

Notification of Policy Revisions Effective May 23, 2011> (Posted July 11, 2011)

Medical Policy	Revision
Clinical Trials	Language removed under Policy section that references reimbursement and claims which does not pertain to coverage criteria.
Morbid Obesity, Surgery	Minor language revisions made in the Indications For Coverage section to reflect current CMS guidelines. Under the section, When Coverage Will Not Be Approved; listed the subsets of Intestinal Bypass surgery and added statement regarding NCD/LCD is currently silent as it pertains to gastric wrapping, due to no specific code identified for the procedure.
External Infusion Pumps	No further criteria changes made; policy is current with CMS guidelines.
Implantable Infusion Pumps	Updated section C: Severe Spasticity under Indication For Coverage section, to remain current with CMS guidelines. The language updated pertains to baclofen listed as an example of a drug used for intrathecal infusion for severe spasticity.
Breast Reduction	Minor language revisions made in the Indications For Coverage section to mirror updated CMS guidelines; Section IV: Schnur scale indicators added per new CMS policy.
Breast Implant Removal	No revisions required; policy current with CMS guidelines.
Speech Language Pathology	Language updated under When Coverage Will Not Be Approved section for clarification of covered service/procedure per updated CMS guidelines: “However, because the code for dysphagia treatment is a comprehensive code that includes all treatment approaches, payment may be made if other medically necessary dysphagia treatments occur during the same session that electrical stimulation is rendered.”
Ventricular Assist Device - VAD	Updated Indications For Coverage section based on CMS language: Under section c, item #1 with the following: “Heart failure symptoms have failed to respond to medical management (including dietary salt

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	<p>restriction, diuretics, digitalis, beta-blockers, and ACE inhibitors) for at least 45 of the last 60 days; or have been balloon pump-dependent for 7 days, or IV inotrope-dependent for 14 days.” Removed item #4 since this criterion was removed from CMS guidelines.</p>
<p>Vertebroplasty/Percutaneous Vertebral Augmentation</p>	<p>Revisions based on new CMS guidelines: Updated title of policy to mirror CMS policy. Kyphoplasty removed as title item.</p> <p>Indications For Coverage section updated: Section A: Removed language pertaining to old policy pertaining to Myeloma, Unstable fractures due to osteonecrosis, and Reinforcement/stabilization of vertebral body prior to surgery. Added 1st two bullet items to new policy per current CMS guidelines.</p> <ul style="list-style-type: none"> • Removed Contraindications from this section of policy. <p>Section B: Updated procedure name as indicated in current CMS policy. Removed language pertaining to Multiple Myeloma and updated with current CMS language.</p> <ul style="list-style-type: none"> • Added 1st bullet relating to Osteolytic vertebral metastasis to mirror. <p>When Coverage Will Not Be Approved section: Used language from CMS guidelines to reference the Contraindications section for clarity.</p> <p>Added language to the Limitations section to the policy to mirror language from new CMS policy.</p>
<p>X-Stop</p>	<p>Updated coverage criteria to reflect current CMS language pertaining to conservative treatment. Item c; added language referencing conservative treatment and included language pertaining to physical therapy/exercise for spine stabilization, build endurance and increase flexibility.</p> <p>Removed language pertaining to, “Examples of non operative treatments” per updated CMS policy. Removed language, “at the same time” from Special Notes section pertaining to ‘services performed on patients who have received another spinal procedure’ and updated the word patient for member.</p>