

PROVIDER Update



Health Net®

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Medical Policies – 2nd Quarter 2018

This provider update includes a listing of new and updated Health Net of California, Inc., Health Net Community Solutions, Inc. and Health Net Life Insurance Company (Health Net) medical policies, including an updated clinical practice guideline approved by Centene's Corporate Clinical Policy Committee and/or Health Net's Medical Advisory Council (MAC) in the second quarter of 2018. For a complete description of the updated medical policies, visit the Health Net provider website at provider.healthnet.com and select *Working with Health Net > Clinical > Medical Policies*.

As Health Net integrates with Centene, Health Net medical policies are in the process of being replaced with Centene clinical policies, which are accessible via the website noted above.

PURPOSE OF HEALTH NET MEDICAL POLICIES

Medical policies provide guidelines for determining medical necessity for specific procedures, equipment and services. For Medicare Advantage plans, apply the Medicare national and local policies for primary coverage guidance. For Medi-Cal plans, apply the appropriate coverage guidelines. All services must be medically necessary to be eligible for benefit coverage, unless otherwise defined in the member's individual benefits contract. The *Evidence of Coverage (EOC)* or *Certificate of Insurance (COI)* is the portion of the benefits contract that delineates the member's benefits in addition to eligibility requirements, and coverage exclusions and limitations. In some cases, legal or regulatory mandates may be applicable and may prevail over medical policy. To the extent there are any conflicts between medical policy guidelines and applicable benefits contract language, the benefits contract language prevails. Medical policy is not intended to override the member benefits contract that defines the member's benefits, nor is it intended to provide medical advice or dictate to providers how to practice. If required, prior authorization must be obtained before services are rendered.

New Policies

Medical Policy	Policy Statement
IMPLANTABLE WIRELESS PAP MONITORING	Implantable wireless pulmonary artery pressure (PAP) monitoring (for example, CardioMEMS™) is considered not medically necessary for all indications, including management of heart failure
PEDIATRIC LIVER TRANSPLANT	Clinical indications and contraindications are included

THIS UPDATE APPLIES TO CALIFORNIA PROVIDERS:

- Physicians
- Participating Physician Groups
- Hospitals
- Ancillary Providers

LINES OF BUSINESS:

- HMO/POS/HSP
- PPO
- EPO
- Medicare Advantage (HMO)
- Medi-Cal
 - Kern
 - Los Angeles
 - Molina
 - Riverside
 - Sacramento
 - San Bernardino
 - San Diego
 - San Joaquin
 - Stanislaus
 - Tulare

PROVIDER SERVICES

provider_services@healthnet.com

EnhancedCare PPO (IFP)

1-844-463-8188

provider.healthnetcalifornia.com

EnhancedCare PPO (SBG)

1-844-463-8188

provider.healthnet.com

Health Net Employer Group HMO, POS, HSP, PPO, & EPO

1-800-641-7761

provider.healthnet.com

IFP – CommunityCare HMO, PPO, PureCare HSP, PureCare One EPO

1-888-926-2164

provider.healthnetcalifornia.com

Medicare (individual)

1-800-929-9224

provider.healthnetcalifornia.com

Medicare (employer group)

1-800-929-9224

provider.healthnet.com

Medi-Cal – 1-800-675-6110

provider.healthnet.com

PROVIDER COMMUNICATIONS

provider.communications@healthnet.com

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fax 1-800-937-6086

Updated Policies

Medical Policy	Change
ADHD ASSESSMENT AND TREATMENT	Added evaluation of iron status (for example, measurement of serum iron and ferritin levels) as not medically necessary. Codes reviewed and updated
APPLIED BEHAVIORAL ANALYSIS	Specified which Diagnostic and Statistical Manual of Mental Disorders (DSM)-IV and DSM-5 diagnoses apply, and broke these into separate criteria points. Added pediatric psychiatrist, neurologist or developmental pediatrician as clinicians that can validate the autism spectrum disorder (ASD) diagnosis
ARTICULAR CARTILAGE DEFECT REPAIRS	Osteochondral implants: added requirement for absent or minimal changes in surrounding articular cartilage
ASSISTED REPRODUCTIVE TECHNOLOGY	Numerous changes to several sections that are listed in the policy under Reviews, Revisions and Approvals. Reworded criteria for clarity in intrauterine insemination (IUI) conversion to in vitro fertilization (IVF) section, and combined with IVF criteria. Corrected definition of severe male factor infertility in IVF section to say sperm concentration <10 million/mL instead of TMS <10 million. Clarified in donor sperm section which indications apply to the male partner. Removed redundant statement in donor egg cycle that the female has an approved ART cycle
BALLOON SINUS OSTIAL DILATION	Clarified in >18 chronic rhinosinusitis (CRS) section that computed tomography (CT) findings of opacification should be in the sinuses, and removed statement that CT findings should be radiographic
CARDIAC BIOMARKER TESTING	Deleted Table 2, diagnosis code list. Clarified in criteria point II that creatine kinase myocardial isoenzyme CK-MB and myoglobin are not medically necessary when billed with CPT code 84484 for troponin
CELL-FREE FETAL DNA TESTING	Added III. Cell-free fetal DNA testing for additional chromosomal abnormalities other than trisomy 21, 18 or 13 are considered not medically necessary, including, but not limited to, other trisomies, aneuploidies or microdeletions. Background information updated
DISC DECOMPRESSION PROCEDURES	Revised I.C.1.a. from a score of <2 on the Medical Research Council 0 to 5 muscle strength scale to a score of <3 per 2017 IQ criteria. Codes updated
GENETIC TESTING	References reviewed and updated. Added I.D: member has not previously undergone genetic testing for the disorder. Added statement that direct-to-consumer genetic testing is not medically necessary
HER2 NEU	Revised policy to include link to recent American Society of Clinical Oncology (ASCO) recommendations for the human epidermal growth factor receptor 2 (HER2) testing algorithm for breast cancer, updated to address the recommended workup for less common clinical scenarios (approximately 5% of cases) observed when using a dual-probe in situ hybridization (ISH) assay
HOSPICE	Removed requirement of documentation that member must no longer be seeking curative treatment, with the possible exception of Children's Health Insurance Program (CHIP). Intensity of Service (Initial): removed redundant language regarding requirement for authorization of each request. Added section for subsequent requests
HYPEREMESIS GRAVIDARUM TREATMENT	Removed step therapy approach in I.C because it is redundant. Removed information about symptoms, food intake, urinary ketones, urine specific gravity, and daily weights

Updated Policies, continued

Medical Policy	Change
INJECTIONS FOR PAIN MANAGEMENT	Removed criteria addressing selective nerve root block (SNRB) from section I. Renamed section I, Cervical/Thoracic/Lumbar/Caudal, Interlaminar ESI. Added section II, Selective Nerve Root Blocks/Transforaminal Epidural Steroid Injections (TFESI) that includes criteria for SNRB/TFESI. C. Added medically necessary criteria to section III, Transforaminal Epidural Steroid Injections, regarding initial injections
NICU APNEA BRADYCARDIA DISCHARGE GUIDELINES	Revised statement in section I, clarifying possibly longer to up to 7 days. Changed <28 weeks gestation to <32 weeks gestation. References reviewed and updated. Replaced in background, "A target level of 10-20ug/ml is sought" with "The therapeutic trough serum concentration is 5 to 25 mg/L" as per UpToDate. Clarified statement under II. Caffeine, that discontinuation of caffeine often occurs before discharge
PANNICULECTOMY	Changed wording in I.D for clarification that weight should be stable after bariatric surgery
PEDIATRIC HEART TRANSPLANT	Specified for each indication the stage of heart failure required, and removed general criteria stating that patient is in stage C or D heart failure. Removed severely limited functional status with poor rehab potential
PERCUTANEOUS LEFT ATRIAL APPENDAGE (WATCHMAN)	Percutaneous Left Atrial Appendage Closure Device (LAAC) for Stroke Prevention: Clarified in I.A and I.B that the anticoagulation therapy recommended is for long-term use. Updated background information to include possible complication associated with the device.
VENTRICULAR ASSIST DEVICES	Clarified in section I.B.3.a. that the phrase "failure to respond to" only applied to optimal medical management, and not balloon or inotrope dependence. Specified that balloon pump and inotrope requirements are ≥, and not exact. Changed cardiac transplantation to heart transplant for consistency
ZIKA VIRUS TESTING	Simplified definition of possible Zika exposure. Numerous changes that are noted in the policy under Reviews, Revisions and Approvals

Clinical Practice Guideline

Guideline	New Guideline Links
GUIDELINES FOR TREATMENT OF LOW BACK PAIN	Links to treatment recommendations are at provider.healthnet.com under <i>Working with Health Net > Clinical > Clinical Practice Guidelines</i> and select <i>American Association of Family Physicians: Low Back Pain</i> or <i>Annals of Internal Medicine: Diagnosis and Treatment of Low Back Pain</i>

ADDITIONAL INFORMATION

If you have questions regarding the information contained in this update, contact the applicable Health Net Provider Services Center within 60 days, by telephone or through the Health Net provider website as listed in the right-hand column on page 1.