who have failed to respond to therapy with clomiphene.<br><br>**2. Spermatogenesis Induction**<br><br>a. **Menopur** has been used for the treatment of spermatogenesis in men with primary and secondary hypogonadotropic hypogonadism in whom the cause of infertility is not due to primary testicular failure. A menotropin, Pergonal, has a spermatogenesis induction indication where clinical studies showed after |

# Clinical Policy Updates

**NEW**

| Policy Title | Effective Date | Coverage Rationale |
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| Human Menopausal Gonadotropins (hMG) Used in the Treatment of Infertility *(continued)* | Nov. 1, 2014 | 3 months of treatment, sperm counts increased from 5 million spermatozoa per mL of ejaculate to 24 mL and successful pregnancy rates were observed.<br>• **New Jersey Large Group Plans**: The Member must be under the care of a board certified reproductive endocrinologist (or urologist, for male patients) and meet the following criteria for age and medical history (as per New Jersey state mandate):<br>o Inability to conceive after 24 months of unprotected intercourse for females less than age 35, **or**<br>o Inability to conceive after 12 months of unprotected intercourse for females greater than or equal to age 35, **or**<br>o Inability to carry conceived pregnancy to live birth, **or**<br>o Inability of male to impregnate a female partner, **or**<br>o One of the partners is considered medically sterile.<br>In addition to the above, the following criteria apply to selection of an hMG agent in the patient for whom the therapy is prescribed:<br>o **MENOPUR® (menotropins for injection) for subcutaneous use:**<br>**Female:** MENOPUR® (menotropins for injection) is a gonadotropin indicated for:<br>▪ Development of multiple follicles and pregnancy in ovulatory women as part of an Assisted Reproductive Technology (ART) cycle<br>**Non-FDA Approved Indications**<br>**1. Ovulation Induction**<br>a. **Menopur** has been used for the treatment of ovulation induction in patients with polycystic ovary syndrome who failed on clomiphene. The ovulation rate compared to Gonal-f was non-inferior, at rates of 85.7% and 85.5% respectively. In other studies, rates of ovulation of 95% and pregnancy rates of 58% to 72% are demonstrated. Because of its high cost, higher incidence of serious side effects, and difficult of administration menotropins are usually reserved to treat patients who have failed to respond to therapy with clomiphene.<br>**2. Spermatogenesis Induction**<br>a. **Menopur** has been used for the treatment of spermatogenesis in men with primary and secondary hypogonadotropic hypogonadism in whom the cause of infertility is not due to primary testicular failure. A menotropin, Pergonal, has a spermatogenesis induction indication where clinical studies showed after 3 months of treatment, sperm counts increased from 5 million spermatozoa per mL of ejaculate to 24 mL and successful pregnancy rates were observed. |

# Clinical Policy Updates

| NEW | | |
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| **Policy Title** | **Effective Date** | **Coverage Rationale** |
| Human Menopausal Gonadotropins (hMG) Used in the Treatment of Infertility *(continued)* | Nov. 1, 2014 | • **New Jersey Small Group Plans**: The Member must be under the care of a board certified reproductive endocrinologist (or urologist, for male patients) and have failed to achieve pregnancy after 12 months of unprotected coitus (sexual intercourse).<br>In addition to the above, the following criteria apply to selection of an FSH agent in the patient for whom the therapy is prescribed:<br><br>○ **MENOPUR® (menotropins for injection) for subcutaneous use:**<br>**Female:** MENOPUR® (menotropins for injection) is a gonadotropin indicated for:<br><br>▪ Development of multiple follicles and pregnancy in ovulatory women as part of an Assisted Reproductive Technology (ART) cycle<br><br>**Non-FDA Approved Indications**<br><br>**1. Ovulation Induction**<br><br>a. **Menopur** has been used for the treatment of ovulation induction in patients with polycystic ovary syndrome who failed on clomiphene. The ovulation rate compared to Gonal-f was non-inferior, at rates of 85.7% and 85.5% respectively. In other studies, rates of ovulation of 95% and pregnancy rates of 58% to 72% are demonstrated. Because of its high cost, higher incidence of serious side effects, and difficult of administration menotropins are usually reserved to treat patients who have failed to respond to therapy with clomiphene.<br><br>**2. Spermatogenesis Induction**<br><br>a. **Menopur** has been used for the treatment of spermatogenesis in men with primary and secondary hypogonadotropic hypogonadism in whom the cause of infertility is not due to primary testicular failure. A menotropin, Pergonal, has a spermatogenesis induction indication where clinical studies showed after 3 months of treatment, sperm counts increased from 5 million spermatozoa per mL of ejaculate to 24 mL and successful pregnancy rates were observed.<br><br>• **New York Large and Small Group Plans:** The Member must be under the care of a board certified reproductive endocrinologist (or urologist, for male patients) and meet the following criteria for age and medical history (as per New York state mandate):<br><br>○ Member has reached 21 years of age, **and**<br>○ Member has not yet reached 45 years of age, **and**<br>○ Member demonstrates at least **one** of the following qualifiers:<br><br>▪ Failure to achieve pregnancy after 12 months or more of regular unprotected heterosexual intercourse; **or** |

## Clinical Policy Updates

| NEW | | |
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| **Policy Title** | **Effective Date** | **Coverage Rationale** |
| Human Menopausal Gonadotropins (hMG) Used in the Treatment of Infertility *(continued)* | Nov. 1, 2014 | ▪ Female age 35 years or older and is unable to achieve pregnancy after 6 months of regular unprotected heterosexual intercourse; **or**<br>▪ Female with documented FSH levels less than or equal to 19 mIU/ml on day 3 of the menstrual cycle; **or**<br>▪ Female with a documented anatomic variant resulting in the inability to achieve pregnancy (e.g., severe pelvic inflammatory disease, endometriosis, or ectopic pregnancy requiring surgical removal of both fallopian tubes); **or**<br>▪ Male with anatomical variants such as aspermia or varicocele resulting in an inability to reproduce.<br>○ In addition to the above, the following criteria apply to selection of n hMG agent in the patient for whom the therapy is prescribed:<br>○ **MENOPUR® (menotropins for injection) for subcutaneous use:**<br>**Female:** MENOPUR® (menotropins for injection) is a gonadotropin indicated for:<br>▪ Development of multiple follicles and pregnancy in ovulatory women as part of an Assisted Reproductive Technology (ART) cycle<br><br>**Non-FDA Approved Indications**<br><br>**1. Ovulation Induction**<br>a. **Menopur** has been used for the treatment of ovulation induction in patients with polycystic ovary syndrome who failed on clomiphene. The ovulation rate compared to Gonal-f was non-inferior, at rates of 85.7% and 85.5% respectively. In other studies, rates of ovulation of 95% and pregnancy rates of 58% to 72% are demonstrated. Because of its high cost, higher incidence of serious side effects, and difficult of administration menotropins are usually reserved to treat patients who have failed to respond to therapy with clomiphene.<br><br>**2. Spermatogenesis Induction**<br>a. **Menopur** has been used for the treatment of spermatogenesis in men with primary and secondary hypogonadotropic hypogonadism in whom the cause of infertility is not due to primary testicular failure. A menotropin, Pergonal, has a spermatogenesis induction indication where clinical studies showed after 3 months of treatment, sperm counts increased from 5 million spermatozoa per mL of ejaculate to 24 mL and successful pregnancy rates were observed.<br><br>**Authorization Guidelines:**<br><br>The following timeframe and quantity guidelines will be applied to authorizations.<br>• **Initial Supply:** Oxford may authorize up to 3 fills (initial supply and 2 refills not to exceed the maximum daily |

# Clinical Policy Updates

| NEW | | |
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| **Policy Title** | **Effective Date** | **Coverage Rationale** |
| Human Menopausal Gonadotropins (hMG) Used in the Treatment of Infertility *(continued)* | Nov. 1, 2014 | dose/refill day [e.g. a refill may consist of 450 IU each day for 2 days]) of a human menopausal gonadotropin (hMG) agent per Member. If used in a mixed protocol with an FSH agent or for ovulation induction or controlled ovarian stimulation, the maximum daily dose is 150 IU/day<br>• **Subsequent Refill(s):** When requested 1 or more months after the first fill: may be authorized for an additional 3 fills subject to benefit considerations and clinical criteria noted above. |

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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Abnormal Uterine Bleeding and Uterine Fibroids | Nov. 1, 2014 | • Reorganized policy content<br>• Updated benefit considerations:<br>○ Replaced references to "Certificates of Coverage (COC)" and "Summary Plan Descriptions (SPD)" with "plan documents"<br>○ Added language to indicate most plan documents provide coverage for unproven services for a life-threatening sickness or condition, at our discretion<br>▪ If a member has a life-threatening sickness or condition (one that is likely to cause death within one year of the request for treatment) we may, in our discretion, consider an otherwise unproven service to be a covered health service for that sickness or condition<br>▪ Prior to such a consideration, we must first establish that there is sufficient evidence to | **Levonorgestrel-Releasing Intrauterine Device**<br>The Mirena® levonorgestrel-releasing intrauterine device (LNG-IUD) is proven and medically necessary for treating menorrhagia in premenopausal women. No other LNG-IUDs have been U.S. Food and Drug Administration (FDA)-approved for this indication. Refer to policy: Contraceptives and certificate of coverage for additional information.<br><br>**Uterine Fibroids**<br>• Uterine artery embolization (UAE) is proven and medically necessary for treating symptomatic uterine fibroids for women who do NOT wish to preserve their childbearing potential. . For information regarding medical necessity review, when applicable, see MCG™ Care Guidelines, 18th edition, 2014, Uterine Artery Embolization, ACG: A-0287 (AC).<br>• Uterine artery embolization (UAE) is unproven and not medically necessary for treating symptomatic uterine fibroids for women who wish to preserve their childbearing potential. The effects of UAE on ovarian and uterine function and on fertility are relatively unknown. Further studies of safety and/or efficacy in published, peer-reviewed medical literature are necessary.<br>• Magnetic resonance imaging (MRI)-guided cryoablation is unproven and not medically necessary for treating uterine fibroids. The published evidence on MRI-guided cryoablation for uterine fibroids is very limited, as the procedure has been evaluated in very few patients. The long-term outcomes and overall health benefits remain unknown. Further long-term studies on larger samples published in peer-reviewed medical literature are necessary to demonstrate the safety and efficacy of this technology.<br>• Magnetic resonance imaging (MRI)-guided focused ultrasound ablation (FUA) is unproven and not medically necessary for treating uterine fibroids. Further studies are needed to determine the long-term efficacy |

## Clinical Policy Updates

| UPDATED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Abnormal Uterine Bleeding and Uterine Fibroids *(continued)* | Nov. 1, 2014 | conclude that, albeit unproven, the service has significant potential as an effective treatment for that sickness or condition<br>○ Replaced language indicating "some 2007 Certificates of Coverage and some Summary Plan Descriptions may provide benefit coverage for MRI-guided focused ultrasound" with "some plan documents may provide coverage for unproven services under certain non-life- threatening conditions at our discretion"<br>• Updated coverage rationale:<br>○ Reformatted and relocated information pertaining to medical necessity review<br>○ Removed reference to specific product name ("Acessa™") for laparoscopic ultrasound-guided radiofrequency ablation<br>• Updated supporting information to reflect the most current description of services, clinical evidence, FDA information, and references | of this procedure and to evaluate the efficacy and safety of this procedure relative to other treatments for uterine fibroids.<br><br>Laparoscopic ultrasound-guided radiofrequency ablation is unproven and not medically necessary for treating uterine fibroids. Further studies are needed to determine the long-term efficacy of this procedure and to evaluate the efficacy and safety of this procedure relative to other treatments for uterine fibroids. |
| Electrical and Ultrasound Bone Growth Stimulators | Nov. 1, 2014 | • Reorganized policy content<br>• Added benefit considerations language for *Essential Health Benefits for Individual and Small Group* plans to indicate:<br>○ For plan years beginning on | Two MCG™ Care Guidelines are identified, one for electrical and electromagnetic bone growth stimulators, and one for Ultrasonic Bone Growth Stimulators.<br><br>For information regarding medical necessity review of electrical and electromagnetic bone growth stimulators, see MCG™ Care Guidelines, 18th |

# Clinical Policy Updates

| UPDATED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Electrical and Ultrasound Bone Growth Stimulators *(continued)* | Nov. 1, 2014 | or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs")<br>○ Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs; however, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans<br>○ The determination of which benefits constitute EHBs is made on a state by state basis; as such, when using this guideline, it is important to refer to the member's specific plan document to determine benefit coverage | Edition, 2014, Bone Growth Stimulators, Electrical and Electromagnetic ACG: A-0565 (AC).<br><br>For information regarding medical necessity review of ultrasonic bone growth stimulators, see MCG™ Care Guidelines, 18th Edition, 2014, Bone Growth Stimulators, Ultrasonic ACG: A-0414 (AC). |
| Electrical Bioimpedance for Cardiac Output Measurement | Nov. 1, 2014 | • Reorganized policy content<br>• Added benefit considerations language for *Essential Health Benefits for Individual and Small Group* plans to indicate: | Electrical bioimpedance is unproven and not medically necessary for the measurement of cardiac output.<br><br>Due to insufficient clinical evidence to support medical efficacy, electrical bioimpedance for the measurement of cardiac output will not be reimbursed |

# Clinical Policy Updates

| UPDATED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Electrical Bioimpedance for Cardiac Output Measurement *(continued)* | Nov. 1, 2014 | ○ For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs")<br>○ Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs; however, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans<br>○ The determination of which benefits constitute EHBs is made on a state by state basis; as such, when using this guideline, it is important to refer to the member's specific plan document to determine benefit coverage<br>• Updated non-coverage rationale; added language to indicate the not medically necessary service is "unproven" | by Oxford. Definitive patient selection criteria for the use of electrical bioimpedance have not been established for measurement of cardiac output, primarily due to inadequate evidence regarding the impact of cardiac output monitoring on patient management or clinical outcomes. Further research is needed to confirm whether electrical bioimpedance can offer comparable clinical utility supply similar information regarding cardiac function, as thermodilution catheterization (TDC). |

# Clinical Policy Updates

| UPDATED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| In-Network Exceptions for Breast Reconstruction Surgery Following Mastectomy | Oct. 1, 2014 | • Updated coverage rationale for *Stage One Breast Reconstruction;* added language to clarify the in-network exception review will be based upon the **precise type** of flap requested by the Member | **In-Network Exception:** A determination made by Oxford to provide coverage for medical services rendered by an out-of-network (non-participating) provider at a level of coverage and cost share equivalent to that which would be applied to the same services if rendered by an in-network (participating) provider.<br><br>Providers are considered in-network only if they participate in the network applicable to the Member's plan (e.g., Oxford Freedom Network, Oxford Liberty Network). UnitedHealth Choice Plus network providers located outside of the tri-state area (CT, NJ, and NY) are considered in-network for the following Oxford products:<br>• All Group POS or PPO<br>• New York Large and Small Group EPO<br>• State of Connecticut Employee Group HMO<br><br>**Stages of Breast Reconstruction:**<br>• Stage 1 - Creation of the breast mound, including tissue expanders/ breast implants<br>• Stage 2 - Nipple and areola reconstruction<br>• Stage 3 - Nipple tattooing<br><br>I. **<u>Stage One Breast Reconstruction</u>** *(Creation of the breast mound)* A Member may request an in network exception for mastectomy and/or breast reconstruction. These requests must be made at least two weeks prior to the scheduled surgery. It is Oxford's obligation to notify the Member that there are teams of participating surgeons who can perform the mastectomy and the reconstruction requested by the attending physician and the Member. (General types being tissue expanders/implants, pedicled tissue flaps, and free tissue transfers.) None of the types of free flaps listed has been shown to be superior to the others. Oxford's review will be based upon the precise type of flap requested by the Member. For example, if a DIEP flap has been requested, Oxford's network obligation will be considered fulfilled only if a participating surgeon is available to perform a DIEP flap. If Oxford can provide such a participating team for the Member, (as outlined in the In Network exception policy) the request for the exception will not be certified. If Oxford cannot find a participating team, then the in-network exception will be certified. |

# Clinical Policy Updates

**UPDATED**

| Policy Title | Effective Date | Summary of Changes | Coverage Rationale |
|---|---|---|---|
| In-Network Exceptions for Breast Reconstruction Surgery Following Mastectomy *(continued)* | Oct. 1, 2014 | | If an exception is certified, it will be only for creation of the breast mound (Stage I reconstruction). The Member will be informed that this exception will not extend to other stages. If the Member requests an in network exception for Stage II, the Member must make that a separate request at the time of the Stage II surgery.<br>II. **Stage Two Breast Reconstruction** *(Nipple and areola reconstruction)* A Member may request an in network exception for the Stage II portion of the surgery at the time of the Stage II surgery. The request will be reviewed just as the Stage I was reviewed. However, certification of Stage I does not require certification of Stage II.<br>III. **Stage Three Breast Reconstruction** *(Nipple tattooing)* A Member may request an in network exception for the Stage III portion of the surgery at the time of the Stage III surgery. However, if stage I and II have been certified as exceptions, then stage III will be certified as well. If no previous in network exceptions have been made for stage I, or stage II then the request will be processed as Stage I or II above.<br>**Types of Reconstructive Procedures**<br>There are three general methods commonly used for breast reconstruction after mastectomy. Oxford's network obligation is to identify any participating surgeon who can perform the reconstruction that the attending physician and the Member choose.<br>1. **Tissue Expanders**<br>Permanent or Temporary tissue expanders are silicone envelopes with an integrated or remote port for episodic injection of saline in the outpatient setting. Most surgeons over-inflate past the desired size. This affords a larger skin envelope that gives some ptosis to the end result. Waiting at least 6 weeks from last expansion to implant exchange is believed to limit the rapid shrinking of expanded skin. At a secondary procedure, the expander is exchanged for a permanent implant.<br>2. **Pedicled Flaps**<br>a. **Transverse Rectus Abdominis Musculocutaneous flap (TRAM)**<br>The physician performs a transverse rectus abdominis myocutaneous |

## Clinical Policy Updates

| UPDATED | | | |
|---|---|---|---|
| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| In-Network Exceptions for Breast Reconstruction Surgery Following Mastectomy *(continued)* | Oct. 1, 2014 | | flap (TRAM) procedure for breast reconstruction. The physician first designs then cuts a skin island flap on the lower abdominal wall. A superior skin and fat flap is elevated off the rectus abdominis muscle. A transverse incision is made in the rectus sheath and the muscle is divided and elevated, keeping the superior epigastric arteries intact for blood supply. Once the muscle is elevated, the physician makes an incision through the chest skin. This is also elevated, creating a pocket for the muscle flap. A connecting tunnel is made between the elevated chest skin and the inferiorly positioned flap. The flap is passed superiorly under the tunnel of tissue, placed into its new position, and sutured, after contouring a breast. The abdominal wall is closed by re-approximating the remaining anterior rectus muscle to the remaining lateral muscle and sheath. Skin edges are brought together and sutured in layers. Suction drains are also placed.<br><br>b. **Latissimus Dorsi Flap**<br>Like the TRAM flaps, this procedure uses muscle in addition to skin and fat to reconstruct the breast. The latissimus dorsi muscle and some of the overlying skin and fat are used from underneath the shoulder and from the back of the chest wall. This tissue is passed underneath the skin of the chest wall and brought forward to reconstruct the breast.<br><br>3. **Free Flaps (CPT 19364)**<br><br>a. **Deep Inferior Epigastric Artery Perforator flap (DIEP)**<br>The deep inferior epigastric perforator (DIEP) flap, is similar to the free TRAM flap, but the blood supply to this flap is based on only one or two of the perforator arteries off of the deep inferior epigastric artery.<br><br>b. **Superior Gluteal Artery Perforator flap (SGAP)**<br>For patients who do not have sufficient abdominal tissue for breast reconstruction but still prefer the use of autologous tissue, an option is the use of the buttock as donor tissue. This donor site can also be used for unilateral or bilateral breast reconstructions. There are two options for blood supply to the flap. When the superior gluteal artery is used, the flap is called a "superior gluteal artery perforator" |

## Clinical Policy Updates

| UPDATED | | | |
|---|---|---|---|
| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| In-Network Exceptions for Breast Reconstruction Surgery Following Mastectomy *(continued)* | Oct. 1, 2014 | | (SGAP) flap and the upper buttock tissue is used. (See below).<br><br>c. **Inferior Gluteal Artery Perforator flap (IGAP)**<br>An IGAP flap is similar to an SGAP flap as described above. IGAP flaps are based lower on the buttock and typically rely on the inferior gluteal artery.<br><br>d. **Free Transverse Rectus Abdominis Muscle flap (Free TRAM)**<br>In the Free TRAM operation, the rectus abdominis muscle is divided from its superior attachments, and only a small portion of muscle is removed. The lower blood vessels remain attached to the muscle and continue to provide blood supply to the skin. The flap is transferred (transplanted) to the chest wall. Using an operating microscope, the surgeon reconnects these blood vessels to blood vessels under the arm.<br><br>None of the different types of free flaps has been shown to be superior to the other types of free flaps. |
| Lithotripsy for Salivary Stones | Nov. 1, 2014 | • Reorganized policy content<br>• Added benefit considerations language for *Essential Health Benefits for Individual and Small Group* plans to indicate:<br>○ For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs")<br>○ Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the | Extracorporeal shock wave lithotripsy (ESWL) is unproven and not medically necessary for the treatment of salivary stones.<br><br>There is insufficient evidence to support the use of ESWL for managing salivary stones. Further research with randomized controlled studies is required to demonstrate the effectiveness of ESWL.<br><br>Endoscopic intracorporeal laser lithotripsy is unproven and not medically necessary for the treatment of salivary stones.<br><br>The evidence regarding intracorporeal laser lithotripsy is limited and includes studies involving a small number of patients. Further research with randomized controlled studies and larger patient sample sizes is required to demonstrate the effectiveness of endoscopic intracorporeal laser lithotripsy |

## Clinical Policy Updates

| UPDATED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Lithotripsy for Salivary Stones *(continued)* | Nov. 1, 2014 | requirement to offer coverage for EHBs; however, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans<br>○ The determination of which benefits constitute EHBs is made on a state by state basis; as such, when using this guideline, it is important to refer to the member's specific plan document to determine benefit coverage<br>• Updated non-coverage rationale; added language to indicate the not medically necessary service is "unproven"<br>• Updated supporting information to reflect the most current clinical evidence, FDA information and references | |
| Medical Supplies | Nov. 1, 2014 | • Updated benefit considerations; added language for *Essential Health Benefits for Individual and Small Group* plans to indicate:<br>○ For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans | Oxford® covers non-routine medical supplies that are required for the treatment of a disease or injury that is covered under the Member's Certificate. Cost shares may apply. Please refer to the Member's certificate of coverage, summary of benefits, and/or health benefits plan documentation for specific details regarding benefit coverage, exclusions, limitations and/or maximums. Routine medical supplies are considered inclusive to the medical care given in any site of service.<br><br>All supplies must be medically necessary and in the appropriate amount for the treatment or maintenance program in progress. Refer to the Maximum Frequency Per Day policy for more detailed information regarding quantities. |

# Clinical Policy Updates

| UPDATED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Medical Supplies *(continued)* | Nov. 1, 2014 | (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs")<br>○ Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs; however, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans<br>○ The determination of which benefits constitute EHBs is made on a state by state basis; as such, when using this guideline, it is important to refer to the member's specific plan document to determine benefit coverage | • **Inpatient and Outpatient**: All *routine* and *non-routine* medical supplies are inclusive to contracted and non-contracted facilities, unless the facility contract states otherwise.<br>• **Office:** *Routine* medical supplies are included in the office visit.<br>A physician may supply *non-routine* medical supplies or the physician may write a prescription for the item to be obtained from a medical supply vendor. *Non-routine* medical supplies must be billed with a HCPCS code. If a HCPCS code does not exist for a specific medical supply, a description of the item must be listed. The reimbursement for the *non-routine* medical supply:<br>○ **With a specific HCPCS code** will be reimbursed at the fee region schedule minus any applicable co-pay, coinsurance or deductible.<br>○ **Without a specific HCPCS code** is the actual cost of the supply (invoice must be requested), minus any applicable co-pay, coinsurance or deductible.<br>• **Home Care:** Supplies obtained for use by a Home Care Provider are only covered under the Home Care benefit. Refer to Home Health Care for additional information.<br>• **Contracted Medical Supply Vendors:** Contracted medical supply vendors will be reimbursed for *non-routine* medical minus any applicable co-pay, coinsurance or deductible when obtained for use by a Member not receiving home care<br>• **Non-contracted Medical Supply Vendors:** Non-contracted medical supply vendors will be reimbursed for *non-routine* medical supplies, at the cost of the supply, minus any applicable co-pay, coinsurance or deductible.<br>*Non-routine* medical supplies purchased by the Member out of pocket, from non-contracted medical supply vendors or from retail pharmacies will be reimbursed to the Member minus any applicable co-pay, coinsurance and deductible. Members are required to submit invoice/receipt to Oxford Health Plans for reimbursement of *non-routine* medical supplies. |
| Meniscus Implant and Allograft | Nov. 1, 2014 | • Reorganized policy content<br>• Added benefit considerations language for *Essential Health Benefits for Individual and Small* | Meniscus allograft transplantation with human cadaver tissue is **proven and medically necessary** for replacement of major meniscus loss due to trauma or previous meniscectomy when all of the following are present: |

# Clinical Policy Updates

| UPDATED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Meniscus Implant and Allograft *(continued)* | Nov. 1, 2014 | *Group* plans to indicate:<br>○ For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs")<br>○ Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs; however, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans<br>○ The determination of which benefits constitute EHBs is made on a state by state basis; as such, when using this guideline, it is important to refer to the member's specific plan document to determine benefit coverage<br>• Updated coverage rationale:<br>○ Reformatted and relocated information pertaining to medical necessity review | • Adult who has achieved mature skeletal growth<br>• Patient has significant knee pain and limited function<br>• Patient is missing more than half of the meniscus due to surgery or injury or has a tear that cannot be repaired<br>• Radiographic criteria established by a standing anteroposterior (AP) view demonstrates all of the following:<br>○ Normal alignment or correctable varus or valgus deformities<br>○ No osteophytes or marginal osteophytes<br>○ No articular cartilage defects<br>○ No significant joint space narrowing<br>• Ligamentous stability has been achieved prior to surgery or achieved concurrently with meniscal transplantation (e.g., concomitant anterior cruciate ligament surgery)<br>• There is minimal to absent degenerative changes in surrounding articular cartilage (Outerbridge Grade II or less)<br>• There is no evidence of active inflammatory arthritis or systemic arthritis<br>• In patients who have failed conservative treatment including:<br>○ Physical therapy; **or**<br>○ Bracing techniques<br><br>Collagen meniscus implants are **unproven and not medically necessary** for the treatment of meniscus injuries or tears.<br><br>There is insufficient evidence that collagen meniscus implants improve health outcomes such as reduction of symptoms and restoration of knee function in patients with meniscus injuries or tears. Additional studies with long term follow-up are needed to determine whether implantation of a collagen scaffold is able to slow joint degeneration, delay the progression of osteoarthritis, and reduce pain for long durations. |

# Clinical Policy Updates

| UPDATED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Meniscus Implant and Allograft *(continued)* | Nov. 1, 2014 | ○ Added language to indicate if service is "proven" or "unproven" to applicable medically necessary/not medically necessary statement<br>○ Removed reference to specific product name ("Menaflex™") for collagen meniscus implants<br>• Updated supporting information to reflect the most current clinical evidence, FDA information and references | |
| Presacral Neurectomy and Uterine Nerve Ablation for Pelvic Pain | Nov. 1, 2014 | • Added benefit considerations language for *Essential Health Benefits for Individual and Small Group* plans to indicate:<br>○ For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs")<br>○ Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs; however, if such plans choose to provide coverage for benefits which are deemed EHBs | Presacral neurectomy is **proven and medically necessary** for treating women with primarily midline pelvic pain unresponsive to medical therapy, which includes the following:<br>• A 3-month trial of oral contraceptives; **or**<br>• If oral contraceptives are contraindicated, menstrual suppression with progesterone or gonadotropin-releasing hormone (GnRH) agonist therapy.<br><br>Presacral neurectomy is **unproven and not medically necessary** for treating lateral pelvic pain or symptoms other than midline pelvic pain. There is a lack of evidence that presacral neurectomy provides a clinical benefit in these patient populations.<br><br>Uterine nerve ablation (UNA) and laparoscopic uterine nerve ablation (LUNA) are **unproven and not medically necessary** for treating chronic pelvic pain associated with dysmenorrhea or endometriosis. There is insufficient evidence in the published clinical literature establishing the effectiveness of UNA and LUNA for the treatment of dysmenorrhea. The durability of pain relief from UNA and LUNA will determine the potential beneficial effect on health outcomes. This will require well-designed clinical studies with long-term results. |

## Clinical Policy Updates

| UPDATED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Presacral Neurectomy and Uterine Nerve Ablation for Pelvic Pain *(continued)* | Nov. 1, 2014 | (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans<br>○ The determination of which benefits constitute EHBs is made on a state by state basis; as such, when using this guideline, it is important to refer to the enrollee's specific plan document to determine benefit coverage<br>• Updated coverage rationale:<br>○ Added language to indicate if service is "proven" or "unproven" to applicable medically necessary/not medically necessary statement<br>○ Reformatted and relocated information pertaining to medical necessity review<br>• Updated supporting information to reflect the most current description of services, clinical evidence and references | |
| Radiology Procedures Requiring Precertification | Oct. 1, 2014 | • Updated list of applicable HCPCS codes to reflect quarterly code edits (effective 10/01/2014); added S8032 | To pre-certify a radiology procedure, please contact CareCore National via one of the two options listed below:<br>• Providers can call CareCore National at 1-877-PRE-AUTH (773-2884)<br>• Providers can log on to the CareCore National website (http://www.carecorenational.com)<br><br>Accreditation requirements for participating providers:<br><br>**Note:** Hospitals are currently excluded from the accreditation requirements listed below. |

# Clinical Policy Updates

| UPDATED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Radiology Procedures Requiring Precertification *(continued)* | Oct. 1, 2014 | | **Exception**: Hospitals that are currently participating in the Oxford network or wish to participate in the Oxford network and perform Coronary CT Angiography (CCTA). Please refer to the Cardiology Procedures Requiring Precertification policy for additional information.<br>• All MRI, PET, and CT studies must be performed on an American College of Radiology accredited machine.<br>• Nuclear Medicine procedures noted with an * are only reimbursable to facilities with one of the following accreditations:<br>○ American College of Radiology (ACR)<br>○ Intersocietal Commission for the Accreditation of Nuclear Medicine (ICANL)<br>• Nuclear Medicine procedures noted with an * are only reimbursable to radiologists and cardiologists with one of the following certifications:<br>○ American Board of Radiology (ABR)<br>○ American Board of Nuclear Medicine (ABNM)<br>○ Certification Board of Nuclear Cardiology (CBNC) [formerly known as the Certification Council of Nuclear Cardiology (CCNC)] |
| Unicondylar Spacer Devices for Treatment of Pain or Disability | Nov. 1, 2014 | • Reorganized policy content<br>• Added benefit considerations language for *Essential Health Benefits for Individual and Small Group* plans to indicate:<br>○ For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories of Essential Health Benefits ("EHBs")<br>○ Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer | Unicondylar spacer devices are **unproven and not medically necessary** for the treatment of knee joint pain or disability from any cause.<br><br>The evidence is lacking to demonstrate that unicondylar spacers are clinically effective, and long-term data are not available to establish the safety and efficacy of these devices. Published evidence consists of small studies with mixed results. It is not evident that this treatment postpones or obviates the need for total joint replacement. |

# Clinical Policy Updates

| UPDATED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Unicondylar Spacer Devices for Treatment of Pain or Disability *(continued)* | Nov. 1, 2014 | coverage for EHBs; however, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans<br>○ The determination of which benefits constitute EHBs is made on a state by state basis; as such, when using this guideline, it is important to refer to the member's specific plan document to determine benefit coverage<br>• Updated non-coverage rationale; added language to indicate the not medically necessary service is "unproven"<br>• Updated supporting information to reflect the most current clinical evidence, FDA information and references | |

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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Drug Coverage Criteria - New and Therapeutic Equivalent Medications | Nov. 1, 2014 | • Revised list of medications requiring precertification through the pharmacy benefit manager (PBM):<br>○ Added Acticlate, Apop 10% gel, Bunavail Film, Cerdelga, Kerydin, Striverdi Respimat and Triumeq<br>○ Updated formulary | Refer to the policy for complete details on the coverage guidelines for Drug Coverage Criteria - New and Therapeutic Equivalent Medications. |

# Clinical Policy Updates

| REVISED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Drug Coverage Criteria - New and Therapeutic Equivalent Medications *(continued)* | Nov. 1, 2014 | alternative(s) for Daytrana, Focalin XR, Generess FE, Methylphenidate extended-release capsule, Methylphenidate extended-release tablet, Quillivant XR, Ritalin LA and Symbicort | |

| REVISED | | | | |
|---|---|---|---|---|
| **Policy Title** | **Effective Date** | **Drug/Medication** | **Status** | **Summary of Changes** |
| Drug Coverage Guidelines | Oct. 1, 2014 | Generic Category – Antihemophilic Factor (Recombinant), FC Fusion Protein: Eloctate | N/A: Implem-entation Cancelled | • New precertification/medical necessity guidelines for Eloctate™ [antihemophilic factor (recombinant), Fc fusion protein] will **not** be adopted on Oct. 1, 2014 as announced in the September 2014 Policy Update Bulletin; **implementation of this policy has been cancelled** |
| Drug Coverage Guidelines | Nov. 1, 2014 | Acticlate (Doxycycline Hyclate) | New | • Added coverage guidelines (precertification requirements apply); refer to Drug Coverage Criteria - New and Therapeutic Equivalent Medications for complete details |
| | | Actimmune (Interferon Gamma-1b) | Updated | • Routine review; no change in coverage guidelines |
| | | Adderall (Amphetamine/ Dextroamphetamin) and Adderall XR Amphetamine/ Dextroamphetamin [Extended Release]) | Updated | • Reformatted coverage criteria; no change in coverage guidelines |
| | | Afinitor (Everolimus) | Revised | • Revised initial authorization criteria for *Advanced Renal Cell Carcinoma* to indicate Afinitor will be approved based on **one** of the following criteria:<br>1. Both of the following:<br>▪ Diagnosis of relapsed or medically unresectable stage IV kidney cancer with predominant *clear cell* histology; **and**<br>▪ *History of failure, contraindication, or intolerance to at least one prior tyrosine kinase inhibitor therapy [e.g., Nexavar (sorafenib), Sutent (sunitinib)] *(*Requirement does not apply to New Jersey plan members)*<br>**or**<br>2. Diagnosis of relapsed or medically unresectable stage IV kidney cancer |

## Clinical Policy Updates

| REVISED | | | | |
|---|---|---|---|---|
| **Policy Title** | **Effective Date** | **Drug/Medication** | **Status** | **Summary of Changes** |
| Drug Coverage Guidelines *(continued)* | Nov. 1, 2014 | Afinitor (Everolimus) *(continued)* | Revised | with predominant *non-clear cell* histology<br>• Revised initial authorization criteria for *Breast Cancer*:<br>○ *Updated criterion outlining prior therapy requirements; expanded list of drugs for which trial and failure, contraindication, or intolerance must be demonstrated to include tamoxifen as an option<br>*(*Requirement does not apply to New Jersey plan members)*<br>• Added initial authorization and reauthorization criteria for the following diagnoses:<br>○ Hodgkin Lymphoma (off-label)<br>○ Soft Tissue Sarcoma (off-label)<br>• Refer to Afinitor for complete details |
| | | Apop 10% Gel (Sulfacetamide) | New | • Added coverage guidelines (precertification requirements apply); refer to Drug Coverage Criteria - New and Therapeutic Equivalent Medications for complete details |
| | | Atralin (Tretinoin) | Updated | • Routine review; no change in coverage guidelines |
| | | Avita (Tretinoin) | Updated | • Routine review; no change in coverage guidelines |
| | | Avodart (Dutasteride) | Revised | • Revised coverage criteria; changed authorization approval period from "12 months" to "60 months"<br>• Refer to Avodart (dutasteride) for complete details |
| | | Berinert (C1 Esterase Inhibitor Human) | Revised | • Revised coverage criteria:<br>○ Added criterion indicating drug can not be used in combination with other approved treatments for acute HAE attacks (e.g., Firazyr, Kalbitor or Ruconest)<br>○ Changed authorization approval period from "60 months" to "12 months"<br>• Refer to Berinert for complete details |
| | | Bunavail Film (Buprenorphine and Naloxone) | New | • Added coverage guidelines (precertification requirements apply); refer to Drug Coverage Criteria - New and Therapeutic Equivalent Medications for complete details |
| | | Caprelsa (Vandetanib) | Updated | • Updated background information (no change in coverage guidelines); added language to indicate Caprelsa may be used in patients with indolent, asymptomatic or slowly progressing disease after careful consideration of the treatment related risks<br>• Refer to Caprelsa (Vandetanib) for complete details |
| | | Cerdelga (Eliglustat) | New | • Added coverage guidelines (precertification requirements apply); refer to Drug Coverage Criteria - New and Therapeutic Equivalent Medications for complete details |

# Clinical Policy Updates

| REVISED | | | | |
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| **Policy Title** | **Effective Date** | **Drug/Medication** | **Status** | **Summary of Changes** |
| Drug Coverage Guidelines *(continued)* | Nov. 1, 2014 | Cinryze (C1 Esterase Inhibitor (Human)) | Revised | • Revised coverage guidelines to indicate precertification through the Pharmacy Benefit Manager is required; refer to Cinryze for applicable coverage criteria |
| | | Cometriq (Cabozantinib) | Revised | • Updated background information to indicate the National Cancer Comprehensive Network (NCCN) recommends use of Cometriq in symptomatic locoregional MTC and asymptomatic/symptomatic distant metastases; NCCN also recommends Cometriq for the treatment of non-small cell lung cancer (NSCLC) with RET gene rearrangement<br>• Revised initial authorization criteria for *Medullary Thyroid Cancer (MTC)* to allow for approval if patient has either progressive or symptomatic disease<br>• Added initial authorization and reauthorization criteria for *Non-Small Cell Lung Cancer (NSCLC) (off-label)*<br>• Refer to Cometriq for complete details |
| | | Concerta (Methylphenidate) | Revised | • Revised coverage guidelines to indicate precertification through the Pharmacy Benefit Manager is required; refer to Concerta for applicable coverage criteria |
| | | Daytrana (Methylphenidate) | Updated | • Reformatted coverage criteria; no change in coverage guidelines |
| | | Depakote (Divalproex Sodium) | Revised | • Revised coverage criteria; updated criterion/requirement for reporting of lack of effectiveness of a therapeutically equivalent generic to allow for **either** of the following:<br>○ Notification to the FDA Adverse Event Reporting System (FAERS); **or**<br>○ Submission of medical records documenting the inadequate response to the therapeutically equivalent generic<br>• Refer to Depakote and Depakote ER for complete details |
| | | Depakote ER (Divalproex Sodium Extended Release) | | |
| | | Desoxyn (Methamphetamine) | Updated | • Reformatted coverage criteria; no change in coverage guidelines |
| | | Dexedrine (Dextroamphetamine) | Updated | • Reformatted coverage criteria; no change in coverage guidelines |
| | | Differin (Adapalene) | Updated | • Routine review; no change in coverage guidelines |
| | | Evista (Raloxifene) | Revised<br>Revised | • Revised coverage criteria; added criterion requiring failure, contraindication or adverse reaction to raloxifene<br>• Refer to Evista for complete details |
| | | Fabior (Tazarotene) | Updated | • Routine review; no change in coverage guidelines |
| | | Firazyr (Icatibant) | Revised | • Revised coverage criteria:<br>○ Added criterion indicating drug can not be used in combination with other approved treatments for acute HAE attacks (e.g., Firazyr, Kalbitor or Ruconest) |

## Clinical Policy Updates

| REVISED | | | | |
|---|---|---|---|---|
| **Policy Title** | **Effective Date** | **Drug/Medication** | **Status** | **Summary of Changes** |
| Drug Coverage Guidelines *(continued)* | Nov. 1, 2014 | Firazyr (Icatibant) *(continued)* | Revised | ○ Changed authorization approval period from "60 months" to "12 months"<br>• Refer to Firazyr for complete details |
| | | Focalin (Dexmethylphenidate HCL)<br>Focalin XR (Dexmethylphenidate HCL [Extended Release]) | Updated | • Reformatted coverage criteria; no change in coverage guidelines |
| | | Inlyta (Axitinib) | Revised | • Updated background information; added language to indicate the NCCN (National Comprehensive Cancer Network) recommends the use of Inlyta as first-line therapy for relapsed or medically unresectable stage IV disease with non-clear cell histology<br>• Revised initial authorization criteria for *Advanced Renal Cell Carcinoma* to include the following criterion (in addition to a diagnosis of renal cell cancer):<br>○ One of the following:<br>▪ Relapse following surgical excision; **or**<br>▪ Both of the following:<br>- Medically or surgically unresectable tumor<br>- Diagnosis of Stage IV disease<br>**and**<br>○ One of the following:<br>▪ Patient with *non-clear cell* histology; **or**<br>▪ Both of the following:<br>- Patient with predominantly *clear cell* histology; **and**<br>- *History of failure, contraindication, or intolerance to one of the following:<br>• Cytokine-based therapy [eg, Interleukin (IL)-2]<br>• Kinase inhibitor therapy [eg, Nexavar (sorafenib), Sutent (sunitinib), Votrient (pazopanib)]<br>• Avastin (bevacizumab) in combination with Interferon (IFN)-alfa therapy<br>• Mammalian target of rapamycin (mTOR) inhibitor therapy [eg, Torisel (temsirolimus)]<br>*(*Requirement does not apply to New Jersey plan members)*<br>• Refer to Inlyta for complete details |

# Clinical Policy Updates

| REVISED | | | | |
|---|---|---|---|---|
| **Policy Title** | **Effective Date** | **Drug/Medication** | **Status** | **Summary of Changes** |
| Drug Coverage Guidelines *(continued)* | Nov. 1, 2014 | Keppra (Levetiracetam)<br>Keppra XR (Levetiracetam Extended Release [XR]) | Revised | • Revised coverage criteria; updated criterion/requirement for reporting lack of effectiveness of a therapeutically equivalent generic to allow for either of the following:<br>○ Notification to the FDA Adverse Event Reporting System (FAERS); or<br>○ Submission of medical records documenting the inadequate response to the therapeutically equivalent generic<br>• Refer to Keppra and Keppra XR for complete details |
| | | Kerydin (Tavaborole) | New | • Added coverage guidelines (precertification requirements apply); refer to Drug Coverage Criteria - New and Therapeutic Equivalent Medications for complete details |
| | | Lamictal (Lamotrigine)<br>Lamictal ODT (Lamotrigine Orally Disintegrating Tablets)<br>Lamictal XR (Lamotrigine Extended Release) | Revised | • Revised coverage criteria; updated criterion/requirement for reporting of lack of effectiveness of a therapeutically equivalent generic to allow for **either** of the following:<br>○ Notification to the FDA Adverse Event Reporting System (FAERS); **or**<br>○ Submission of medical records documenting the inadequate response to the therapeutically equivalent generic<br>• Refer to Lamictal, Lamictal ODT and Lamictal XR for complete details |
| | | Menopur (Menotropins) | Updated | • Added reference link to related policy titled Human Menopausal Gonadotropins (hMG) Used in the Treatment of Infertility |
| | | Metadate CD ([Controlled Release Brand Only)<br>Metadate ER<br>Methylin and Methylin ER (Methylphenidate) | Updated | • Reformatted coverage criteria; no change in coverage guidelines |
| | | Neurontin (Gabapentin) | Revised | • Revised coverage criteria; updated criterion/requirement for reporting of lack of effectiveness of a therapeutically equivalent generic to allow for **either** of the following:<br>○ Notification to the FDA Adverse Event Reporting System (FAERS); **or**<br>○ Submission of medical records documenting the inadequate response to the therapeutically equivalent generic<br>• Refer to Neurontin for complete details |
| | | Nexavar (Sorafenib Tosylate) | Revised | • Revised initial authorization criteria for the following diagnoses:<br>○ **Renal Cell Carcinoma (RCC)**: Added additional criterion requiring one of the following:<br>▪ Relapse following surgical excision; **or**<br>▪ Both of the following:<br>- Medically or surgically unresectable tumor |

## Clinical Policy Updates

**REVISED**

| Policy Title | Effective Date | Drug/Medication | Status | Summary of Changes |
|---|---|---|---|---|
| Drug Coverage Guidelines *(continued)* | Nov. 1, 2014 | Nexavar (Sorafenib Tosylate) *(continued)* | Revised | - Diagnosis of Stage IV disease<br>○ **Hepatocellular Carcinoma**: Added additional criterion requiring one of the following:<br>▪ Patient has metastatic disease; **or**<br>▪ Patient has extensive liver tumor burden; **or**<br>▪ Patient is inoperable by performance status or comorbidity (local disease or local disease with minimal extrahepatic disease only); **or**<br>▪ Both of the following:<br>- Patient is not a transplant candidate<br>- Disease is unresectable<br>○ **Thyroid Cancer** [Previously listed as Thyroid Cancer (off-label)]: Updated guidelines to indicate coverage will be approved based on the following criteria:<br>▪ All of the following:<br>- Diagnosis of **one** of the following:<br>• Follicular carcinoma<br>• Hürthle cell carcinoma<br>• Papillary carcinoma<br>**and**<br>- One of the following:<br>• Locally recurrent disease<br>• Metastatic disease<br>**and**<br>- One of the following:<br>• Patient has symptomatic disease<br>• Patient has progressive disease<br>**and**<br>- Disease is refractory to radioactive iodine treatment<br>**or**<br>▪ All of the following:<br>- Diagnosis of disseminated medullary thyroid carcinoma; **and**<br>- Patient has symptomatic disease; **and**<br>- *History of failure, contraindication, or intolerance to one of the following *(*Requirement does not apply to New Jersey plan members)*:<br>• Caprelsa (vandetanib)<br>• Cometriq (cabozantinib)<br>○ **Soft Tissue Sarcoma (off label)**: Updated guidelines to indicate |

# Clinical Policy Updates

| REVISED | | | | |
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| **Policy Title** | **Effective Date** | **Drug/Medication** | **Status** | **Summary of Changes** |
| Drug Coverage Guidelines *(continued)* | Nov. 1, 2014 | Nexavar (Sorafenib Tosylate) *(continued)* | Revised | coverage will be approved based on the following criteria:<br>▪ Diagnosis of angiosarcoma; **or**<br>▪ Diagnosis desmoid tumors/aggressive fibromatosis<br>○ **Gastrointestinal Stromal Tumors (GIST) (off-label)**: *Updated criterion outlining prior therapy requirements; expanded list of drugs for which trial and failure, contraindication, or intolerance must be demonstrated to include Stivarga (regorafenib) as an option *(*Requirement does not apply to New Jersey plan members)*<br>• Refer to Nexavar for complete details |
| | | Oxtellar XR (Oxcarbazepine Extended Release) | Revised | • Revised coverage criteria; updated criterion/requirement for reporting of lack of effectiveness of a therapeutically equivalent generic to allow for **either** of the following:<br>○ Notification to the FDA Adverse Event Reporting System (FAERS); **or**<br>○ Submission of medical records documenting the inadequate response to the therapeutically equivalent generic<br>• Refer to Oxteller XR for complete details |
| | | Procentra (Dextroamphetamine) | Updated | • Reformatted coverage criteria; no change in coverage guidelines |
| | | Quillivant XR (Methylphenidate HCL) | | |
| | | Raloxifene (Generic) | New | • Added coverage guidelines (precertification requirements apply); refer to Raloxifene for complete details |
| | | Regranex (Becaplermin Gel) | Updated | • Routine review; no change in coverage guidelines |
| | | Retin-A and Retin-A Micro (Tretinoin) | Updated | • Routine review; no change in coverage guidelines |
| | | Ritalin (Methylphenidate) | Updated | • Reformatted coverage criteria; no change in coverage guidelines |
| | | Ritalin LA (Methylphenidate Hydrochloride [Extended Release]) | | |
| | | Ritalin SR (Methylphenidate [Controlled-Release]) | | |
| | | Ruconest (C1 Esterase Inhibitor [Recombinant]) | New | • Added coverage guidelines (precertification requirements apply); refer to Ruconest for complete details |

# Clinical Policy Updates

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| **Policy Title** | **Effective Date** | **Drug/Medication** | **Status** | **Summary of Changes** |
| Drug Coverage Guidelines *(continued)* | Nov. 1, 2014 | Soliris (Eculizumab) | New | • Added coverage guidelines (precertification requirements apply); refer to Soliris (eculizumab) for complete details |
| | | Stavzor (Valproic Acid) | Revised | • Revised coverage criteria; updated criterion/requirement for reporting of lack of effectiveness of a therapeutically equivalent generic to allow for **either** of the following:<br>○ Notification to the FDA Adverse Event Reporting System (FAERS); **or**<br>○ Submission of medical records documenting the inadequate response to the therapeutically equivalent generic<br>• Refer to Stavzor for complete details |
| | | Striverdi Respimat (Olodaterol) | New | • Added coverage guidelines (precertification requirements apply); refer to Drug Coverage Criteria - New and Therapeutic Equivalent Medications for complete details |
| | | Sutent (Sunitinib) | Revised | • Revised initial authorization criteria for the following diagnoses:<br>○ **Renal Cell Carcinoma (RCC)**: Added additional criterion requiring one of the following:<br>▪ Relapse following surgical excision; **or**<br>▪ Both of the following:<br>- Medically or surgically unresectable tumor<br>- Diagnosis of Stage IV disease<br>○ **Thyroid Carcinoma (off-label)**: Updated guidelines to indicate coverage will be approved based on the following criteria:<br>▪ All of the following:<br>- Diagnosis of one of the following:<br>• Follicular carcinoma<br>• Hürthle cell carcinoma<br>• Papillary carcinoma<br>**and**<br>- One of the following:<br>• Locally recurrent disease<br>• Metastatic disease<br>**and**<br>- One of the following:<br>• Patient has symptomatic disease<br>• Patient has progressive disease<br>**and**<br>- Disease is refractory to radioactive iodine treatment<br>**or**<br>▪ All of the following: |

## Clinical Policy Updates

| REVISED | | | | |
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| **Policy Title** | **Effective Date** | **Drug/Medication** | **Status** | **Summary of Changes** |
| Drug Coverage Guidelines *(continued)* | Nov. 1, 2014 | Sutent (Sunitinib) *(continued)* | Revised | - Diagnosis of disseminated medullary thyroid carcinoma; **and**<br>- Patient has symptomatic disease; **and**<br>- *History of failure, contraindication, or intolerance to one of the following *(*Requirement does not apply to New Jersey line of business)*:<br>• Caprelsa (vandetanib)<br>• Cometriq (cabozantinib)<br>• Refer to Sutent for complete details |
| | | Tazorac (Taxarotene) | Updated | • Routine review; no change in coverage guidelines |
| | | Topamax (Topiramate) | Revised | • Revised coverage criteria; updated criterion/requirement for reporting of lack of effectiveness of a therapeutically equivalent generic to allow for **either** of the following:<br>○ Notification to the FDA Adverse Event Reporting System (FAERS); **or**<br>○ Submission of medical records documenting the inadequate response to the therapeutically equivalent generic<br>• Refer to Topamax for complete details |
| | | Tretin-X (Tretinoin) | Updated | • Routine review; no change in coverage guidelines |
| | | Trileptal (Oxcarbazepine) | Revised | • Revised coverage criteria; updated criterion/requirement for reporting of lack of effectiveness of a therapeutically equivalent generic to allow for **either** of the following:<br>○ Notification to the FDA Adverse Event Reporting System (FAERS); **or**<br>○ Submission of medical records documenting the inadequate response to the therapeutically equivalent generic<br>• Refer to Trileptal for complete details |
| | | Triumeq (Dolutegravir / Abacavir / Lamivudine) | New | • Added coverage guidelines (precertification requirements apply); refer to Drug Coverage Criteria - New and Therapeutic Equivalent Medications for complete details |
| | | Trokendi XR (Topiramate) | Revised | • Revised coverage criteria; updated criterion/requirement for reporting of lack of effectiveness of a therapeutically equivalent generic to allow for **either** of the following:<br>○ Notification to the FDA Adverse Event Reporting System (FAERS); **or**<br>○ Submission of medical records documenting the inadequate response to the therapeutically equivalent generic<br>• Refer to Trokendi XR for complete details |
| | | Votrient (Pazopanib) | Revised | • Revised initial authorization criteria for the following diagnoses:<br>○ **Renal Cell Carcinoma (RCC)**: Added additional criterion requiring one of the following:<br>▪ Relapse following surgical excision; **or** |

# Clinical Policy Updates

**REVISED**

| Policy Title | Effective Date | Drug/Medication | Status | Summary of Changes |
|---|---|---|---|---|
| Drug Coverage Guidelines *(continued)* | Nov. 1, 2014 | Votrient (Pazopanib) *(continued)* | Revised | ▪ Both of the following:<br>- Medically or surgically unresectable tumor<br>- Diagnosis of Stage IV disease<br>○ **Thyroid Carcinoma (off-label)**: Updated guidelines to indicate coverage will be approved based on the following criteria:<br>▪ Diagnosis of one of the following:<br>- Follicular carcinoma<br>- Hürthle cell carcinoma<br>- Papillary carcinoma<br>**and**<br>▪ One of the following:<br>- Locally recurrent disease<br>- Metastatic disease<br>**and**<br>▪ One of the following:<br>- Patient has symptomatic disease<br>- Patient has progressive disease<br>**and**<br>▪ Disease is refractory to radioactive iodine treatment<br>• Refer to Votrient for complete details |
| | | Vyvanse (Lisdexamfetamine) | Updated | • Reformatted coverage criteria; no change in coverage guidelines |
| | | Zenzedi (Dextroamphetamine Sulfate) | Updated | • Reformatted coverage criteria; no change in coverage guidelines |
| | | Zonegran (Zonisamide) | Revised | • Revised coverage criteria; updated criterion/requirement for reporting of lack of effectiveness of a therapeutically equivalent generic to allow for **either** of the following:<br>○ Notification to the FDA Adverse Event Reporting System (FAERS); **or**<br>○ Submission of medical records documenting the inadequate response to the therapeutically equivalent generic<br>• Refer to Zonegran for complete details |

# Clinical Policy Updates

**REVISED**

| Policy Title | Effective Date | Summary of Changes | Coverage Rationale |
|---|---|---|---|
| Outpatient Physical & Occupational Therapy for Self-Funded Groups | Nov. 1, 2014 | • Reorganized policy content<br>• Revised conditions of coverage:<br>○ Updated guidelines to indicate authorization/precertification with Medical Director review is required in the outpatient and office settings<br>○ Updated list of applicable site(s) of service to include the home setting (no referral or authorization required)<br>○ Updated special considerations language to indicate:<br>▪ Requests for long-term physical therapy require a long-term physical therapy rider and the referral must come from the member's PCP<br>▪ OptumHealth Care Solutions Clinician review is required if the request does not meet criteria and/or there is a question regarding whether the request is a covered benefit when the date of service (DOS) is on or after 01/01/2014 and the member's plan is not Citigroup (CI3198) or Brooks Brothers (BB1627)<br>▪ Authorization is required for in network initial therapy evaluation and all subsequent visits | **For all Oxford self-funded products for dates of service prior to 01/01/2014 AND for all Citigroup (CI3198) or Brooks Brothers (BB1627) products regardless of date of service**<br><br>Oxford covers medically necessary Physical and Occupational Therapy services. Coverage is for acute conditions only whereby services must begin within six months of the later to occur:<br>a. The date of the injury or illness that caused the need for therapy,<br>b. The date the Member is discharged from a hospital where surgical treatment is rendered, **or**<br>c. The date outpatient surgical care was rendered.<br><br>In no event will the therapy continue beyond 365 days after such event.* (*Long term rider may alter coverage criteria)<br><br>Services must be performed by a duly licensed and certified provider. All services must be within the scope of the provider's license in order to be eligible for reimbursement.<br><br>Up to three (3) modalities/therapeutic procedures will be accepted, without additional documentation, per date of service. Services in excess of three (3) modalities/therapeutic procedures will be reviewed upon receipt of clinical documentation.<br><br>**Referral Requirements:**<br>• Oxford Members enrolled on gated self-funded groups are required to have a referral for all in-network physical or occupational therapy services. Members enrolled in non-gated products are not required to have a referral.<br>• Referrals can be issued by the following: Member's PCP, General Surgeon, Gynecological Oncologist, Hematologist-Oncologist, Neurologist, Oncologist, Orthopedists, Pain Management Specialist, Physiatrist, Neurosurgeon, and Rheumatologist.<br><br>**Exception:** In the case of long-term physical therapy (long-term physical therapy rider required), the referral must come from the Member's PCP.<br><br>**For All Oxford self-funded Products for dates of service after 01/01/2014** |

# Clinical Policy Updates

| REVISED | | | |
|---|---|---|---|
| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Outpatient Physical & Occupational Therapy for Self-Funded Groups *(continued)* | Nov. 1, 2014 | when the DOS is on after 01/01/2014 and the member's plan is not Citigroup (CI3198) or Brooks Brothers (BB1627)<br>▪ Refer to the *Coverage Rationale* section of the policy for additional information regarding utilization review for medical necessity by OptumHealth Care Solutions when the DOS is on or after 01/01/14 and the member's plan is not a Citigroup (CI3198) or Brooks Brothers (BB1627)<br>• Updated benefit considerations; clarified language pertaining to accumulation of benefits<br>• Revised coverage rationale:<br>○ Reorganized content/guidelines by the following DOS and product type classifications:<br>▪ All self-funded product members for DOS **prior to** 01/01/2014 **and** all Citigroup (CI3198) and Brooks Brothers (BB1627) product member regardless of date of service<br>▪ All self-funded product members for DOS **after** 01/01/2014 [except Citigroup (CI3198) or | **Reminder:** The following guidelines do **not** apply to Citigroup (CI3198) or Brooks Brothers (BB1627).<br><br>Oxford has delegated certain administrative services related to Physical and Occupational Therapy services to OptumHealth Care Solutions. OptumHealth Care Solutions, a UnitedHealth Group company, will administer the physical and occupational therapy benefit for Oxford products. OptumHealth Care Solutions is a leading physical medicine company that has significant experience working with physical and occupational therapists and physicians, in promoting high quality, affordable physical medicine and rehabilitation services.<br><br>You may access OptumHealth Care Solutions clinical policies at the following website: https://www.myoptumhealthphysicalhealth.com.<br><br>Services managed by OptumHealth Care Solutions include:<br>• Utilization Review functions for a designated list of CPT and HCPCS codes for outpatient physical and occupational therapy for fully insured commercial products, excluding self-funded Members.<br>• First level administrative, Utilization Management Member and provider appeals, Member appeals, and external appeals where applicable.<br><br>**Note:** Oxford has not delegated 2nd level Member internal appeals, external Member appeals, and regulatory inquiries to OptumHealth Care Solutions.<br><br>This policy applies to a specific list of CPT and HCPCS codes, regardless of the specialty of the treating provider. Refer to the Applicable Codes section below for a list of the CPT and HCPCS codes.<br><br>• **Exception:** If a chiropractor provides any of the services specified by the CPT or HCPCS codes in this policy, those services will continue to accrue separately towards the chiropractic benefit, if available. For chiropractic services refer to Manipulative Therapy policy for additional information.<br><br>This policy applies in the outpatient setting only. The outpatient setting for physical therapy and occupational therapy includes hospital outpatient treatment facilities, outpatient facilities at or affiliated with rehabilitation hospitals. |

## Clinical Policy Updates

| REVISED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Outpatient Physical & Occupational Therapy for Self-Funded Groups *(continued)* | Nov. 1, 2014 | Brooks Brothers (BB1627) product members]<br>○ Added coverage guidelines for self-funded product members for DOS **after** 01/01/2014 [except Citigroup (CI3198) or Brooks Brothers (BB1627) product members] to indicate:<br>▪ OptumHealth Care Solutions will administer the physical and occupational therapy benefit; services managed by OptumHealth Care Solutions include:<br>- Utilization review functions for a designated list of CPT and HCPCS codes for outpatient physical and occupational therapy for fully insured commercial products, excluding self-funded members<br>- First level administrative, utilization management member and provider appeals, member appeals, and external appeals where applicable<br>▪ You may access | Physical and occupational therapy provided in the home will be managed under the home care benefit (per the Member's certificate). All home care services require precertification. Refer to policy: Home Health Care for additional information.<br><br>In the case of occupational therapy, the referral must come from one of the following:<br>• The Member's primary care physician (PCP)<br>• General Surgeon<br>• Gynecological Oncologist<br>• Hematologist Oncologist<br>• Neurologist<br>• Oncologist<br>• Orthopedist<br>• Physiatrist<br>• Neurosurgeon<br>• Pain Management Specialist or Rheumatologist<br><br>Refer to the Referrals policy for additional information.<br><br>**In-Network subsequent physical and occupational therapy:**<br>In-Network subsequent physical and occupational therapy (not rendered by a chiropractor) requires utilization review by OptumHealth Care Solutions to determine medical necessity. An initial evaluation report must be submitted to OptumHealth Care Solutions within ten calendar days of the initial visit or prior to the second visit, whichever occurs first.<br><br>All services rendered by UnitedHealthcare Choice Plus providers in the service area will be subject to retrospective review.<br><br>**Out-of-network physical and occupational therapy:**<br>OptumHealth Care Solutions will review out-of-network physical and occupational therapy services for medical necessity after the services have been received and the claims are submitted.<br><br>Members also have the option through a Voluntary Prior Approval Process to submit a treatment plan. The prior approval process is completely voluntary. Out-of-Network providers are not required to pre-authorize services. All |

## Clinical Policy Updates

| REVISED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Outpatient Physical & Occupational Therapy for Self-Funded Groups *(continued)* | Nov. 1, 2014 | OptumHealth Care Solutions' clinical policies at the following website: https://www.myoptumhealthphysicalhealth.com<br>▪ This policy applies to a specific list of CPT and HCPCS codes, regardless of the specialty of the treating provider; refer to the *Applicable Codes* section of the policy for details<br>- Exception: If a chiropractor provides any of the services specified by the CPT or HCPCS codes listed in this policy, those services will continue to accrue separately towards the chiropractic benefit, if available; refer to the policy titled *Manipulative Therapy* for additional information on coverage guidelines for chiropractic services, if applicable<br>▪ This policy applies in the outpatient setting only; the outpatient setting for physical therapy and occupational therapy includes hospital outpatient treatment | initial evaluations and subsequent visits must be authorized when using the Voluntary Prior Approval Process.<br><br>Members are financially responsible for all out-of-network services determined to be not medically necessary.<br><br>**Note:**<br>• For chiropractic services, refer to the policy titled Manipulative Therapy for additional information.<br>• For services provided by complementary and alternative medicine (CAM) providers, refer to policy titled Complementary and Alternative Medicine (CAM) Contracted Rate Program. CAM providers include:<br>o Acupuncturists<br>o Dieticians and Nutritional Counselors<br>o Massage Therapists<br>o Naturopathic Physicians (CT only - due to state licensing statutes)<br>o Yoga Instructors<br>• For rehabilitation services for the treatment of Autism, refer to the policy titled Autism.<br>• Utilization management and prior approval will continue to be subject to Member's certificate of coverage.<br>• Services must be performed by a duly licensed and certified provider. All services must be within the scope of the provider's license in order to be eligible for reimbursement. |

## Clinical Policy Updates

| REVISED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Outpatient Physical & Occupational Therapy for Self-Funded Groups *(continued)* | Nov. 1, 2014 | facilities, outpatient facilities at or affiliated with rehabilitation hospitals<br>▪ Physical and occupational therapy provided in the home will be managed under the home care benefit (per the member's certificate of coverage) and all home care services require precertification; refer to the policy titled *Home Health Care* for additional information<br>▪ In the case of occupational therapy, the referral must come from one of the following (refer to policy titled *Referrals* for additional information):<br>- The member's primary care physician (PCP)<br>- General surgeon<br>- Gynecological oncologist<br>- Hematologist oncologist<br>- Neurologist<br>- Oncologist<br>- Orthopedist<br>- Physiatrist<br>- Neurosurgeon<br>- Pain management specialist or rheumatologist | |

# Clinical Policy Updates

| REVISED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Outpatient Physical & Occupational Therapy for Self-Funded Groups *(continued)* | Nov. 1, 2014 | ▪ In-network subsequent physical and occupational therapy (not rendered by a chiropractor) requires utilization review by OptumHealth Care Solutions to determine medical necessity; an initial evaluation report must be submitted to OptumHealth Care Solutions within ten calendar days of the initial visit or prior to the second visit, whichever occurs first<br>▪ All services rendered by UnitedHealthcare Choice Plus providers in the service area will be subject to retrospective review<br>▪ OptumHealth Care Solutions will review out-of-network physical and occupational therapy services for medical necessity after the services have been received and the claims are submitted<br>▪ Members also have the option through a Voluntary Prior Approval Process to submit a treatment plan; the prior approval process is completely voluntary | |

## Clinical Policy Updates

| REVISED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Outpatient Physical & Occupational Therapy for Self-Funded Groups *(continued)* | Nov. 1, 2014 | ▪ Out-of-Network providers are not required to pre-authorize services<br>▪ All initial evaluations and subsequent visits must be authorized when using the *Voluntary Prior Approval Process*<br>▪ Members are financially responsible for all out-of-network services determined to be not medically necessary<br>▪ Utilization management and prior approval will continue to be subject to member's certificate of coverage<br>▪ Services must be performed by a duly licensed and certified provider; all services must be within the scope of the provider's license in order to be eligible for reimbursement<br>• Revised definitions of "occupational therapy (OT)" and "physical therapy (PT)"<br>• Revised lists of applicable procedure codes:<br>○ Added language to indicate the listed CPT/HCPCS codes require utilization review for all self-funded products for DOS after 01/01/2014 [**Exception**: Utilization review of physical and | |

## Clinical Policy Updates

| REVISED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Outpatient Physical & Occupational Therapy for Self-Funded Groups *(continued)* | Nov. 1, 2014 | occupational therapy does not apply to Members enrolled in Citigroup (CI3198) or Brooks Brothers (BB1627) products regardless of the DOS]<br>○ Updated list of applicable CPT codes:<br>▪ Added 97001*, 97003 and 97139 (*cannot be billed by an occupational therapist)<br>▪ Added language to indicate:<br>- For self-funded products for DOS on or after 01/01/2014 [**except** for Citigroup (CI3198) or Brooks Brothers (BB1627) products], evaluations billed on the same day of a treatment modality will be paid out according to the established evaluation rate only<br>• Updated supporting information to reflect the most current description of services and references | |
| Outpatient Physical and Occupational Therapy (OptumHealth Care Solutions Arrangement) | Nov. 1, 2014 | • Reorganized policy content<br>• Replaced references to "OptumHealth" with "OptumHealth Care Solutions"<br>• Revised conditions of coverage:<br>○ Updated applicable benefit | Oxford has delegated certain administrative services related to Physical and Occupational Therapy services to OptumHealth Care Solutions. OptumHealth Care Solutions, a UnitedHealth Group company, will administer the physical and occupational therapy benefit for Oxford products. OptumHealth Care Solutions is a leading physical medicine company that has significant experience working with physical and occupational therapists and physicians, |

# Clinical Policy Updates

| REVISED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Outpatient Physical and Occupational Therapy (OptumHealth Care Solutions Arrangement) *(continued)* | Nov. 1, 2014 | type classification(s); replaced "physical therapy benefit" with "general benefits package or long term therapy"<br>○ Updated special considerations language to indicate:<br>▪ Refer to the *Benefits Considerations* section of the policy for exceptions and additional details<br>▪ Requests for long-term physical therapy require a long-term physical therapy rider *and the referral must come from the member's PCP*<br>▪ OptumHealth Care Solutions Clinician review is required if the request does not meet criteria and/or there is a question regarding whether the request is a covered benefit<br>▪ Authorization is required for in network initial therapy evaluation and all subsequent visits<br>▪ Refer to the *Coverage Rationale* section of the policy for additional information regarding utilization review for medical necessity by OptumHealth Care Solutions<br>• Revised benefit considerations: | in promoting high quality, affordable physical medicine and rehabilitation services.<br><br>You may access OptumHealth Care Solutions clinical policies at the following website: https://www.myoptumhealthphysicalhealth.com.<br><br>Services managed by OptumHealth Care Solutions include:<br>• Utilization Review functions for a designated list of CPT and HCPCS codes for outpatient physical and occupational therapy for fully insured commercial products, excluding self-funded Members.<br><br>**Exceptions:** This policy does not apply to:<br>○ New Jersey Small and New Jersey Individual plans (included in OptumHealth Care Solutions arrangement, but excluded from this policy). Refer to Physical, Occupational and Speech Therapy including Cognitive/Neuropsychological Rehabilitation for New Jersey Small and New Jersey Individual Plans.<br>○ Self-funded Groups Refer to: Outpatient Physical & Occupational Therapy for Self-Funded Groups for additional information.<br><br>• First level administrative, Utilization Management Member and provider appeals, Member appeals, and external appeals where applicable.<br><br>**Note:** Oxford has not delegated 2nd level Member internal appeals, external Member appeals, and regulatory inquiries to OptumHealth Care Solutions.<br><br>This policy applies to a specific list of CPT and HCPCS codes, regardless of the specialty of the treating provider. Refer to the Applicable Codes section in this policy for a list of the CPT and HCPCS codes.<br><br>**Exception:** If a chiropractor provides any of the services specified by the CPT or HCPCS codes in this policy, those services will continue to accrue separately towards the chiropractic benefit, if available. For chiropractic services refer to Manipulative Therapy policy for additional information.<br><br>This policy applies in the outpatient setting only. The outpatient setting for physical therapy and occupational therapy includes hospital outpatient treatment facilities, outpatient facilities at or affiliated with rehabilitation hospitals. |

# Clinical Policy Updates

| REVISED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Outpatient Physical and Occupational Therapy (OptumHealth Care Solutions Arrangement) *(continued)* | Nov. 1, 2014 | ○ Added language to indicate all products have specific benefit limitations/benefit maximums determined by group and individual products; refer to the member's certificate of coverage for specific limitations/maximums<br>○ Updated *Exceptions to Coverage Exclusions* for Connecticut, New York, and Massachusetts residents being treated as part of an Early Intervention or Birth to Three Program; replaced content with a reference link to the policy titled *Speech Therapy and Early Intervention Programs/Birth to Three* for applicable guidelines<br>• Updated/clarified coverage rationale:<br>○ Added reference link to policy titled *Manipulative Therapy* for additional information on coverage guidelines for chiropractic services, if applicable<br>○ Replaced reference(s) to:<br>▪ "CPT codes" with "CPT and HCPCS codes"<br>▪ "Prior approval" with "precertification"<br>▪ "Member's policy" with "member's certificate of coverage"<br>• Revised definition of "physical | Physical and occupational therapy provided in the home will be managed under the home care benefit (per the Member's certificate). All home care services require precertification. Refer to policy: Home Health Care for additional information.<br><br>In the case of occupational therapy, the referral must come from one of the following:<br>• The Member's PCP,<br>• General Surgeon,<br>• Gynecological Oncologist,<br>• Hematologist-Oncologist,<br>• Neurologist,<br>• Oncologist,<br>• Orthopedists,<br>• Physiatrist,<br>• Neurosurgeon,<br>• Pain Management Specialist or Rheumatologist.<br><br>Refer to the Referrals policy for additional information.<br><br>**In-Network subsequent physical and occupational therapy:**<br>In-Network subsequent physical and occupational therapy (not rendered by a chiropractor) requires utilization review by OptumHealth Care Solutions to determine medical necessity. An initial evaluation report must be submitted to OptumHealth Care Solutions within ten calendar days of the initial visit or prior to the second visit, whichever occurs first.<br><br>All services rendered by UnitedHealthcare Choice Plus providers in the service area will be subject to retrospective review.<br><br>**Out-of-network physical and occupational therapy:**<br>OptumHealth Care Solutions will review out-of-network physical and occupational therapy services for medical necessity after the services have been received and the claims are submitted.<br><br>Members also have the option through a Voluntary Prior Approval Process to submit a treatment plan. The prior approval process is completely voluntary. Out-of-Network providers are not required to pre-authorize services. All initial evaluations and subsequent visits must be authorized when using the |

## Clinical Policy Updates

| REVISED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Outpatient Physical and Occupational Therapy (OptumHealth Care Solutions Arrangement) *(continued)* | Nov. 1, 2014 | therapy"<br>• Added list of applicable (non-reimbursable) CPT/HCPCS codes: 97005, 97006, and S8990<br>• Updated supporting information to reflect the most current description of services | Voluntary Prior Approval Process.<br><br>Members are financially responsible for all out-of-network services determined to be not medically necessary.<br><br>**Notes:**<br>• For chiropractic services refer to Manipulative Therapy policy for additional information.<br>• For services provided by complementary and alternative medicine (CAM) providers, refer to policy: Complementary and Alternative Medicine (CAM) Contracted Rate Program. CAM providers include:<br>○ Acupuncturists<br>○ Dieticians and Nutritional Counselors<br>○ Massage Therapists<br>○ Naturopathic Physicians (CT only - due to state licensing statutes)<br>○ Yoga Instructors<br>• For rehabilitation services for the treatment of Autism, please refer to the following policy: Autism.<br>• Utilization management and prior approval will continue to be subject to Member's certificate of coverage.<br>• Services must be performed by a duly licensed and certified provider. All services must be within the scope of the provider's license in order to be eligible for reimbursement. |
| Plagiocephaly and Craniosynostosis Treatment | Nov. 1, 2014 | • Reorganized policy content<br>• Updated benefit considerations; added language for *Essential Health Benefits for Individual and Small Group* plans to indicate:<br>○ For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) to provide coverage for ten categories | Cranial orthotic devices are **reconstructive and medically necessary** for:<br><br>a) craniosynostosis following surgical correction<br>b) treatment of craniofacial asymmetry in infants 3-18 months of age with severe nonsynostotic positional plagiocephaly when all the following criteria are present (1, 2 and 3):<br><br>1. Infant is 18 months of age or younger<br>2. Severe asymmetry is present with or without torticollis<br>3. There is lack of substantial improvement following conservative therapy of at least 2 months duration with cranial repositioning and stretching therapy.<br><br>Severe plagiocephaly is defined as an asymmetry of 10 mm or more in one of the following anthropometric measures: cranial vault, skull base, or orbitotragial depth; OR a cephalic index at least two standard deviations |

## Clinical Policy Updates

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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Plagiocephaly and Craniosynostosis Treatment *(continued)* | Nov. 1, 2014 | of Essential Health Benefits ("EHBs")<br>○ Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs; however, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans<br>○ The determination of which benefits constitute EHBs is made on a state by state basis; as such, when using this guideline, it is important to refer to the enrollee's specific plan document to determine benefit coverage<br>• Updated coverage rationale:<br>○ Reformatted and relocated information pertaining to medical necessity review<br>○ Added reference to the *description of services* section of the policy for additional information regarding anthropometric measurements and Cephalic Index graph<br>• Updated list of applicable HCPCS codes; added A8003<br>• Updated supporting information | above or below the mean for the appropriate gender/age. Clinical evidence demonstrates improved surgical outcomes with the post-operative use of the orthotic device.<br><br>**Note**: Please see description of services section for additional information regarding Anthropometric measurements and Cephalic Index graph.<br><br>Cranial orthotic devices are **cosmetic and not medically necessary** in infants with mild to moderate plagiocephaly.<br><br>There are no definitive data demonstrating that there are adverse health effects associated with a mild to moderate degree of cranial asymmetry, and, therefore, it is unclear whether treatment of these individuals provides a future health benefit, or merely a cosmetic effect. In general, severe plagiocephaly occurs in utero and is present at birth. Limited clinical evidence suggests that it may be associated with future ocular and/or oral abnormalities. Acquired plagiocephaly occurs following the placement of the infant in a supine sleeping position to prevent sudden infant death syndrome, and is ordinarily mild to moderate. Positional plagiocephaly has not been linked to future comorbidities.<br><br>Surgical treatment to repair craniosynostosis is **reconstructive and medically necessary** irrespective of the approach used.<br><br>Less invasive procedures including endoscopic strip craniectomy and spring-mediated cranioplasty are **proven non-preferentially and medically necessary** as a form of surgical treatment to repair craniosynostosis. |

# Clinical Policy Updates

| REVISED | | | |
|---|---|---|---|
| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Plagiocephaly and Craniosynostosis Treatment *(continued)* | Nov. 1, 2014 | to reflect the most current description of services, clinical evidence, FDA information and references | |
| Preventive Care | Jan. 1, 2015* | ***Implementation Delayed**: The changes noted below will not be effective on Oct. 1, 2014 as previously announced in the September 2014 Policy Update Bulletin; implementation of the revised policy has been postponed until **Jan. 1, 2015**.*<br>• Revised list of applicable procedure and diagnosis codes for preventive care services:<br>○ Changed tentative effective date of ICD-10 code set implementation from "10/01/14" to "10/01/15"<br>**Abdominal Aortic Aneurysm Screening**<br>○ Added June 2014 USPSTF 'B' rating (no impact to benefit guidelines)<br>**Cervical Cancer Screening, Pap Smear**<br>○ Updated service description; added language to indicate adolescents should no longer be routinely screened for cervical dysplasia until age 21 (Bright Futures, March 2014)<br>○ Updated claims edit criteria; added benefit age limit of 21-65 years (ends on 66th birthday)<br>**Colorectal Cancer Screening**<br>○ Revised coverage guidelines for *fecal occult blood testing, sigmoidoscopy, or colonoscopy*:<br>▪ Updated service description; added USPSTF interval/frequency recommendations<br>▪ Updated list of applicable codes; changed sub-header/title for "Code Group 3" to "Code Group 3 (for Pathology)"<br>▪ Updated claims edit criteria:<br>- Added benefit age limit of 50-75 years (ends on 76th birthday) in accordance with USPSTF October 2008 rating<br>- Added language specific to Code Group 3 (for Pathology) to indicate services are preventive when performed for a colorectal cancer screening; preventive benefits only apply when the surgeon's claim is preventive<br>○ Revised coverage guidelines for *computed tomographic colonography (virtual colonoscopy):*<br>▪ Updated claims edit criteria;<br>- Added benefit age limit of 50-75 years (ends on 76th birthday) in accordance with USPSTF October 2008 rating<br>- Added language to indicate prior authorization requirements may apply<br>**Formal Developmental/Autism Screening (Bright Futures)**<br>○ Updated service description; added language to indicate:<br>▪ A formal, standardized autism screen is recommended during the 9 month visit<br>▪ A formal, standardized developmental screen is recommended during the 18 month visit, including a formal autism screen | |

# Clinical Policy Updates

**REVISED**

| Policy Title | Effective Date | Summary of Changes | Coverage Rationale |
|---|---|---|---|
| Preventive Care *(continued)* | Jan. 1, 2015* | ▪ A formal, standardized autism screen is recommended during the 24 month visit<br>▪ A formal, standardized developmental screen is recommended during the 30 month visit<br>○ Updated claims edit criteria; changed benefit age limit to 0-2 years (ends on 3rd birthday) in accordance with Bright Futures recommendations for formal standardized developmental/autism screening<br>• Reorganized *Pregnancy Diagnosis Code List* for clarity (reformatted table, removed code ranges, and itemized code listings)<br>• Updated *Hepatitis C Virus Infection Diagnosis Code List*:<br>○ Corrected typographical error; replaced "Z2" with "Z21"<br>Refer to the policy for complete details on the coverage rationale for Preventive Care. | |
| Total Artificial Heart | Nov. 1, 2014 | • Reorganized policy content<br>• Added benefit considerations language to indicate:<br>○ When deciding coverage for a total artificial heart for a person who has end-stage heart disease, refer to the member-specific benefit document for further information; some Certificates of Coverage allow coverage of experimental/investigational/ unproven treatments for life-threatening illnesses when certain conditions are met<br>○ For *Essential Health Benefits for Individual and Small Group* plans:<br>▪ For plan years beginning on or after January 1, 2014, the Affordable Care Act of 2010 (ACA) requires fully insured non-grandfathered individual and small group plans (inside and outside of Exchanges) | The SynCardia® temporary Total Artificial Heart (formerly known as the CardioWest™ temporary Total Artificial Heart) is proven and medically necessary as a bridge to heart transplantation in patients who meet **all** of the following criteria:<br>• At risk of imminent death from biventricular failure<br>• Have no other medical or surgical treatment options<br>• Eligible for heart transplantation<br>• Have sufficient space in the chest cavity to accommodate the device. Generally this includes patients who have a body surface area ≥ 1.7m$^2$<br>**Note:**<br>• At this time, only the 70cc SynCardia device has been approved by the U.S. Food and Drug Administration (FDA).<br>• The Freedom® portable driver system is FDA approved for use with the SynCardia device in clinically stable patients. See the FDA section for additional information.<br>The AbioCor® implantable replacement heart is unproven and not medically necessary as an alternative to heart transplantation.<br>There is limited evidence that the AbioCor replacement heart, as a permanent replacement for the failing heart, improves survival. Well-designed studies are needed to establish the safety and efficacy of this device. |

## Clinical Policy Updates

| REVISED | | | |
|---|---|---|---|
| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Total Artificial Heart *(continued)* | Nov. 1, 2014 | to provide coverage for ten categories of Essential Health Benefits ("EHBs")<br>▪ Large group plans (both self-funded and fully insured), and small group ASO plans, are not subject to the requirement to offer coverage for EHBs; however, if such plans choose to provide coverage for benefits which are deemed EHBs (such as maternity benefits), the ACA requires all dollar limits on those benefits to be removed on all Grandfathered and Non-Grandfathered plans<br>▪ The determination of which benefits constitute EHBs is made on a state by state basis; as such, when using this guideline, it is important to refer to the member's specific plan document to determine benefit coverage<br>• Revised coverage rationale:<br>○ Added language to indicate if service is "proven" or "unproven" to applicable medically necessary/not medically necessary statement | |

## Clinical Policy Updates

| REVISED | | | |
|---|---|---|---|
| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Total Artificial Heart *(continued)* | Nov. 1, 2014 | ○ Revised patient selection criteria for SynCardia™ temporary total artificial heart to more closely match FDA indications<br>• Updated supporting information to reflect the most current description of services, clinical evidence, FDA information and references | |
| Vision Services | Nov. 1, 2014 | • Updated lists of applicable codes:<br>***Benefit and Rider Considerations***<br>○ HCPCS codes:<br>▪ Added S0620 and S0621<br>○ ICD-9 diagnosis codes:<br>▪ Added 367.20 and 367.89<br>▪ Removed 368.13 and 379.31<br>***Non-covered Devices and Services***<br>○ Added list of CPT/HCPCs codes representing surgery that is intended to allow you to see better without glasses or other vision correction and are not covered: 65760, 65765, 65767, 65771, S0800, S0810, and S0812<br>○ Removed list of HCPCS codes representing low vision rehabilitation: G9041, G9042, G9043, and G9044<br>○ ICD-10 diagnosis codes:<br>▪ Added H52.09<br>▪ Removed H27.00, | Oxford will provide coverage for ophthalmologic services performed by ophthalmologists or optometrists subject to the benefit/rider, referral, and provider scope/privileging considerations outlined in the Procedures and Responsibilities section of the Vision Services policy. |

## Clinical Policy Updates

| REVISED | | | |
|---|---|---|---|
| **Policy Title** | **Effective Date** | **Summary of Changes** | **Coverage Rationale** |
| Vision Services *(continued)* | Nov. 1, 2014 | H27.01, H27.02, H27.03, H53.141, H53.142, H53.143 and H53.149 | |

# Administrative Policy Updates

**UPDATED**

| Policy Title | Effective Date | Summary of Changes | Administrative Guidelines |
|---|---|---|---|
| Filing Deadlines for Claims Submissions | Nov. 1, 2014 | • Revised policy application language; updated list of examples for documenting proof of hardcopy claim submission to include *"a copy of a screen print from the accounting software to show the date you submitted the claim, etc."* | **Original Claim Filing Deadlines for Providers** |

| Provider Status | CT LOB | NY LOB | NJ LOB |
|---|---|---|---|
| Participating | **90 days from the date of service (DOS)** | **120 days from the DOS**<br><br>**Example:** A Claim for services rendered on 4/01/2011 will be subject to a filing deadline of 07/29/2011. | **180 days from the DOS**<br><br>**Example:** A claim for services rendered on 04/10/2011 will be subject to a filing deadline of 10/07/2011. |
| Non-participating | **180 days from the DOS** | | |

**Notes:**

- All New Jersey Non-Participating providers having rendered services to a New Jersey Member without an assignment of benefit elected are not eligible to submit claims for payment.
- When the member's line of business (LOB) state and the provider's state conflict, the member's LOB state dictates the filing deadline.

**Original Claim Filing Deadlines for Members**

| Claims Submitted By: | Original Claim |
|---|---|
| • New Jersey LOB Members seeking reimbursement for services rendered by a Non-participating Provider | **90 days from the DOS** to submit proof of loss* (i.e., they have not made an assignment to the provider and are submitting the claims themselves).<br>• **Example:** A claim for services rendered on 04/01/2011 will be subject to a filing deadline of 06/30/2011. |
| • New York LOB Members seeking reimbursement for services rendered by a Non-participating Provider | **120 Days from the Date of Service**<br>• **Example:** A Claim for services rendered on 4/01/2011 will be subject to a filing deadline of 07/29/2011. |

# Administrative Policy Updates

**UPDATED**

| Policy Title | Effective Date | Summary of Changes | Administrative Guidelines |
|---|---|---|---|
| Filing Deadlines for Claims Submissions *(continued)* | Nov. 1, 2014 | | • All other LOB Members seeking reimbursement for services rendered by a Non-participating Provider, **180 Days from the Date of Service** • **Example:** A claim for services rendered on 04/10/2011 will be subject to a filing deadline of 10/07/2011.<br>***If the member is unable to submit the claim for services within 90 days, the member must submit the claim as soon as it is reasonably possible to do so.<br><br>**Exceptions to Original Claim Deadline**<br>• New Jersey Public Sector LOBs are an exception to the above deadlines for NJ LOBs.<br>• If coordination of benefits (COB) has caused a delay in the receipt of an explanation of benefits (EOB), letter of denial, etc. from the primary carrier, the provider will have 90 days from the date of the primary carrier EOB to submit the claim to Oxford.<br>• When processing inpatient hospital and facility claims, the discharge date is used as the starting point to determine the time frame for submission.<br>• All maternity related services may be reimbursed up to 90 days from the delivery date.<br>• If a previously denied authorization has been updated to an approved status, the timeframe within which to file a claim begins with the date the appeal determination was made as noted in the authorization.<br>• Except as otherwise specified in the Member's Certificate, failure to request reimbursement within the required time does not bar reimbursement if it was not reasonably possible to submit within the timeframe due to physical or mental incapacitation. However, the request must be made as soon as reasonably possible as determined by Oxford.<br>• Certain products may have specific timeframes regarding the submission of claims. Please refer to the Member's Certificate for specific limitations/maximums.<br>• All New York Participating Providers having rendered services to a New York Commercial Member for claims submitted after April 1, 2010, if a claim is submitted past the filing deadline due to an unusual occurrence (e.g., provider illness, provider's computer breakdown, fire, or flood) and the provider has a historical pattern of timely submissions of claims, the provider may request reconsideration of the claim.<br>• Delegated arrangements may have different filing deadlines. Please refer to the contract with the delegated arrangement.<br>• Certain providers may have specific filing deadlines listed in their |

# Administrative Policy Updates

**UPDATED**

| Policy Title | Effective Date | Summary of Changes | Administrative Guidelines |
|---|---|---|---|
| Filing Deadlines for Claims Submissions *(continued)* | Nov. 1, 2014 | | contract.<br><br>**Submission of Additional Information**<br>Payment for services may be denied due to a lack of necessary, complete, or conflicting information. When Oxford denies a service requesting additional information, Commercial and Self-funded Members are given **45 days from the date of receipt of an Explanation of Benefits (EOB) or Remittance Advice** to submit the requested additional information, regardless of the provider's status with the Oxford network.<br><br>**Exceptions:**<br>1. Network providers may have specific filing deadlines for additional information listed in their contract. Please refer to the provider contract for specific timeframes.<br>2. Certain products may have specific timeframes regarding the submission of claims. Please refer to the Member's Certificate for specific limitations/maximums.<br>3. Delegated arrangements may have different filing deadlines. Please refer to the contract with the delegated arrangement.<br><br>If the Member wishes to submit the additional information outside of the allotted 45 days, he or she must submit an appeal of the initial decision.<br><br>**Appeals**<br>For appeals guidelines and processes, please refer to Oxford the following policies:<br><br>• Expedited Appeal Process<br>• Member Administrative Grievance and Appeal (Non Utilization Management) Process and Timeframes<br>• Practitioner/Provider Administrative Claim Appeal Process<br>• Utilization Management Appeal Process and Timeframes for Connecticut Plans<br>• Utilization Management Appeal Process and Timeframes for New York Plans<br>• Utilization Management Appeal Process and Timeframes for New Jersey Plans |

# Administrative Policy Updates

| UPDATED | | | |
|---|---|---|---|
| **Policy Title** | **Effective Date** | **Summary of Changes** | **Administrative Guidelines** |
| Filing Deadlines for Claims Submissions *(continued)* | Nov. 1, 2014 | | **Proof of Timely Filing**<br>In the event that a provider disputes the denial of an original claim for untimely filing, the provider must be able to show proof of submission within the filing deadline.<br><br>**Electronic Submission**<br>As proof, the provider must submit two EDI acceptance reports. One report will show the date the batch was sent, number of claims sent, and the number of accepted claims vs. rejected claims. The rejected claims will show error details and the claims should be corrected and resent. The other report will show a listing of the claims by patient name that were received by the clearinghouse. These reports are supplied to Providers and facilities directly from the clearinghouse.<br><br>**Note:**<br>• Oxford will not accept a transmission report that only indicates the claim(s) were sent to the clearinghouse. Providers are responsible for checking their clearinghouse reports to ensure that the claim was accepted, and forwarded to Oxford.<br><br>**Hardcopy Submissions**<br>As proof, the provider must submit documentation showing that Oxford has received the hardcopy claim (receipt for certified letter, a copy of a screen print from the accounting software to show the date you submitted the claim, etc.). |
| Timeframe Standards for Benefit Administrative Initial Decisions | Nov. 1, 2014 | • Reorganized definitions by applicable state and product<br>• Replaced references to "line of business (LOB)" with "product" | Oxford follows all State, Federal and NCQA guidelines regarding timeframes for Benefit Administrative initial determinations. In order to be compliant with all mandated timeframes, Oxford adheres to the strictest timeframe. Failure to adhere to applicable state, federal or regulatory resolution timeframes for any state in which Oxford is licensed to perform Utilization Management, may result in a technical reversal of the initial determination.<br><br>Refer to the policy for complete details on Timeframe Standards for Benefit Administrative Initial Decisions. |

# Administrative Policy Updates

**REVISED**

| Policy Title | Effective Date | Summary of Changes | Administrative Guidelines |
|---|---|---|---|
| Expedited Appeal Process | Nov. 1, 2014 | • Reorganized definitions by applicable state and product<br>• Revised policy language:<br>○ Replaced references to "lines of business" with "products"<br>○ Updated guidelines for *expedited appeal for utilization review issues;* replaced language indicating "upon receipt of the appeal, Oxford will provide reasonable access to our clinical *peer* reviewer within one business day" with "upon receipt of the appeal, Oxford will provide reasonable access to our clinical reviewer within one business day"<br>○ Updated guidelines for *external appeal review for CT products only*; replaced language indicating "Oxford shall provide continued coverage of an ongoing course of treatment pending the outcome of the *Stage 3* external appeal" with "Oxford shall provide continued coverage of an ongoing course of treatment pending the outcome of the external appeal" | **Criteria for Expedited Appeal**<br><br>An expedited appeal requested by a:<br><br>**Requestor** / **Will be granted if…**<br>Member or the Member's representative — it is determined that the standard allowable review timeframe would seriously jeopardize the Member's life, health or their ability to regain maximum functioning<br>Physician on behalf of a Member and with the Member's consent or with knowledge of the Member's condition — the physician indicates that by applying the standard timeframe it would seriously jeopardize the Member's life, health or their ability to regain maximum functioning<br><br>An expedited appeal process has been established for appeal of an adverse determination involving:<br>1. Continued, extended health care services, procedures or treatments or additional services for an insured undergoing a course of continued treatment prescribed by a health care provider, or<br>2. A health care provider that believes an immediate appeal is warranted except any retrospective determination.<br><br>An expedited appeal can apply to the following:<br><br>**Issue Type** / **Definition**<br>Benefit Administrative Issues — Denials based on benefit exclusions or benefit limitations.<br>Utilization Review Issues — Denials that concern medical necessity determinations or services that are considered experimental or investigational.<br><br>For additional information, refer to Oxford policies: Experimental/Investigational Treatment and Experimental/Investigational Treatment for NJ Plans.<br><br>**Note for CT Products Only**: While an expedited appeal is being reviewed as a result of a denial of a concurrent review urgent care request, the treatment shall be continued without Member liability until the Member has |

# Administrative Policy Updates

| REVISED | | | |
|---|---|---|---|
| **Policy Title** | **Effective Date** | **Summary of Changes** | **Administrative Guidelines** |
| Expedited Appeal Process *(continued)* | Nov. 1, 2014 | | been notified of the appeal decision.<br><br>**Notification and Determination Process**<br><br>When Oxford receives a request for an expedited appeal, Oxford will contact the Member within **24 hours** of receipt of the expedited request as to whether the appeal:<br>• **Has met** the criteria and will be processed as expedited; **or**<br>• **Has not met** the criteria for expedited and will be processed as a standard appeal/grievance.<br><br>Oxford will:<br>A. Conduct a review of the appeal that does not give regard to the denial decision. The Member will be given an opportunity to submit written comments, documents, medical records, photos, peer review or other information relevant to the Member's appeal.<br>B. Perform a full investigation of the substance of the appeal including any aspects of clinical care and then will issue a written and verbal determination. Full documentation of the substance of the appeal and the actions taken will be maintained in an appeal file.<br><br>Upon request, Members may access and obtain copies of all documents relevant to the Member's appeal. For additional information, refer to Disclosure Policy.<br><br>**Expedited Grievance/Appeal for Benefit Administrative Issues**<br><br>Oxford will, upon notification, render a decision that will include written notification to the Member, within:<br>• **48 hours** from receipt of all necessary information; **or**<br>• **72 hours** from receipt of the Grievance, whichever is shorter.<br><br>Grievances for determinations of services that have already been provided cannot be appealed on an expedited basis.<br><br>**Expedited Appeal for Utilization Review Issues**<br><br>The appeal may be made in writing, facsimile, or by telephone. Upon receipt of the Appeal, Oxford will:<br>A. Provide reasonable access to our clinical reviewer within one business |

# Administrative Policy Updates

**REVISED**

| Policy Title | Effective Date | Summary of Changes | Administrative Guidelines |
|---|---|---|---|
| Expedited Appeal Process *(continued)* | Nov. 1, 2014 | | day.<br>B. Provide access to our facsimile machines or other services as needed.<br>C. Appoint an individual to review the appeal who is a practitioner in the same or similar specialty who typically treats the medical condition, performs the procedure or provides the treatment, this will be an individual who was not involved in the original determination and who does not report to the individual that made the initial determination.<br><br>**Note:** Oxford administers benefit coverage for substance abuse and mental health disorders in coordination with OptumHealth Behavioral Solutions. For additional information regarding the Expedited Appeals Process for substance abuse and mental health disorders please refer to https://www.providerexpress.com/.<br><br>Oxford will render a decision to either uphold or reverse the Adverse Determination. The decision will include written notification to the Member; within **2 business days** from receipt of all necessary information or **72 hours** from receipt of the appeal, whichever is shorter. Retrospective Final Adverse Determinations cannot be appealed on an expedited basis.<br>**Note:** For NY plans and products, written notification will be sent to the Member or the Member's Designee and the Provider. Written notification to the member's health care provider shall be transmitted electronically, to the extent practicable, in a manner and form agreed to by the parties.<br><br>Oxford shall provide continued coverage of an ongoing course of treatment pending the outcome of the Stage 1 and Stage 2 internal appeals.<br><br>**Expedited Appeal for Utilization Review Issues – Line of Business Specific Information**<br><br>**Product:** **CT Products Only**<br>**Product Specific Information:**<br>i. Oxford will communicate all necessary information, including our decision, to the Member, or the Member's authorized representative, by telephone, facsimile, electronic means or any other expeditious method available.<br>ii. Connecticut Public Act 13-3, requires that "named" Behavioral Health services are automatically deemed urgent care requests with a 24 hour turnaround time (no |

# Administrative Policy Updates

**REVISED**

| Policy Title | Effective Date | Summary of Changes | Administrative Guidelines | |
|---|---|---|---|---|
| Expedited Appeal Process *(continued)* | Nov. 1, 2014 | | | physician certification required). This requirement applies to all pre-authorization and concurrent determinations, appeals and external review determinations.<br>Specifically, the following services related to a substance abuse disorder, co-occurring mental health disorder or mental health disorder are impacted by the Public Act and its 24 hour turnaround time:<br>○ Inpatient Services<br>○ Partial Hospitalization<br>○ Residential Treatment<br>○ Intensive Outpatient Services necessary to keep a covered person from requiring an inpatient admission. |
| | | | **Rhode Island Members and Providers Only** | i. An expedited review is provided at both the first and second level of internal appeals.<br>ii. Oxford will render a decision to either uphold or reverse the Adverse Determination.<br>iii. The decision will include written notification to the Member and Provider within **2 business days** from receipt of all necessary information or from receipt of the appeal, whichever is shorter. |
| | | | **NY Products Only** | i. Expedited appeals which do not result in a resolution satisfactory to the claimant may be appealed further through the standard appeal process or through the external appeal process.<br>ii. The 60 day timeframe for provider, or four month timeframe for Member or Designee, requesting an external appeal begins upon the receipt of the final adverse determination of the Expedited Appeal, regardless of whether or not a standard appeal is requested, by choosing to request a standard appeal, the time may expire for the claimant to request an external appeal. Refer to policy: Utilization Management Appeal Process and Timeframes for New York Plans. |
| | | | **Self-Funded Products** | i. The appeal may be made in writing or by telephone.<br>ii. Upon receipt of the Appeal, Oxford will provide reasonable access to our clinical peer reviewer.<br>iii. Oxford will |

# Administrative Policy Updates

**REVISED**

| Policy Title | Effective Date | Summary of Changes | Administrative Guidelines |
|---|---|---|---|
| Expedited Appeal Process *(continued)* | Nov. 1, 2014 | | ○ Provide access to our facsimile machines or other services as needed.<br>○ Render a decision to either uphold or reverse the Adverse Determination. The decision will include written notification to the Member; within **2 business days** from receipt of all necessary information or **72 hours** from receipt of the appeal, whichever is shorter.<br>○ Review the request and then contact the plans benefit administrator with the information necessary for the plan to make the final determination.<br>○ Send out the final determination letter to the Member, informing the Member of the plan's final determination on appeal.<br>**Note:** Retrospective Final Adverse Determinations cannot be appealed on an expedited basis.<br><br>**External Appeal Review – Applies to for CT Products Only**<br><br>Members of Connecticut lines of business also have the option to request review by an independent review organization in emergency or life-threatening circumstances. Members must first exhaust Oxford's internal appeal mechanism unless it is determined that the time frame for completion of an expedited internal appeal would:<br><br>A. Seriously jeopardize the life or health of the covered person or would jeopardize the covered person's ability to regain maximum function or<br>B. The denial of coverage is based on a determination that the recommended or requested health care service or treatment is experimental or investigational and the covered person's treating health care professional certifies in writing that such recommended or requested health care service or treatment would be significantly less effective if not promptly initiated.<br><br>**Note:** In an emergency or life threatening situation described in "a" above, the member, or the member's provider acting on the member's behalf with the member's consent, would not need to exhaust all internal appeals in this situation in order to file for an external appeal. |

# Administrative Policy Updates

| REVISED | | | |
|---|---|---|---|
| **Policy Title** | **Effective Date** | **Summary of Changes** | **Administrative Guidelines** |
| Expedited Appeal Process *(continued)* | Nov. 1, 2014 | | The expedited appeal application must be filed with the Connecticut Insurance Department immediately following receipt of Oxford's initial adverse determination or at any level of adverse appeal determination.<br><br>If Oxford failed to adhere to timeframe requirements on any level (Initial review or appeal), the member is deemed to have exhausted Oxford's internal grievance process and may file an external review, regardless of whether Oxford asserts substantial compliance or deminimis error. Additionally, Oxford has discretion to waive its internal grievance process and the requirement for a covered person to exhaust such process prior to filing a request for an external appeal or expedited external appeal.<br><br>If the expedited appeal is not accepted on an expedited basis, and the member has not previously exhausted Oxford's internal appeal, the member may resume the internal appeal process and then may file for a standard external appeal within 120 days following receipt of the final denial letter.<br><br>If the internal appeals process was previously exhausted, the member's rejected expedited appeal will automatically be eligible for consideration for standard external appeal. The member is not required to submit a new application.<br><br>If a member chooses to file an expedited external appeal, the member must submit the appeal on the "Expedited Request Form" and "Request for External Appeal" application form available on the State of Connecticut Department of Insurance website. Members may also request a copy of the forms by calling Customer Care at the toll-free number listed on the member ID card.<br><br>Within one calendar day after receiving a copy of an expedited external review request from the State of Connecticut Insurance Commissioner, Oxford must complete a preliminary review to determine whether the:<br><br>1. Member was a covered person under the health benefit plan at the time the health care service was requested or provided;<br>2. Involved health care service is a covered service under the Member's health benefit plan except for Oxford's determination that it does not meet its requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness; |

# Administrative Policy Updates

| REVISED | | | |
|---|---|---|---|
| **Policy Title** | **Effective Date** | **Summary of Changes** | **Administrative Guidelines** |
| Expedited Appeal Process *(continued)* | Nov. 1, 2014 | | 3. Member has provided all the information and forms required to process an expedited external review. If the service or treatment is experimental or investigational, Oxford must also determine whether the:<br>○ Requested health care treatment that is the subject of the determination (a) is a covered benefit under the Member's health benefit plan except for Oxford's determination that the service or treatment is experimental or investigational and (b) is not explicitly excluded under the Member's health benefit plan;<br>○ Member's treating health care professional has certified that (a) standard health care treatments have not been effective in improving the Member's medical condition, (b) standard health care treatments are not medically appropriate for the person, or (c) there is no available standard health care treatment covered by Oxford that is more beneficial than the requested health care treatment; and<br>○ Member's treating health care professional (a) has recommended a health care treatment that he or she certifies, in writing, is likely to be more beneficial to the Member than any available standard health care treatments or (b) is a licensed, board certified, or board eligible health care professional qualified to practice in the area of medicine appropriate to treat the member's condition and has certified, in writing, that scientifically valid studies using accepted protocols demonstrate that the health care treatment the covered person requested is likely to be more beneficial than any available standard health care treatments.<br><br>Oxford must notify the Commissioner and the Member in writing on whether the request is complete and eligible for external review on the day the preliminary report is completed for an expedited external review request. The Commissioner may specify the form for Oxford's initial determination notice.<br><br>If the request is not:<br>• **Complete,** Oxford's notice must specify the information needed to perfect the request.<br>• **Eligible for expedited external review**, the notice must include the reasons for its ineligibility. The notice must include a statement informing the Member that he or she can appeal this determination to the Commissioner. Regardless of Oxford's initial determination that a request for an expedited external review is ineligible for review, the |

# Administrative Policy Updates

| REVISED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Administrative Guidelines** |
| Expedited Appeal Process *(continued)* | Nov. 1, 2014 | | Commissioner may determine, pursuant to the terms of the Member's health benefit plan, that the request is eligible and assign an independent review organization to conduct it.<br><br>Oxford shall provide continued coverage of an ongoing course of treatment pending the outcome of the External appeal.<br><br>Within one calendar day of receiving notice that an expedited external review request is eligible for review, the State of Connecticut Insurance Commissioner must:<br>1. Assign an independent review organization to conduct the review (randomly from among qualified organizations),<br>2. Notify Oxford of the organization's name, and<br>3. Notify the member in writing of the eligibility and acceptance for review. The written notice must include:<br>a) Q statement that the Member may submit, within five business days after receiving the notice, additional information in writing to the organization for consideration and<br>b) Where and how such additional information must be submitted. If additional information is submitted later than five business days after the Member received the notice, the organization may, but is not be required to, accept and consider it.<br><br>Within one calendar day after receiving the name of the assigned independent review organization, Oxford must provide the organization any information it considered in making the determination under review. If Oxford fails to timely provide the information, the organization:<br>1. Must not delay performing the review; and<br>2. May terminate the review and make a decision to reverse the determination.<br><br>**Note:** Within one business day after terminating the review and deciding to reverse the determination, the organization must notify the commissioner, Oxford, and member in writing.<br><br>The organization must review all the information received from the member and Oxford. Upon receiving any new information from the Member, the organization has one business day to forward it to Oxford. If the Member submits new information, Oxford will have the opportunity to review the |

# Administrative Policy Updates

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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Administrative Guidelines** |
| Expedited Appeal Process *(continued)* | Nov. 1, 2014 | | information and reconsider the original decision. This reconsideration will not delay the external review. However, if Oxford decides to reverse its original denial, Oxford has 1 business day to notify the Commissioner, independent review organization and the Member of the reversal. At this point, the external review will be terminated.<br><br>**External Review Decision Timeframe:**<br>The external review agent will render a decision for expedited external reviews in 72 hours. For expedited external reviews involving an experimental or investigational treatment or service, as expeditiously as the Member's medical condition requires, but not later than five calendar days, and expedited behavioral health services in 24 hours. |
| Laboratory Services Protocol | Nov. 1, 2014 | • Changed policy title; previously titled *National Laboratory Services Protocol, Lab Corporation of America Referring Provider Protocol*<br>• Added reference link to policy titled *In-Office Laboratory Testing and Procedures List*<br>• Updated applicable lines of business/products; removed language indicating "this policy applies to UnitedHealthcare and its affiliates; this policy does not apply to non-participating physicians or to benefit plans where laboratory services are the financial risk of the physician or medical group"<br>• Updated policy purpose language to indicate "the purpose of this policy is to communicate the Oxford Laboratory Services Protocol"<br>• Removed definition of:<br>  ○ Administrative action<br>  ○ Appeals committee | Participating physicians and health care professionals are required to refer laboratory services to a participating laboratory provider in our network, except as otherwise authorized by us or a Payer.<br><br>This policy applies to:<br>• All participating physicians and health care professionals;<br>• All laboratory services, clinical and anatomic, ordered by physicians and health care professionals.<br><br>This policy does not apply to:<br>• Non-participating physicians;<br>• benefit plans where laboratory services are the financial risk of the physician or medical group; or<br>• Laboratory services provided by physicians in their offices.<br><br>Oxford maintains a robust network of regional and local providers of laboratory services. These participating laboratories provide a comprehensive range of laboratory services on a timely basis to meet the needs of the physicians participating in the Oxford network. Participating laboratories also provide clinical data and related information to support HEDIS reporting, care management, the UnitedHealth Premium Designation program and other clinical quality improvement activities. It is important to note that in many benefit plans, Customers receiving services in out-of-network laboratories may incur increased financial liability and therefore higher out-of-pocket expenses. |

# Administrative Policy Updates

**REVISED**

| Policy Title | Effective Date | Summary of Changes | Administrative Guidelines |
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| Laboratory Services Protocol *(continued)* | Nov. 1, 2014 | ○ Regional administrative management committee (RAMC)<br>• Revised policy language to indicate:<br>○ Participating physicians and health care professionals are required to refer laboratory services to a participating laboratory provider in our network, except as otherwise authorized by us or a payer<br>○ This policy applies to:<br>▪ All participating physicians and health care professionals<br>▪ All laboratory services, clinical and anatomic, ordered by physicians and health care professionals<br>○ This policy does not apply to:<br>▪ Non-participating physicians<br>▪ Benefit plans where laboratory services are the financial risk of the physician or medical group or<br>▪ Laboratory services provided by physicians in their offices<br>○ If assistance is required to locate a participating laboratory provider, contact Network Management<br>• Revised procedures and responsibilities language to | Participating physicians and health care professionals are required to refer laboratory services to a participating laboratory provider in our network, except as otherwise authorized by us or a Payer.<br><br>In the unusual circumstance that you require a specific laboratory test for which you believe no participating laboratory is available, please contact Oxford in advance to confirm that the specific laboratory test is covered.<br><br>If Oxford identifies an ongoing and material practice of referrals to out-of-network laboratory service providers, Oxford will inform the responsible participating physicians of the issue and remind them that physicians in the Oxford network are required by contract to refer their patients to other network providers. While it is our expectation that these actions will rarely be necessary, please note that continued referrals to non-participating laboratories may, after appropriate notice, subject the referring physician to one or more of the following administrative actions for failure to comply with this protocol:<br>• Loss of eligibility for the Practice Rewards programs;<br>• A decreased fee schedule; or<br>• Termination of network participation, as provided in your agreement with us.<br><br>Referrals for laboratory services that result in a physician earning a profit, including, but not limited to the following, are not allowed:<br>• Profits resulting from an investment in an entity for which the referring physician or health care professional generates business; or<br>• Profits resulting from collection, processing and/or transport of specimens.<br><br>Failure to comply with this protocol may result in:<br>• A decreased fee schedule; or<br>• Termination of network participation, as provided in your agreement with us. |

# Administrative Policy Updates

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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Administrative Guidelines** |
| Laboratory Services Protocol *(continued)* | Nov. 1, 2014 | indicate:<br>○ Oxford maintains a robust network of regional and local providers of laboratory services; these participating laboratories provide a comprehensive range of laboratory services on a timely basis to meet the needs of the physicians participating in the Oxford network and participating laboratories also provide clinical data and related information to support HEDIS reporting, care management, the UnitedHealth Premium Designation program and other clinical quality improvement activities<br>○ It is important to note that in many benefit plans, Customers receiving services in out-of-network laboratories may incur increased financial liability and therefore higher out-of-pocket expenses<br>○ Participating physicians and health care professionals are required to refer laboratory services to a participating laboratory provider in our network, except as otherwise authorized by us or a payer<br>○ In the unusual circumstance that you require a specific laboratory test for which you | |

# Administrative Policy Updates

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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Administrative Guidelines** |
| Laboratory Services Protocol *(continued)* | Nov. 1, 2014 | believe no participating laboratory is available, please contact Oxford in advance to confirm that the specific laboratory test is covered<br>○ If Oxford identifies an ongoing and material practice of referrals to out-of-network laboratory service providers, Oxford will inform the responsible participating physicians of the issue and remind them that physicians in the Oxford network are required by contract to refer their patients to other network providers; while it is our expectation that these actions will rarely be necessary, please note that continued referrals to non-participating laboratories may, after appropriate notice, subject the referring physician to one or more of the following administrative actions for failure to comply with this protocol:<br>▪ Loss of eligibility for the Practice Rewards programs;<br>▪ A decreased fee schedule; or<br>▪ Termination of network participation, as provided in your agreement with us | |

# Administrative Policy Updates

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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Administrative Guidelines** |
| Laboratory Services Protocol *(continued)* | Nov. 1, 2014 | ○ Referrals for laboratory services that result in a physician earning a profit, including, but not limited to the following, are not allowed:<br>▪ Profits resulting from an investment in an entity for which the referring physician or health care professional generates business; or<br>▪ Profits resulting from collection, processing and/or transport of specimens<br>○ Failure to comply with this protocol may result in:<br>▪ A decreased fee schedule; or<br>▪ Termination of network participation, as provided in your agreement with us | |
| Member Administrative Grievance & Appeal (Non UM) Process & Timeframes | Nov. 1, 2014 | • Reorganized definitions by applicable state and product<br>• Revised policy language to indicate this policy represents regulatory standards as well as contractual agreements with Oxford Members, Providers and other health care professionals; Oxford follows these guidelines to comply with the claimants right to appeal administrative determinations<br>• Revised procedures and responsibilities: | This policy represents regulatory standards as well as contractual agreements with Oxford Members, Providers and other health care professionals. Oxford follows these guidelines to comply with the claimant's right to appeal administrative determinations.<br><br>Refer to the policy for complete details on Member Administrative Grievance & Appeal (Non UM) Process & Timeframes. |

# Administrative Policy Updates

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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Administrative Guidelines** |
| Member Administrative Grievance & Appeal (Non UM) Process & Timeframes *(continued)* | Nov. 1, 2014 | ○ Replaced reference to "lines of business" with "products"<br>○ Updated overview language for Connecticut (CT) products to indicate the noted guidelines apply to members undergoing treatment pending the outcome of an appeal or grievance<br>○ Updated guidelines for second level/Grievance Review Board appeal; removed "peer review" documentation from the list of submission opportunities for grievance review | |
| Timeframe Standards for Utilization Management (UM) Initial Decisions | Nov. 1, 2014 | • Reorganized definitions by applicable state and product<br>○ Added definition of "clinical peer" for Connecticut (CT) products<br>• Revised policy language:<br>○ Replaced references to "lines of business" with "products"<br>○ Updated guidelines for *utilization management reviews for CT products only* to indicate, when conducting utilization management reviews, Oxford or its designated utilization review agent must:<br>▪ Collect only information necessary, including pertinent clinical data, to make the utilization review or benefit | Oxford follows all State, Federal and NCQA guidelines regarding timeframes for Utilization Management initial determinations this includes Behavioral Health and Pharmacy initial determinations, and excludes issues of fraud or abuse. Although Oxford's goal is to adhere to the strictest timeframe applicable to all of its lines of business, Oxford will meet the mandated timeframes applicable to the particular request. Failure to adhere to applicable state, federal or regulatory resolution timeframes for any state in which Oxford or its delegate is licensed to perform Utilization Management, may result in a technical reversal of the initial determination.<br><br>Refer to the policy for complete details on Timeframe Standards for Utilization Management (UM) Initial Decisions. |

# Administrative Policy Updates

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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Administrative Guidelines** |
| Timeframe Standards for Utilization Management (UM) Initial Decisions *(continued)* | Nov. 1, 2014 | determination<br>▪ Ensure the review is conducted in a manner that ensures the independence and impartiality of the individual or individuals involved in making the utilization review determination<br>- All adverse utilization review determinations must be evaluated by an appropriate clinical peer (refer to the Definitions section) not involved in the initial or previous adverse determination<br>▪ Make no decisions regarding the hiring, compensation, termination, promotion or other similar matters of such individual or individuals based on the likelihood that such individual or individuals will supports the denial of benefits<br>○ Updated guidelines for *notice of an adverse benefit determination*: removed language indicating contact information will be provided for the "commissioner's office" and "Division of | |

# Administrative Policy Updates

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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Administrative Guidelines** |
| Timeframe Standards for Utilization Management (UM) Initial Decisions *(continued)* | Nov. 1, 2014 | Consumer Affairs within the Insurance Department"<br>○ Updated *strict adherence requirements*; added language to clarify the noted rules apply if Oxford fails to adhere to the requirements for rendering decisions (as outlined in the policy) | |

# Reimbursement Policy Updates

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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Reimbursement Guidelines** |
| Modifier Reference Policy | Nov. 1, 2014 | • Updated policy application language; replaced references to "other health care professionals" with "other *qualified* health care professionals"<br>• Updated reimbursement guidelines; edited descriptions for the following modifiers:<br>○ Modifier 77: Changed description from "repeat procedure or service by another physician or other qualified health care professional" to "repeat procedure or service by another physician or other qualified health care professional "<br>○ Modifier 79: Changed description from "unrelated procedure or service by the same physician during the postoperative period (the physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure)" to "unrelated procedure or service by the same physician or other qualified health care professional during the postoperative period" | Refer to the Modifier Reference Policy for applicable reimbursement guidelines. |
| Modifier SU Policy | Nov. 1, 2014 | • Updated policy application language; replaced references to "other health care professionals" | The Centers for Medicare and Medicaid Services (CMS) indicates that the Health Care Common Procedure Coding System (HCPCS) modifier SU, *Procedure performed in physician's office (to denote use of facility and* |

# Reimbursement Policy Updates

| UPDATED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Reimbursement Guidelines** |
| Modifier SU Policy *(continued)* | Nov. 1, 2014 | with "other *qualified* health care professionals"<br>• Updated reimbursement guidelines; added examples of costs included in the practice expense RVU<br>• Revised definitions; removed definition of "Modifier SU" and "Practice Expense Relative Value Units" | *equipment),* is not payable unless a provider's contract states otherwise. CMS establishes Relative Value Units (RVU) for CPT and HCPCS codes that include the costs of running an office (such as rent, equipment, supplies and non-physician staff costs) which are referred to as the practice expense RVU. In accordance with CMS, Oxford does not allow reimbursement for services appended with modifier SU in an office place of service unless a provider's contract states otherwise, since the use of the office facility and equipment is included in the practice expense RVU, or the costs associated with operating an office.<br><br>If the charges associated with the use of the modifier SU are submitted by a different provider than the physician performing the office procedure, they will not be considered for separate reimbursement since these practice expenses are considered included in the reimbursement for the physician performing the service. |
| New Patient Visit Policy | Oct. 1, 2014 | • Updated list of applicable HCPCS codes to reflect quarterly code edits (effective 10/01/2014); revised description for G0438 | According to the Centers for Medicare and Medicaid Services (CMS), a New Patient is a patient who has not received any professional services from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.<br><br>Therefore, Oxford will reimburse a New Patient Evaluation and Management (E/M) code only when the elements of that definition have been met.<br><br>In the instance where a physician is on-call or covering for another physician and billing under the same Federal Tax Identification number, the patient's encounter with the on-call physician is classified as it would have been classified by the physician who was not available. This patient is not considered a New Patient merely because the visit is covered by an on-call physician from whom the patient has not previously received services.<br><br>For the purposes of this policy, Same Specialty Physician is defined as a Physician and/or Other Qualified Health Care Professional of the same group and same specialty reporting the same Federal Tax Identification number.<br><br>Refer to the policy for the list of applicable CPT and HCPCS codes for new patient visits. |

# Reimbursement Policy Updates

| UPDATED | | | |
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| **Policy Title** | **Effective Date** | **Summary of Changes** | **Reimbursement Guidelines** |
| Reduced Services Policy | Nov. 1, 2014 | • Updated policy application language; replaced references to "other health care professions" with "other *qualified* health care professionals" | There are no industry standards for reimbursement of claims billed with modifier 52 from the Centers for Medicare and Medicaid Services (CMS) or other professional organizations. Oxford's standard for reimbursement of modifier 52 is 50% of the Allowable Amount for the unmodified procedure.<br><br>This modifier is not used to report the elective cancellation of a procedure before anesthesia induction, intravenous (IV) conscious sedation, and/or surgical preparation in the operating suite.<br><br>Modifier 52 should not be used with an evaluation and management (E/M) service. |
| Urgent Care Policy | Nov. 1, 2014 | • Updated policy application language; replaced references to "other health care professions" with "other qualified health care professionals" | The American Medical Association Current Procedural Terminology (CPT®) Professional Edition gives the following instruction for code selection: "Select the name of the procedure or service that accurately identifies the service performed."<br><br>According to Centers for Medicare and Medicaid Services (CMS), Place of Service (POS) Codes Database: "Place of service codes and descriptions should be used on professional claims to specify the entity where service(s) were rendered."<br><br>Consistent with CPT® and CMS, physicians and other healthcare professionals should report the evaluation and management, and/or procedure code(s) that specifically describe the service(s) performed. Additionally a place of service code should be utilized to report where service(s) were rendered.<br><br>Oxford will not reimburse S9088 (Services provided in an urgent care center (list in addition to code for service). S9088 is informational as it pertains to the place of service not the specific service provided. |