Gateway Health℠

August 15, 2017

PROVIDER UPDATE

An Update for Gateway Health℠ Providers and Clinicians

Pennsylvania Medicaid Policy Updates for 9-15-17

NEW MEDICAL POLICY

NEW DRUG POLICIES

REVISED MEDICAL POLICIES

REVISED DRUG POLICIES

Cardiac Rehabilitation, Phase II Outpatient

CLINICAL MEDICAL POLICY	
Policy Name:	Cardiac Rehabilitation, Phase II Outpatient
Policy Number:	MP-057-MD-PA
Responsible Department(s):	Medical Management
Provider Notice Date:	08/15/2017
Original Effective Date:	09/15/2017
Annual Approval Date:	07/15/2018
Revision Date:	N/A
Products:	Gateway Health℠ Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Gateway Health℠ provides coverage under the medical-surgical benefits of the Company's Medicaid products for medically necessary outpatient and medically supervised Phase II cardiac rehabilitation programs. Phase III and phase IV cardiac rehabilitation programs are considered maintenance programs and considered not medically necessary.

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 Gateway provider website at:

http://gatewayhealthplan.com/MedicalPolicies

DISCLAIMER

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

Pulmonary Rehabilitation (PR)

CLINICAL MEDICAL POLICY	
Policy Name:	Pulmonary Rehabilitation (PR)
Policy Number:	MP-058-MD-PA
Responsible Department(s):	Medical Management
Provider Notice Date:	08/15/2017
Original Effective Date:	09/15/2017
Annual Approval Date:	07/15/2017
Revision Date:	N/A
Products:	Gateway Health℠ Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Gateway Health℠ provides coverage under the medical-surgical benefits of the Company's Medicaid products for medically necessary pulmonary rehabilitation.

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 Gateway provider website at:

http://gatewayhealthplan.com/MedicalPolicies

DISCLAIMER

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

Botox (onabotulinumtoxinA) Injections

CLINICAL MEDICAL POLICY	
Policy Name:	Botox (onabotulinumtoxinA) Injections
Policy Number:	MP-024-MD-PA
Responsible Department(s):	Medical Management; Clinical Pharmacy
Provider Notice Date:	08/15/2017
Original Effective Date:	09/15/2017
Annual Approval Date:	07/15/2018
Revision Date:	N/A
Products:	Gateway Health℠ Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Gateway Health℠ provides coverage under the medical benefits of the Company's Medicaid products for medically necessary injections of Botox (onabotulinumtoxinA) injections.

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 Gateway provider website at:

http://gatewayhealthplan.com/MedicalPolicies

DISCLAIMER

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

Erbitux (cetuximab)

CLINICAL MEDICAL POLICY	
Policy Name:	Erbitux (cetuximab)
Policy Number:	MP-034-MD-PA
Responsible Department(s):	Medical Management; Clinical Pharmacy
Provider Notice Date:	08/15/2017
Original Effective Date:	09/15/2017
Annual Approval Date:	07/15/2018
Revision Date:	N/A
Products:	Gateway Health℠ Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Gateway Health℠ provides coverage under the medical-surgical benefits of the Company's Medicaid products for medically necessary intravenous infusions of Erbitux (cetuximab).

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 Gateway provider website at:

http://gatewayhealthplan.com/MedicalPolicies

DISCLAIMER

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

Granulocyte Colony Stimulating Factors (G-CSFs: Neupogen, Granix)

CLINICAL MEDICAL POLICY	
Policy Name:	Granulocyte Colony Stimulating Factors (G-CSFs: Neupogen, Granix)
Policy Number:	MP-016-MD-PA
Responsible Department(s):	Medical Management; Clinical Pharmacy
Provider Notice Date:	08/15/2017
Original Effective Date:	09/15/2017
Annual Approval Date:	07/15/2018
Revision Date:	N/A
Products:	Gateway Health℠ Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Gateway Health℠ provides coverage under the medical or pharmacy benefits of the Company's Medicaid products for medically necessary Granulocyte Colony Stimulating Factor (G-CSF) such as Neupogen, Granix.

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 Gateway provider website at:

http://gatewayhealthplan.com/MedicalPolicies

DISCLAIMER

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

Kyprolis (carfilzomib)

CLINICAL MEDICAL POLICY	
Policy Name:	Kyprolis (carfilzomib)
Policy Number:	MP-043-MD-PA
Responsible Department(s):	Medical Management; Clinical Pharmacy
Provider Notice Date:	08/15/2017
Original Effective Date:	09/15/2017
Annual Approval Date:	07/15/2018
Revision Date:	N/A
Products:	Gateway Health℠ Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Gateway Health℠ provides coverage under the medical-surgical benefits of the Company's Medicaid products for medically necessary intravenous infusions of Kyprolis (carfilzomib).

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 Gateway provider website at:

http://gatewayhealthplan.com/MedicalPolicies

DISCLAIMER

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

Rituxan (rituximab)

CLINICAL MEDICAL POLICY	
Policy Name:	Rituxan (rituximab)
Policy Number:	MP-031-MD-PA
Responsible Department(s):	Medical Management
Provider Notice Date:	08/15/2017
Original Effective Date:	09/15/2017
Annual Approval Date:	07/15/2018
Revision Date:	N/A
Products:	Gateway Health℠ Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Gateway Health℠ provides coverage under the medical surgical benefits of the Company's Medicaid products for medically necessary intravenous administration of Rituxan (rituximab).

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 warrants individual consideration, based upon review of applicable medical records.

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

http://gatewayhealthplan.com/MedicalPolicies

DISCLAIMER

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

Long-Term Use 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-PA
Responsible Department(s):	Medical Management
Provider Notice Date:	08/15/2017
Original Effective Date:	09/15/2017
Annual Approval Date:	07/15/2018
Revision Date:	06/21/2017
Products:	Gateway Health℠ Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Gateway Health℠ provides coverage under the durable medical equipment (DME) benefits of the Company's Medicaid products for medically necessary long-term use of continuous glucose monitors.

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 warrants individual consideration, based upon review of applicable medical records.

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

http://gatewayhealthplan.com/MedicalPolicies

DISCLAIMER

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

Fetal Aneuploidy Testing Using Noninvasive Cell-Free Fetal DNA

CLINICAL MEDICAL POLICY	
Policy Name:	Fetal Aneuploidy Testing Using Noninvasive Cell-Free Fetal DNA
Policy Number:	MP-003-MD-PA
Responsible Department(s):	Medical Management
Provider Notice Date:	08/15/2017
Original Effective Date:	09/15/2017
Annual Approval Date:	07/15/2018
Revision Date:	05/05/2017
Products:	Gateway Health℠ Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Gateway Health℠ provides coverage for laboratory benefit under the medical benefits of the Company's Medicaid products for medically necessary, noninvasive, circulating cell-free DNA prenatal testing of fetal aneuploidy as screening tools for trisomy 21 (Down syndrome), trisomy 18 (Edwards syndrome), or trisomy 13 (Patau syndrome).

Gateway Health℠ does not provide coverage for circulating cell-free DNA microdeletions genetic testing. The service is considered experimental and therefore is considered not medically necessary.

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 Gateway provider website at:

http://gatewayhealthplan.com/MedicalPolicies

DISCLAIMER

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

Genetic Testing for Colorectal Cancer Susceptibility

CLINICAL MEDICAL POLICY	
Policy Name:	Genetic Testing for Colorectal Cancer Susceptibility
Policy Number:	MP-018-MD-PA
Approved By:	Medical Management
Provider Notice Date:	08/15/2017
Original Effective Date:	09/15/2017
Annual Approval Date:	07/15/2018
Revision Date:	03/01/2017; 05/10/2017
Products:	Pennsylvania Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Gateway Health provides coverage under the laboratory medical-surgical benefits of the Company's Medicaid products for medically necessary genetic testing for colorectal cancer susceptibility.

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 Gateway provider website at:

http://gatewayhealthplan.com/MedicalPolicies

DISCLAIMER

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

Spinraza (nusinersen)

CLINICAL MEDICAL POLICY	
Policy Name:	Spinraza (nusinersen)
Policy Number:	MP-048-MD-PA
Responsible Department(s):	Medical Management; Clinical Pharmacy
Provider Notice Date:	08/15/2017
Original Effective Date:	09/15/2017
Annual Approval Date:	07/15/2018
Revision Date:	07/20/2017
Products:	Gateway Health℠ Medicaid
Application:	All participating hospitals and providers
Page Number(s):	1

POLICY SUMMARY

Gateway Health℠ provides coverage under the medical benefits of the Company's Medicaid products for medically necessary intravenous administration of Spinraza (nusinersen).

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 Gateway provider website at:

http://gatewayhealthplan.com/MedicalPolicies

DISCLAIMER

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