Notification of Policy Revisions Effective September 20, 2010 (Posted November 24, 2010)

Medical Policy	Revision
Cardiac Rehabilitation	The policy was updated to reflect the Medicare guidelines effective January 2010. Policy includes an additional coverage indication which is not included in the Medicare manual - Compensated/Stable Class II, Class III, or Class IV Heart Failure. Thirty –six (36) sessions are covered without prior approval and the coverage is not limited to a time period. Prior approval is required for sessions exceeding 36. Services may be ordered by a contracted or non-contracted cardiologist. Coverage of intensive cardiac rehabilitation and applicable codes were added to the policy.
Oral Chemotherapy Medications	The policy was updated to include a new medication covered by CMS effective June 2010- Oforta (fludarabine phosphate).
Pulmonary Rehabilitation	The indication for coverage was updated to reflect the Medicare guidelines. The only coverage indication is “moderate to very severe chronic obstructive pulmonary disease (COPD) defined as GOLD classification II, III, and IV when referred by the physician treating the chronic respiratory condition”. Previous coverage criteria were deleted. The special notes section was updated to reflect coverage of thirty-six (36) sessions. Prior approval is required for sessions beyond 36. The GOLD classification table was added to the glossary of terms section.
Rehabilitation Therapy-Inpatient	The policy includes the CMS guidelines effective January 2010 for coverage of inpatient rehabilitation facility services. Prior approval is required for coverage consideration. A Medical Director review is required if the medical necessity for the level of care does not meet the CMS guidelines.
Sacral Nerve Stimulators for Urinary Incontinence	Policy was revised so indications for coverage are consistent with CMS guidelines. Added language to define sacral nerve stimulation (SNS) and describe the steps of SNS. In the section title” When coverage will not be approved”, replaced “investigational” with “not medically necessary” to be consistent with the CMS policy.
Speech Language Pathology (SLP) Services	Minor revision to the policy to include coverage criteria for a speech evaluation.

Vertebroplasty and Kyphoplasty, Percutaneous	The policy was revised so the criteria are consistent with the CMS guidelines. Vertebroplasty- the language in the indications for coverage section was changed from "accepted standard medical treatment" to "less invasive medical treatment". Examples of less invasive medical treatment were inserted for staff to use as a reference. Added another absolute contraindication for vertebroplasty which is a lack of available emergency decompressive surgery (to relieve compression secondary to epidural or foraminal leakage. In the Kyphoplasty section, added two contraindications- current anticoagulant therapy with an abnormal coagulation panel and sepsis and/or active infection. Also changed the time line for "established deformities" from >6 weeks to >10 weeks to be consistent with the LCD.

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