HIGHMARK Delaware
HEALTH OPTIONS

April 15, 2018

PROVIDER UPDATE

An Update for Highmark Health Options Providers and Clinicians

Updated Policy Notices for 5/15/18 Effective Date

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Fecal Transplant

CLINICAL MEDICAL POLICY	
Policy Name:	Fecal Microbiota Transplant
Policy Number:	MP-066-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018
Issue Date:	05/15/2018
Original Effective Date:	05/15/2018
Annual Approval Date:	03/13/2019
Revision Date:	N/A
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Highmark Health Options may provide coverage under the medical-surgical benefits of the Company's Medicaid products for medically necessary fecal microbiota transplants in patients with recurrent Clostridium difficile infections.

*The full version of this medical policy is available on the Highmark Health Options provider website at:

https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

Electrical Bone Growth Stimulation – Spinal

CLINICAL MEDICAL POLICY	
Policy Name:	Electrical Bone Growth Stimulation-Spinal
Policy Number:	MP-067-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018
Issue Date:	05/15/2018
Effective Date:	05/15/2018
Annual Approval Date:	03/13/2018
Revision Date:	N/A
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Highmark Health Options may provide coverage under the medical-surgical and DME benefits of the Company's Medicaid products for medically necessary invasive and non-invasive electrical bone growth stimulators as an adjunct to lumbar spinal fusion procedures.

*The full version of this medical policy is available on the Highmark Health Options provider website at:

https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

Genetic Testing Panels

CLINICAL MEDICAL POLICY	
Policy Name:	Genetic Testing Panels
Policy Number:	MP-071-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018
Issue Date:	05/15/2018
Original Effective Date:	05/15/2018
Annual Approval Date:	03/13/2019
Revision Date:	N/A
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Highmark Health Options may provide coverage under the medical-surgical benefits of the Company's Medicaid products for medically necessary genetic testing panels.

*The full version of this medical policy is available on the Highmark Health Options provider website at:

https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

Transcranial Magnetic Stimulators

CLINICAL MEDICAL POLICY	
Policy Name:	Repetitive Transcranial Magnetic Stimulation (rTMS)
Policy Number:	MP-089-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018
Issue Date:	05/15/2018
Effective Date:	05/15/2018
Annual Approval Date:	03/13/2019
Revision Date:	N/A
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Highmark Health Options may provide coverage under the behavioral health benefits of the Company's Medicaid products for medically necessary repetitive transcranial magnetic stimulation.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

*The full version of this medical policy is available on the Highmark Health Options provider website at:

https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

DISCLAIMER

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Bariatric Surgery

CLINICAL MEDICAL POLICY	
Policy Name:	Bariatric Surgery
Policy Number:	MP-004-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018; 05/07/2016
Issue Date:	05/15/2018
Effective Date:	05/15/2018; 06/07/2016
Annual Approval Date:	03/19/2019
Revision Date:	11/29/2017; 08/09/2017, 03/14/2017
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
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REVISED POLICY SUMMARY

Highmark Health Options provides coverage under the medical-surgical benefits of the Company's Medicaid products for medically necessary bariatric surgical procedures for patients who are 18 years of age or older and diagnosed with persistent morbid obesity for at least two years (24 months).

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records. Bariatric surgery in children and adolescents may be covered under the Pennsylvania Medicaid fee schedule, if medically necessary. Requests are considered on a case-by-case basis.

The following changes have been applied to this policy:

- Added a definitions;
- Criteria updates, including: Preoperative diet requirements and comorbidities, Moved surgeries from eligible section to non-covered surgeries;
- Added a contraindication;
- 2018 Coding updates
- Added supporting literature to Summary of Literature;
- Added references

*The full version of this medical policy is available on the Highmark Health Options provider website at:
https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

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Oncotype DX)

CLINICAL MEDICAL POLICY	
Policy Name:	Gene Expression Profiling in Tumor Tissue (Oncotype DX)
Policy Number:	MP-005-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018; 11/01/2016
Issue Date:	05/15/2018
Effective Date:	05/15/2018; 12/01/2016
Annual Approval Date:	03/13/2019
Revision Date:	12/14/2019; 08/09/2017; 03/14/2017
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
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POLICY SUMMARY

Highmark Health Options provides coverage as a laboratory service under its medical benefits for medically necessary Gene Expression Profiling diagnostic testing for breast.

The following changes have been applied to this policy:

- Added a definition;
- Added non-coverage indications to #2; reformatted procedure section and summary of literature;
- Updated and revised summary of literature to meet current societal recommendations;
- Added references

*The full version of this medical policy is available on the Highmark Health Options provider website at:

https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

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Genetic Testing for Cystic Fibrosis

CLINICAL MEDICAL POLICY	
Policy Name:	Genetic Testing for Cystic Fibrosis
Policy Number:	MP-006-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018; 11/01/2016
Issue Date:	05/15/2018
Effective Date:	05/15/2018; 12/01/2016
Annual Approval Date:	03/13/2019
Revision Date:	03/14/2017
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Highmark Health Options provides coverage under its laboratory benefits for medically necessary genetic testing for cystic fibrosis utilizing appropriate mutation panels.

The following changes have been applied to this policy:

- Removed diagnosis code E84.1 from diagnosis code table.
- Deleted ICD-10 Diagnosis Code Z36
- Added ICD-10 code Z84.81
- Added coverage statement regarding infants under the Procedures-diagnostic section.
- New information on testing strategies added to literature.
- Added detailed genetic counseling requirements.

*The full version of this medical policy is available on the West Virginia Family Health provider website at:

http://www.wvfh.com/providers/bulletins-policies

DISCLAIMER

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Hyperbaric Oxygen Therapy

CLINICAL MEDICAL POLICY	
Policy Name:	Hyperbaric Oxygen Therapy (HBOT)
Policy Number:	MP-007-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018; 11/01/2016
Issue Date:	05/15/2018
Effective Date:	05/15/2018; 12/01/2016
Annual Approval Date:	03/13/2019
Revision Date:	10/21/2017; 08/09/2017; 03/14/2017
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Highmark Health Options may provide coverage under the medical-surgical benefits of the Company's Medicaid products for medically necessary hyperbaric oxygen therapy (HBOT) services for specific medical conditions.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

*The full version of this medical policy is available on the Highmark Health Options provider website at:

https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

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BRCA 1 & BRCA 2

CLINICAL MEDICAL POLICY	
Policy Name:	BRCA1 and BRCA2 Genetic Mutation Testing and Related Genetic Counseling
Policy Number:	MP-011-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018; 11/01/2016
Issue Date:	05/15/2018
Effective Date:	05/15/2016; 12/01/2016
Annual Approval Date:	03/13/2019
Revision Date:	12/06/2017; 08/09/2017; 03/14/2017
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
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POLICY SUMMARY

Highmark Health Options may provide coverage under the laboratory section of its medical benefits for medically necessary BRCA testing.

The following changes have been applied to this policy:

- Revised first-degree relative to include half-sibling
- Added letter C to address repeat testing under procedures section

*The full version of this medical policy is available on the Highmark Health Options provider website at:

https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

Chromosomal Microarray

CLINICAL MEDICAL POLICY	
Policy Name:	Chromosomal Microarray Analysis: Comparative Genomic Hybridization (CGH) and Single Nucleotide Polymorphism (SNP)
Policy Number:	MP-012-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018; 11/01/2016
Issue Date:	05/15/2018; 12/01/2016
Effective Date:	05/15/2018; 12/01/2016
Annual Approval Date:	03/13/2019
Revision Date:	12/11/2017; 08/09/2017; 03/14/2017
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
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POLICY SUMMARY

Highmark Health Options may provide coverage under the medical benefits of the Company's Medicaid products for medically necessary chromosomal microarray analysis which includes Comparative Genomic Hybridization (CGH) and Single Nucleotide Polymorphism (SNP) laboratory procedures.

The following changes have been applied to this policy:

- Added Autism Spectrum to medically necessary criteria under procedure (section 1);
- Added HCPCS code S3870 to Procedure code table;
- Deleted stillborn ICD-10 codes

*The full version of this medical policy is available on the Highmark Health Options provider website at:

https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

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Negative Pressure Wound Therapy

CLINICAL MEDICAL POLICY	
Policy Name:	Negative Pressure Wound Therapy in the Outpatient Setting
Policy Number:	MP-022-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018; 11/01/2016
Issue Date:	05/15/2018; 12/01/2016
Effective Date:	05/15/2018; 12/01/2016
Annual Approval Date:	03/13/2019
Revision Date:	12/20/2017; 08/09/2017; 03/14/2017
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

REVISED POLICY SUMMARY

Highmark Health Options may provide coverage under the Durable Medical Equipment (DME) benefit of the Company's Medicaid products for medically necessary electrically powered negative pressure, vacuum assisted wound closure therapy.

The following changes have been applied to this policy:

- In Section 1 C, number 1: The >90 day requirement for chronic stage III and IV pressure ulcers has been changed to >30 days.
- Removed incorrect criterion from Section 3;
- Updated literature;
- Revised covered procedure codes-removed A9272 and added A6550, A7000, A7001 and E2402;
- Updated reference sources

*The full version of this medical policy is available on the Highmark Health Options provider website at:
https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

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Passive Oscillatory Devices

CLINICAL MEDICAL POLICY	
Policy Name:	Passive Oscillatory Devices in the Outpatient Setting
Policy Number:	MP-029-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018; 11/01/2016
Issue Date:	05/15/2018
Effective Date:	05/15/2018; 12/01/2016
Annual Approval Date:	03/13/2019
Revision Date:	12/06/2017; 08/09/2017; 03/14/2017
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Highmark Health Options may provide coverage under the Durable Medical Equipment (DME) benefit of the Company's Medicaid products for medically necessary passive oscillatory/high-frequency chest wall oscillation devices.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

*The full version of this medical policy is available on the Highmark Health Options provider website at:

https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

DISCLAIMER

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Skin Replacement Therapy

CLINICAL MEDICAL POLICY	
Policy Name:	Skin Replacement Therapy for Chronic Non-healing Wounds in the Outpatient Setting
Policy Number:	MP-032-MD-DE
Approved By:	Medical Management
Provider Notice Date:	04/15/2018; 04/01/2017
Issue Date:	05/15/2018
Original Effective Date:	05/15/2018; 05/01/2017
Annual Approval Date:	03/13/2019
Revision Date:	N/A
Products:	Highmark Health Options Medicaid Products
Application:	All participating hospitals and providers
Page Number(s):	1

REVISED POLICY SUMMARY

Highmark Health Options may provide coverage under the medical-surgical benefits of the Company's Medicaid products for medically necessary skin replacement products when used in the treatment of chronic, non-healing wounds.

The following changes have been applied to this policy:

- Added ABI to Definition section;
- Added The diabetic foot ulcer is free of infection;
- Wound must have adequate circulation and presence of acceptable peripheral pulses or as evidenced by ankle-brachial index (ABI) of 0.65 or greater in the limb being treated. Added an index of greater than 0.45 is needed to heal;
- Added MariGen as a non-covered products.

*The full version of this medical policy is available on the Highmark Health Options provider website at:

https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

DISCLAIMER

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Custom Made Oral Appliances

CLINICAL MEDICAL POLICY	
Policy Name:	Custom Made Oral Appliances in the Treatment of Obstructive Sleep Apnea (OSA)
Policy Number:	MP-039-MD-DE
Approved By:	Medical Management
Provider Notice Date:	04/15/2018; 04/01/2017
Issue Date:	05/15/2018
Original Effective Date:	05/15/2018; 05/01/2017
Annual Approval Date:	03/13/2019
Revision Date:	12/20/2017; 08/09/2017
Products:	Highmark Health Options Medicaid products
Application:	All participating hospitals and providers
Page Number(s):	1

REVISED POLICY SUMMARY

Highmark Health Options provides coverage under the Durable Medical Equipment benefits of the Company's Medicaid products for medically necessary oral appliances in the treatment of Obstructive Sleep Apnea (OSA) when specific criteria are met.

The following changes have been applied to this policy:

- Added HCPCS code E0485 to non-covered procedure table
- Added member age to criteria under Procedures section

*The full version of this medical policy is available on the Highmark Health Options provider website at:

https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

DISCLAIMER

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Continuous Glucose Monitoring of Interstitial Fluid

CLINICAL MEDICAL POLICY	
Policy Name:	Long-Term Use Continuous Glucose Monitoring of Interstitial Fluid
Policy Number:	MP-040-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018; 04/15/2017; 10/15/2017
Issue Date:	05/15/2018
Original Effective Date:	05/15/2018; 05/15/2017; 11/15/2017
Annual Approval Date:	03/13/2019
Revision Date:	12/20/2017; 08/09/2017
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

REVISED POLICY SUMMARY

Highmark Health Options may provide coverage under the durable medical equipment (DME) benefits of the Company's Medicaid products for medically necessary long-term use of continuous glucose monitors. The policy's medical necessity coverage has been expanded.

The following changes have been applied to this policy:

- The criteria for medical necessity has been updated for the following:
  - Removal of 30-day requirement in Letter I
  - Deletion of table of FDA-approved CGM devices
- Updated and revised CMS coverage position
- Updated Professional Society table
- Updated Summary of Literature and Reference Sources sections
- Added new CGM HCPCS codes K0553 and K0554
- Added additional ICD-10 codes which include: E10.22-29, E10.3211-13, E10.3291-93, E10.3311-13, E10.3391-93, E10.3411-13, E10.3491-93, E10.3511-13, E10.3521-23, E10.3531-33, E10.354-43, E10.3551-53, E10.3591-93, E10.37X1-X3, E10.41-49, E10.52, E10.59, E10610, and E10.618 & Z79.4.

*The full version of this medical policy is available on the Highmark Health Options provider website at:

https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

DISCLAIMER

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding payment and coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

Bronchial Thermoplasty

CLINICAL MEDICAL POLICY	
Policy Name:	BCR-ABL1 Testing in Chronic Myelogenous Leukemia and Acute Lymphoblastic Leukemia
Policy Number:	MP-017-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018; 11/01/2016
Issue Date:	05/15/2018
Effective Date:	05/15/2018; 12/01/2016
Annual Approval Date:	03/13/2019
Revision Date:	12/12/2017; 08/10/2017; 03/14/2017
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Highmark Health Options may provide coverage under the medical laboratory testing benefits of the Company's Medicaid products for medically necessary Philadelphia chromosome testing.

The following changes have been applied to this policy:

- Added definitions;
- 2018 Procedure code update: added 0016U; deleted 81401 & 81403;
- 2018 Diagnosis code update: Added ICD-10: C92.20, C92.21, C92.22, C92.90, C92.91 & C92.92;
- Updated Reference Sources

*The full version of this medical policy is available on the Highmark Health Options provider website at:

https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

DISCLAIMER

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding payment and coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

Wearable Cardioverter-Defibrillators in the Home Setting

CLINICAL MEDICAL POLICY	
Policy Name:	Wearable Cardioverter-Defibrillators in the Home Setting
Policy Number:	MP-001-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018; 11/01/2016
Issue Date:	05/15/2018
Effective Date:	05/15/2018; 12/01/2016
Annual Approval Date:	03/13/2019
Revision Date:	01/26/2018; 08/09/2017; 02/15/2017
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

REVISED POLICY SUMMARY

Highmark Health Options may provide coverage as a Durable Medical Equipment (DME) benefit of the Company's Medicaid products for a medically necessary wearable cardioverter-defibrillator (WCD) as a treatment in the home setting. A prescription for the device must be from a professional provider that will provide usage instructions, and the device must be from a DME provider. A wearable cardioverter-defibrillator (K0606) is a temporary external device that is an alternative to an implantable cardioverter-defibrillator (ICD). It is primarily intended for temporary conditions for which an implantable device is contraindicated or for a period of time during which the need for a permanent implantable device is uncertain.

*The full version of this medical policy is available on the Highmark Health Options provider website at:

https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

DISCLAIMER

Noninvasive Positive Pressure Ventilation in Home

CLINICAL MEDICAL POLICY	
Policy Name:	Noninvasive Positive Pressure Intermittent Ventilation in the Home Setting
Policy Number:	MP-002-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018; 11/01/2016
Issue Date:	05/15/2018
Effective Date:	05/15/2018; 12/01/2016
Annual Approval Date:	03/13/2019
Revision Date:	01/22/2019; 08/09/2017; 03/14/2017
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Highmark Health Options provides coverage as a durable medical equipment (DME) benefit of the Company's Medicaid products under its medical benefits for medically necessary intermittent noninvasive positive pressure ventilation (NPPV) devices in the home setting.

This medical policy has been designed to address the medical necessity requirements for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical situation warrants individual consideration, based on review of appropriate medical records. This medical policy does not address the use of NPPV in the treatment of acutely ill or hospitalized patients.

The following changes have been applied to this policy:

- 2018 Coding Revisions: New Diagnosis code R06.03 has been added.

*The full version of this medical policy is available on the Highmark Health Options provider website at:
https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

DISCLAIMER

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Whole Exome and Whole Genome

CLINICAL MEDICAL POLICY	
Policy Name:	Whole Exome and Whole Genome Sequencing for Diagnosis of Genetic Disorders
Policy Number:	MP-013-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018; 11/01/2016
Issue Date:	05/15/2018
Effective Date:	05/15/2018; 12/01/2016
Annual Approval Date:	03/13/2019
Revision Date:	12/13/2017; 08/09/2017; 03/14/2017
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
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POLICY SUMMARY

Highmark Health Options does not provide coverage under the medical surgical laboratory benefits of the Company's Medicaid products for whole exome and whole genome testing.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

*The full version of this medical policy is available on the Highmark Health Options provider website at:

https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

DISCLAIMER

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BCR-ABL1 Testing in Chronic Myelogenous Leukemia and Acute Lymphoblastic Leukemia

CLINICAL MEDICAL POLICY	
Policy Name:	BCR-ABL1 Testing in Chronic Myelogenous Leukemia and Acute Lymphoblastic Leukemia
Policy Number:	MP-017-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018; 11/01/2016
Issue Date:	05/15/2018
Effective Date:	05/15/2018; 12/01/2016
Annual Approval Date:	03/13/2019
Revision Date:	12/12/2017; 08/10/2017; 03/14/2017
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
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POLICY SUMMARY

Highmark Health Options may provide coverage under the medical laboratory testing benefits of the Company's Medicaid products for medically necessary Philadelphia chromosome testing.

The following changes have been applied to this policy:

- Added definitions;
- 2018 Procedure code update: added 0016U; deleted 81401 & 81403;
- 2018 Diagnosis code update: Added ICD-10: C92.20, C92.21, C92.22, C92.90, C92.91 & C92.92;
- Updated Reference Sources

*The full version of this medical policy is available on the Highmark Health Options provider website at:

https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

DISCLAIMER

Panniculectomy/Abdominoplasty/Lipectomy

CLINICAL MEDICAL POLICY	
Policy Name:	Panniculectomy/Abdominoplasty/Lipectomy
Policy Number:	MP-041-MD-DE
Responsible Department(s):	Medical Management
Provider Notice Date:	04/15/2018; 04/01/2017
Issue Date:	05/15/2018
Effective Date:	04/15/2018; 05/01/2017
Annual Approval Date:	03/13/2019
Revision Date:	12/20/2017
Products:	Highmark Health Options Medicaid
Application:	All participating hospitals and providers
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POLICY SUMMARY

Highmark Health Options may provide coverage under the medical-surgical benefits of the Company's Medicaid products for medically necessary panniculectomy surgical procedures. This policy excludes the coverage of abdominoplasty and lipectomy surgical procedures, due to the procedures being cosmetic in nature. The Procedure Code section of the policy has been revised.

The following changes have been applied to this policy:

- removed Procedure code 00802 since isn't relevant to policy

*The full version of this medical policy is available on the Highmark Health Options provider website at:

https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

Implantable Cardioverter-Defibrillator/Subcutaneous Implantable Cardioverter-Defibrillator (ICD/SICD)

CLINICAL MEDICAL POLICY	
Policy Name:	Implantable Cardioverter-Defibrillator/Subcutaneous Implantable Cardioverter-Defibrillator (ICD/SICD)
Policy Number:	MP-049-MD-DE
Approved By:	Medical Management Medical Policy
Provider Notice Date:	04/15/2018; 08/01/2017
Issue Date:	05/15/2018
Original Effective Date:	05/15/2018; 09/01/2017
Annual Approval Date:	03/19/2019
Revision Date:	10/23/2017
Products:	Delaware Medicaid
Application:	All participating hospitals and providers
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POLICY SUMMARY

Highmark Health Options provides coverage under the medical surgical benefits of the Company's Medicaid products for medically necessary Implantable Cardioverter-Defibrillator (ICD) and Subcutaneous Implantable Cardioverter-Defibrillator (S-ICD) procedures.

The following changes have been applied to this policy:

- 2018 Coding Revisions: Diagnosis code I50.1 has been updated

*The full version of this medical policy is available on the Highmark Health Options provider website at:

https://highmarkhealthoptions.com/providers/MedicalAndPaymentPolicy

DISCLAIMER

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding payment and coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.