Provider Press

Provider information

June 2015 / Vol. 19, No. 2

BlueCross BlueShield Minnesota

BLUE CROSS AND BLUE SHIELD OF MINNESOTA TO IMPLEMENT CHANGE TO PRIOR AUTHORIZATION PROCESS

As stewards of healthcare expenditure for our customers, we are charged with ensuring the highest quality, evidence based care for our subscribers. One method for doing so is through the prior authorization process. While cost savings may be realized from prior authorization, the primary purpose is to ensure that evidence based care is provided to subscribers.

Our foundational philosophy: Prior authorization is a tactic that is applied judiciously and selectively. We reserve this approach for procedures that have demonstrated significant variability in utilization both locally and nationally, or excessive utilization instead of more conservative approaches.

To request a service, procedure or item that requires prior authorization, providers submit clinical information to the health plan. The Utilization Management team reviews the clinical information and determines if the request meets medical necessity criteria based on current Medical Policy and accepted standards of care. By definition, Prior Authorizations are completed *before* the service happens (pre-service).

Currently, when a provider submits a claim for a procedure which requires a prior authorization, but a prior authorization was not obtained, Blue Cross denies the claim as lacking complete medical records to make a final benefit determination and requests clinical information from the provider. The Utilization Management team then reviews the medical records and service to determine medical necessity based on current Medical Policy and accepted standards of care. At this point the claim can be paid, but it may be denied based on those criteria even though the service has already been provided.

Our subscribers do not receive an optimal experience when a claim for a procedure is denied after the service is rendered.

Our providers are at greater financial risk with our current process. Even today, if a service is found not medically necessary after the fact (on retrospective review), the provider is liable for the cost of the service.

Beginning with September 1, 2015 dates of service, Blue Cross will follow other Minnesota payers and begin enforcing the contractual requirement for participating providers to complete the prior authorization (PA) process for services on the current PA list. ***Blue Cross will deny claims as provider liability for lack of prior authorization*** and the submitting provider will have 60 days in which to file an appeal.

For the lists to determine if a procedure requires prior authorization, please follow these steps:

1. Access the Provider Section of the Blue Cross website at **providers.bluecrossmn.com**
2. Click on the "Medical Policy" link found under "Tools and Resources"
3. Follow the site instructions to reach the active policies section and then the pre-certification/ pre-authorization lists

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Provider Press

Provider Press is a quarterly newsletter available online at **providers.bluecrossmn.com**. Issues are published in March, June, September and December.

Inside preview

FYI

PUBLICATIONS AVAILABLE ONLINE

The following is a list of Quick Points and Bulletins published from March 2015 to May 2015 that are available online at **providers.bluecrossmn.com**. As a reminder, Bulletins are mailed to all participating providers affected by the information. Quick Points are available only on our website unless noted otherwise in the bottom left corner of the publication.

QUICK POINTS	TITLE
QP8-15	Medical Necessity Criteria Change for Minnesota Health Care Programs (MHCP) Members
QP9-15	SecureBlue (MSHO) Members Post Cataract Eyewear Benefit for Implants with Intraocular Lens
QP10-15	ICD-10 Code Structure, Terminology, and Medical Coding Documentation
QP11-15	Emergency Room and Same Day Inpatient Admission Reminder
QP12-15	Changes to Optician Network for Commercial Business
BULLETINS	**TITLE**
P3-15	Elimination of Prior Authorization Requirements for Three Medical Policies
P4-15	New Drug-related Prior Authorization Criteria: Afrezza® Prior Authorization with Quantity Limit
P5-15	Medical Necessity Review Criteria Vendor Change for Behavioral Health
P6-15	April 2015 HCPCS Code Updates
P7-15	Addition of Drugs to the Self-Administered Oral Oncology Prior Authorization with Quantity Limit Program
P8-15	Reminder: Common Carrier Providers Mileage Trip Log Documentation
P9-15	Reimbursement Policy Development
P10-15	Upcoming 2015 Commercial Preventive Benefit Changes
P11-15	Update on Manual Wheelchair Benefit Determination Requests for Platinum Blue
P12-15	ICD-10 Coding and General Billing Reminders
P13-15	New Prior Authorization Requirement for Hip Arthroplasty and Hip Resurfacing
P14-15	Verify Subscriber Eligibility Prior to Providing Health Services
P15-15	Special Transportation Services & Common Carrier Network Participation Automobile Liability Insurance Requirements
P16-15	Addition of Drugs to Two Prior Authorization Programs: Self-Administration Oral Oncology with Quantity Limit and Weight Loss with Quantity Limit
P17-15	Modifier -54 Payment Reduction
P18-15	Modifier Requirement for Coding Appeals
P19-15	Anesthesia Policy Update
P20-15	SecureBlue (MSHO) Change in Notice of Medicare Non-Coverage (NOMNC) Letter

Provider Demographic Change Form

The Provider Demographic Change form needs to be completed when your address, phone number, hospital affiliation or office hours change. Go to **providers.bluecrossmn.com** and enter "provider demographic change form" in the search window to obtain the form. Completed forms can be:

Emailed to: Provider.Data@bluecrossmn.com

Faxed to **(651) 662-6684**

Mailed to:
Blue Cross and Blue Shield of Minnesota
PDO, R316
P.O. Box 64560
St. Paul, MN 55164-0560

FYI

PROVIDER MANUAL UPDATES

The following is a list of Blue Cross and Blue Shield of Minnesota provider manuals that have been updated from March 2015 to May 2015. As a reminder, provider manuals are available online at **providers.bluecrossmn.com**. To view the manuals, select "Forms & publications," then "manuals." Updates to the manuals are documented in the "Summary of changes" section of the online manuals.

MANUAL NAME	CHAPTER NUMBER AND TITLE	CHANGE
Provider Policy and Procedure Manual	Chapter 10, Appeals	Content change to Coding Appeals
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Coding section	Content changes to the following sections: • Preventive Care Services • Preventive Services Required Under the PPACA
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Behavioral Health section	Content changes to the following sections: • Medication/Pharmacologic Management • Pre-certification and concurrent review for children's and adolescent residential mental health services • Pre-certification and concurrent review for residential substance use disorder services
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Durable Medical Equipment section	• Content change to Oxygen and Oxygen Aiding Equipment • New topic added: Minnesota Health Care Program (MHCP) and Minnesota Senior Care Plus (MSC+) Subscribers Require Pre-Certification for Lift Chair and Seat Lift Mechanism
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Medical Services section	Content change to Health Care Home (HCH)

2015 HOLIDAY SCHEDULE

Provider services will be closed on the following days in 2015:

Monday, May 25

Friday, July 3

Monday, September 7

Thursday, November 26

Friday, November 27

Thursday, December 24

Friday, December 25

With the exception of the dates stated above, representatives answering the provider services numbers are available to assist you 8 a.m. to 5 p.m. Monday through Thursday, and 9 a.m. to 5 p.m. on Friday.

CODING CORNER

CONSULTATIONS REMINDER

The Centers for Medicare & Medicaid Services (CMS) does not allow submission of inpatient and outpatient consultation codes for Medicare claims. This coding and submission is followed but only for our Medicare business. There is no change for all other lines of business. Blue Cross accepts all valid HIPAA medical codes. The consultation codes 99241-99245 and 99251-99255 are valid CPT codes and as such will be accepted. We expect that the documentation will support any code submitted.

WHAT IS THE CORRECT UNIT FOR AN UNLISTED HCPCS/CPT CODE?

That unit would be one and only one. If an unlisted code is submitted to Blue Cross with more than one unit, that service will be denied.

Unlisted codes have no specific definition including no indication of a unit of measurement, such as "each" or "per", or a dosage indicator. Blue Cross policy is supported by the following state policy found in the MN Uniform Companion Guide (**http://www.health.state.mn.us/auc/guides.htm**).

> **A.3.4.2. Units (basis for measurement)**
> The number of units is the number of services performed and reported per service line item as defined in the code description unless instructed differently in this appendix.
>
> The following are clarifications/exceptions:
>
> • Report one unit for all services without a measure in the description.

ICD-10 HELP WITH SUMMER MALADIES

The days are getting longer and warmer, but watch out; there are dangers lurking. For example, watch where you walk. You do not want to step into a bee's nest or poison ivy. Be careful when you cast your fishing line, and of course, wear sunscreen. But if not, at least there is a code for whatever may happen.
For example,

- Bee stings – T63.443 Toxic effect of venom of bees, assault
- Poison ivy exposure – L24.7 Irritant contact dermatitis due to plants, except food
- Fish hook stuck in hand – S61.442A Puncture wound with foreign body of left hand, initial encounter
- Sunburn – L55.9 Sunburn, unspecified

Note: these ICD-10 codes are valid with dates of service October 1, 2015 and after.

CODING CORNER

BLUE CROSS AND BLUE SHIELD OF MINNESOTA TO IMPLEMENT CHANGE TO PRIOR AUTHORIZATION PROCESS continued from page 1

Remember, only those services on the lists require prior authorization. Please do not request prior authorization for services not on the lists. Claims for those services will process through the claims system according to the subscriber's benefits.

The Pre-Certification/Pre-Authorization aka Prior Authorization requirements vary between Blue Cross' Commercial plans, MN Government Programs plans and Medicare plans, therefore, please carefully review the applicable policy related to the subscriber's plan.

Also as a reminder, claims that are denied as provider liability are not eligible to be billed to subscribers.

The only exception is in cases where the subscriber has signed a pre-service payment consent form indicating that the subscriber knows that the specific health services are not covered (or in this instance, not covered because prior authorization was either not sought or not granted), and that the subscriber agrees to assume financial liability for such specific health services.

LIKE CLOCKWORK

You can rely on the quarterly HCPCS medical code updates to usher in coding changes, whether they be more added codes, discontinued codes and maybe some revised codes. As usual, Blue Cross will publish a Provider Bulletin closer to the July 1, 2015, effective date with all the details.

SITE SPECIFIC EDITS

The site specific code auditing logic uses modifiers attached to procedure codes to determine if the procedures being audited were performed at the same anatomic site. Procedures that can be performed on the left side (e.g., left leg/ankles) or the right side (e.g., right leg/ankles) of the body are valid with the –LT and –RT modifiers. Site specific modifiers are not intended to represent an anterior or posterior incision of the same site.

FYI

ICD-10 CODE STRUCTURE, TERMINOLOGY, AND MEDICAL CODING DOCUMENTATION

Note: The information below was also published on April 27, 2015, in Provider Quick Points QP10-15.

The ICD-10 federal compliance date of October 1, 2015 is now less than six months away. Blue Cross is prepared and ready for ICD-10. All Blue Cross business processes and technical systems impacted by ICD-10 will be compliant and ready to accept and adjudicate ICD-10 claims.

ICD-10-CM [International Classification of Diseases, 10th Edition, Clinical Modification] and ICD-10-PCS [International Classification of Diseases, 10th Edition, Procedure Classification System] will replace ICD-9-CM in all healthcare settings–provider and payer–for inpatient and outpatient diagnosis; and inpatient procedure documentation and reporting. ICD-10-CM and ICD-10-PCS include changes in organization and structure, incorporate much greater detail and specificity and have been updated to be consistent with current clinical practices.

Resources

To aid in your transition, Blue Cross has made the following educational materials related to the new ICD-10 code structure available under the ICD-10 compliance link at **providers.bluecrossmn.com**.

ICD-10 diagnosis codes – the job aid

ICD-10 procedure codes – the job aid

Quick reference guide – diagnosis codes

Quick reference guide – procedure codes

Structure of an ICD-10 code

In addition, the Centers for Medicare & Medicaid Services (CMS) has ICD-10 educational materials for providers available at the following webpage. These educational materials can help guide the medical documentation practices which are needed to support the specificity of ICD-10 coding:

http://www.cms.gov/Medicare/Coding/ICD10/ProviderResources.html

Questions: If you have questions, please contact provider services at **(651) 662-5200** or **1-800-262-0820**.

QUALITY IMPROVEMENT

PCC QUALITY OF CARE COMPLAINT REPORT

Providers are required to complete the Blue Plus Quality of Care Complaint report for all written and verbal complaints from Blue Plus, Prepaid Medical Assistance Program and MinnesotaCare subscribers on a quarterly basis, per Minnesota Department of Health regulations. Complaints logged at the provider offices are to be investigated and resolved by the provider's office whenever possible.

These complaints are reported to Blue Plus in January, April, July and October for the preceding three months. The Primary Care Clinic (PCC) must submit a quarterly report even if the facility does not receive any complaints for the quarter. Your contract outlines the procedures required for your Quality of Care (QOC) PCC complaint reporting adherence agreement.

Complaints should no longer be directed to the attention of a single designated person. Sending your PCC QOC complaint report form to any source not listed below may delay the processing of your PCC QOC complaint report.

To access the PCC Blue Plus Quality of Care Complaint Report Form, go to **providers.bluecrossmn.com** and select "Forms & publications," then "forms - clinical operations."

Submit quarterly PCC QOC reports using one of these methods:

Email: pcc.complaint@bluecrossmn.com

Secure fax line: **(651) 662-4004**

Mail: Blue Plus
Attn: Quality Health Management Dept.
R472
P.O. Box 64179
St. Paul, MN 55164-0179

FYI

HELPFUL PHONE NUMBERS	
BLUELINE (voice response unit)	**(651) 662-5200 or 1-800-262-0820**
BlueCard® member benefits or eligibility	**1-800-676-BLUE (2583)**
FEP® (voice response unit)	**(651) 662-5044 or 1-800-859-2128**
Availity	**1-800-282-4548**
Provider services	**(651) 662-5200 or 1-800-262-0820**
Please verify these numbers are correctly programmed into your office phones.	

FYI

ICD-10 CODING AND GENERAL BILLING REMINDERS

Note: The information below was also published on April 6, 2015, in Provider Bulletin P12-15.

The ICD-10 federal compliance date of October 1, 2015, is rapidly approaching. The time is now to complete your final preparations for implementation of the updated code set. To help you prepare for the impacts of ICD-10, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) is publishing the following reminders.

Coding Reminders
Code all diagnosis and procedures to the greatest level of specificity possible.

Medical record documentation must support the code selection on the claim transactions.

General Billing Reminders
Blue Cross will not extend the timely filing deadlines or advance payments to any providers who fail to comply with the ICD-10 mandate. Claims must be submitted timely to Blue Cross. Any claims received after the timely filing period specified in your Participating Provider Service Agreement will be denied as provider liability. Please work with your software vendor and clearinghouse to make sure you are ready to submit ICD-10 coded claims by the compliance date.

Only one version of the code set (ICD-9 or ICD-10) is allowed per submitted claim.

ICD-9 only must be used on claims with service dates and inpatient discharge dates prior to October 1, 2015.

ICD-10 only must be used on claims with service dates and inpatient discharge dates October 1, 2015, and after.

Claims with service dates spanning October 1, 2015, must be submitted as two separate claims transactions with the exception of inpatient services. Please refer to CMS MLN Matters publication for more information:

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1325.pdf.

Use the correct code qualifier indicating whether the code is ICD-9 or ICD-10 for the code set being reported in the HIPAA transaction.

Review your claim acknowledgement reports timely to ensure claims have been correctly submitted and accepted by Blue Cross. Claims rejected on these reports must be corrected and submitted again. Claims rejected on acknowledgment reports are not considered submitted for timely filing purposes.

Use CMS resources for answers to common submission questions. The CMS resources can be found at **http://www.cms.gov/Medicare/Coding/ICD10/Medicare-Fee-For-Service-Provider-Resources.html**.

Additional information is available under the ICD-10 compliance link on our website at **providers.bluecrossmn.com**.

Questions? If you have questions, please contact provider services at **(651) 662-5200 or 1-800-262-0820**.

FYI

REDUCING RACIAL AND ETHNIC DISPARITIES IN DEPRESSION MANAGEMENT – PROVIDER TOOLKIT NOW AVAILABLE

Depression is the most common form of mental illness in the United States, with the majority of individuals diagnosed and treated in primary care. Despite effective treatment strategies, racial and ethnic disparities exist in both treatment engagement and retention. Providers are well-positioned to address some of the barriers to successful treatment among racial and ethnic minority groups; however, their impact will be limited if they do not recognize how culture can influence a patient's experience of depression.

To help address this, Blue Cross worked with four other metro health plans (HealthPartners, Medica, Hennepin Health/Metropolitan Health Plan and UCare) and Stratis Health to develop a Provider Toolkit with resources for primary care providers working with patients experiencing depression. The toolkit emphasizes racial and cultural perspectives and includes information and resources on:

- best practices for depression care
- cultural competency
- shared decision making
- mental health resources for patients and providers

You can download the Toolkit on the Provider Tools and Resources page of the Blue Cross website at **https://www.bluecrossmn.com/Page/mn/en_US/provider-tools-and-resources**. It also is available on the Stratis Health website at **http://www.stratishealth.org/pip/antidepressant.html**.

The toolkit was created as part of a new Performance Improvement Project (PIP) focused on improving antidepressant medication adherence among Blue Advantage Prepaid Medical Assistance Program (PMAP) and MinnesotaCare subscribers. Additional activities being implemented as part of this PIP include:

- **Provider Webinars.** The health plan collaborative will sponsor a series of webinars over the next two years addressing topics related to cultural competency and depression management, such as perceptions of mental health among diverse communities across Minnesota and shared decision making. Watch for future announcements about the webinars in Provider Quick Points.
- **Subscriber Outreach.** Research suggests that basic health education about depression and antidepressants can improve treatment adherence. Therefore, Blue Cross created a medication "tip sheet" for subscribers that answers common questions about antidepressants, provides tips for improving adherence (e.g., setting up refill reminders) and encourages subscribers to talk with their physician and pharmacist about any issues or questions they have regarding their medication or treatment.

continued on next page

FYI

- **Subscriber Outreach.** continued from previous page
  In February, 2015, Blue Cross began mailing the tip sheet together with a cover letter to PMAP and MinnesotaCare subscribers from racial and ethnic minority groups who, based on pharmacy claims, recently filled a new prescription for an antidepressant medication. Blue Cross also is conducting telephonic outreach to a subset of subscribers at higher risk for self-discontinuation of medication treatment. The goal of the telephonic outreach is to reinforce the messaging in the letters and connect subscribers to appropriate resources. A Registered Nurse conducts the outreach.
- **Prescriber Outreach.** To help prescribers identify patients who may be experiencing medication issues, Blue Cross plans to begin notifying prescribers if we identify that a subscriber is overdue for a refill of his or her antidepressant medication. We expect to initiate this outreach by early summer.

Thank you for the quality care you provide to your patients and our subscribers. Working together, we can reduce barriers to depression treatment and improve health outcomes among the individuals we both serve.

REALLY SIMPLE SYNDICATION

Not all provider publications are mailed out to providers. The majority of our informational Quick Points and the quarterly Provider Press are posted to our website for providers to view. Providers frequently ask us how they can be advised when new publications are added to the website at **providers.bluecrossmn.com**.

Providers can sign up to get RSS (really simple syndication) feeds of our latest news releases and updates to provider-related forms and publications. A sample of the feeds that can be requested includes:

- Bulletins
- Forms: admin updates and contracting
- Forms: credentialing
- Forms: pre-certification and pre-authorization
- Manuals
- Provider Press
- Quick Points

Go to **providers.bluecrossmn.com** and enter "RSS" in the search window to learn more about RSS. Questions about RSS feeds specific to your internal systems should be directed to your IT support area.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

Medical and behavioral health policies are available for your use and review on the Blue Cross and Blue Shield of Minnesota website at **providers.bluecrossmn.com**. From this site, there are two ways to access medical policy information depending on the patient's Blue Plan membership.

For out-of-area Blue Plan patients:

Select "Medical Policy PreCert/PreAuth Router" and click Go. You will be taken to the page where you select either medical policy or pre-certification/prior authorization and enter the patient's three-letter alpha prefix as found on their member identification card, and click Go. Once you accept the requirements, you will be routed to the patient's home plan where you can access medical policy or pre-certification/pre-authorization information.

For local Blue Cross and Blue Shield of Minnesota plan patients:

Select "Medical policy" (under the Tools & Resources), read and accept the Blue Cross Medical Policy Statement, and then select "View All Active Policies." You have now navigated to the Blue Cross and Blue Shield of Minnesota Medical and Behavioral Health Policy Manual, where there are several selections to assist with your inquiry.

The "What's New" section identifies our latest new or revised policies approved by Blue Cross' Medical and Behavioral Health Policy Committee at least **50** days ago. These policies are now effective, and providers should begin following these policies immediately. These policies also appear in the "Active Policy" section of the Medical and Behavioral Health Policy Manual.

The "Upcoming Policies" section lists new or revised policies approved by the Blue Cross Medical and Behavioral Health Policy Committee and are effective **50** days from the date they were posted to the "Upcoming Policies" section of the Medical and Behavioral Health Policy Manual.

The "Active Policy" section contains the entire list of policies effective at the time of your inquiry. Please note, DHS Programs (Coverage Guidelines for DHS Programs - MHCP Manual) and Medicare Contractors (Part A – National Government Services [NGS], Part B – National Government Services [NGS], Home Health and Hospice – National Government Services [NGS], Durable Medical Equipment Medicare Administrative Contractor – National Government Services [NGS], and The Centers for Medicare and Medicaid Services – CMS) have separate sections.

The "Pre-Certification/Pre-Authorization" section identifies various services, procedures, prescription drugs, and medical devices that require pre-certification/pre-authorization. The following Pre-Certification/Pre-Authorization Lists are provided for review: Commercial (including BlueLink TPA), MN Government Programs, and Medicare Plans. These lists are not exclusive to medical policy services only; they encompass other services that are subject to pre-certification/pre-authorization requirements.

If you have additional questions regarding medical or behavioral health policy issues, call provider services at **(651) 662-5200** or **1-800-262-0820** for assistance.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

MEDICAL AND BEHAVIORAL HEALTH POLICY ACTIVITY

Policies Effective: 04/20/15 Notification Posted: 02/26/15

Policies developed

Vestibular Evoked Myogenic Potential (VEMP) Testing

- Vestibular evoked myogenic potential (VEMP) testing is considered INVESTIGATIVE for all indications due to the lack of clinical evidence demonstrating its impact on improved health outcomes.

Policies revised

Chromosomal Microarray Analysis and Next Generation Sequencing to Evaluate Patients with Developmental Delay/Intellectual Disability or Autism Spectrum Disorder

- Chromosomal microarray analysis may be considered MEDICALLY NECESSARY for diagnosing a genetic abnormality in children with apparent nonsyndromic cognitive developmental delay/intellectual disability (DD/ID) or autism spectrum disorder (ASD) according to accepted Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria when ALL of the following conditions are met:

  A. Any indicated biochemical tests for metabolic disease have been performed, and results are non-diagnostic; AND

  B. FMR1 gene analysis (for Fragile X), when clinically indicated, is negative; AND

  C. ASD or apparent non-syndromic DD/ID in a child with multiple anomalies not specific to a well-delineated genetic syndrome; AND

  D. The results of the genetic testing have the potential to impact the clinical management of the patient; AND

  E. Testing is requested after the parent(s) and/or legal guardian(s) have been engaged in face-to-face genetic counseling with a healthcare professional who has the appropriate genetics training and experience and is independent of the laboratory performing the test.

- Chromosomal microarray analysis is considered INVESTIGATIVE for the following due to a lack of clinical evidence demonstrating its impact on improved health outcomes:

  A. All other cases of suspected genetic abnormality in children with developmental delay/intellectual disability or autism spectrum disorder

  B. To confirm the diagnosis of a disorder or syndrome that is routinely diagnosed based on clinical evaluation alone. These include but are not limited to attention deficit hyperactivity disorder (ADHD), learning disability, growth retardation, or speech delay

  C. As a stand-alone diagnostic test

  D. Prenatal testing or screening

  E. Population screening

- Panel testing using next-generation sequencing is considered INVESTIGATIVE in all cases of suspected genetic abnormality in children with DD/ID or ASD.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

Sleep Disorder Testing in Adults

- **UNATTENDED PORTABLE SLEEP STUDY – INITIAL STUDY**

A single unattended portable sleep study (performed on either one night or consecutive nights) in the home or clinic setting with a Type II or III device (minimum of 4 recording channels including oxygen saturation, respiratory movement, ECG or heart rate and airflow) may be considered MEDICALLY NECESSARY under the following circumstances:

A. Performed under the supervision of a physician and interpreted by a physician who is either a diplomate of the American Board of Sleep Medicine, a recognized subspecialty of the American Board of Medical Specialties (ABMS), or an active staff member of a sleep center or laboratory accredited by the American Academy of Sleep Medicine (AASM) or The Joint Commission;
   AND
B. Patient meets ALL of the following:
   1. Habitual snoring and/or observed apneas;
      AND
   2. Excessive daytime sleepiness evidenced by an Epworth Sleepiness Scale score greater than 10 or sleepiness that interferes with daily activities and is not explained by other conditions;
      AND
   3. Patient has no evidence by history or physical examination of a health condition that might alter ventilation or require alternative treatment, including any of the following:
      a. Central sleep apnea
      b. Congestive heart failure
      c. Moderate to severe chronic pulmonary disease
      d. Pulmonary hypertension
      e. Obesity hypoventilation syndrome
      f. Narcolepsy
      g. Parasomnia
      h. Periodic limb movements in sleep
      i. Restless legs syndrome
      j. Neuromuscular disease
      k. Seizure disorder
      OR
C. Patient is scheduled for bariatric surgery and has no evidence by history or physical examination of a health condition that might alter ventilation or require alternative treatment as described in B.3 above.

- **UNATTENDED PORTABLE SLEEP STUDY – REPEAT STUDY**

A single unattended portable sleep study (performed on either one night or consecutive nights) in the home or clinic setting with a Type II or III device (minimum of 4 recording channels including oxygen saturation, respiratory movement, ECG or heart rate and airflow) may be considered MEDICALLY NECESSARY under the following circumstances:

A. Performed under the supervision of a physician and interpreted by a physician who is either a diplomate of the American Board of Sleep Medicine, a recognized subspecialty of the American Board of Medical Specialties (ABMS), or an active staff member of a sleep center or laboratory accredited by the American Academy of Sleep Medicine (AASM) or The Joint Commission;
   AND
B. One of the following:
   1. To assess efficacy of surgery or oral appliances/devices;

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OR

2. To re-evaluate the diagnosis of OSA and need for continued CPAP. Examples include significant change in weight or change in symptoms suggesting that CPAP should be re-titrated or possibly discontinued.

- **POLYSOMNOGRAPHY – INITIAL STUDY**

Attended polysomnography performed in a sleep laboratory may be considered MEDICALLY NECESSARY as a diagnostic test in patients with:

A. Previous home study that was technically inadequate for a patient with signs/symptoms that indicate a high index of suspicion of obstructive sleep apnea (i.e., habitual snoring and/or observed apneas with excessive daytime sleepiness evidenced by an Epworth Sleepiness Scale score greater than 10 or sleepiness that interferes with daily activities and is not explained by other conditions);
   OR
B. Observed apneas during sleep;
   OR
C. Obesity hypoventilation syndrome;
   OR
D. Symptoms characteristic of narcolepsy;
   OR
E. Patient meets the following criteria:
   1. At least two of the following:
      a. Excessive daytime sleepiness evidenced by an Epworth Sleepiness Scale greater than 10 or sleepiness that interferes with daily activities and is not explained by other conditions
      b. Habitual snoring or gasping/choking episodes associated with awakening
      c. Documented systemic hypertension
      d. A body mass index greater than 35 kg/m^2
      e. Craniofacial or upper airway soft tissue abnormalities

   AND

   2. One or more of the following
      a. Moderate or severe congestive heart failure;
      b. Stroke/transient ischemic attack;
      c. Coronary artery disease or significant tachycardia or bradycardic arrhythmias;
      d. Pulmonary hypertension;
      e. Prior to scheduled bariatric surgery;
      f. Patient has evidence by history or physical examination of a health condition that might alter ventilation or require alternative treatment, including any of the following:
         - Central sleep apnea
         - Moderate to severe chronic pulmonary disease
         - Parasomnia
         - Periodic limb movements in sleep
         - Restless legs syndrome
         - Neuromuscular disease
         - Seizure disorder

- **POLYSOMNOGRAPHY – REPEAT STUDY**

A. Polysomnography may be considered MEDICALLY NECESSARY in patients who meet criteria for an in-laboratory PSG, when performed to initiate and titrate positive airway pressure (PAP) when:

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

1. Split-night PSG on the initial study did not allow for the resolution of the vast majority of obstructive respiratory events during positive airway pressure titration;
   AND
2. One of the following is present:
   a. AHI or RDI on initial PSG is 15 or greater;
   OR
   b. AHI or RDI on initial PSG is between 5 and 14 with any of the following associated symptoms:
      - Excessive daytime sleepiness
      - Documented hypertension
      - Ischemic heart disease
      - History of stroke

B. Subsequent attended PSG following a course of treatment may be considered MEDICALLY NECESSARY:
1. To assess efficacy of treatment (e.g., CPAP, oral appliances, surgery);
   OR
2. To re-evaluate the diagnosis of obstructive sleep apnea and need for continued CPAP. Examples include significant change in weight or change in symptoms suggesting that CPAP should be re-titrated or possibly discontinued;
   OR
3. Failure of resolution of symptoms or recurrence of symptoms during treatment.

- **MULTIPLE SLEEP LATENCY TESTING (MSLT)**

MSLT is considered MEDICALLY NECESSARY:

A. In patients:
1. With symptoms characteristic of narcolepsy including cataplexy, hypnagogic hallucinations and/or sleep paralysis when the individual being evaluated has excessive daytime sleepiness (e.g. Epworth Sleepiness Scale greater than 10) characterized by inappropriate daytime napping of greater than 3 months duration;
   AND
2. OSA has been ruled out after a PSG has been performed and interpreted;
   OR

B. OSA has been diagnosed and symptoms of narcolepsy persist despite adequate treatment with positive airway pressure therapy.

- **INVESTIGATIVE INDICATIONS**

The following are considered INVESTIGATIVE due to a lack of evidence demonstrating improved health outcomes.

A. Unattended sleep studies for all indications not listed in sections I and II including but not limited to the following:
1. Unattended portable sleep studies with a Type IV device or any device that does not record RDI/AHI and also simultaneously record oxygen saturation, heart rate and respiratory analysis.
2. Overnight pulse oximetry
3. Diagnostic audio recording to screen patients for sleep apnea

B. Abbreviated daytime sleep study (e.g. PAP-NAP) as a supplement to standard sleep studies

C. MSLT for all other indications not listed in section V including but not limited to the following:
1. Use of portable MSLT performed in the home setting
2. For initial evaluation and diagnosis of OSA
3. Assessing the effectiveness of therapy
4. Evaluation of patients who are suspected of having excessive sleepiness due to insomnia, circadian rhythm disorders, periodic limb movement disorder, medical disorders or neurologic disorders other than narcolepsy.

D. Maintenance of wakefulness testing (MWT) for evaluation, diagnosis or assessment of response to therapy for OSA

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- **Documentation Submission**

  Documentation supporting the medical necessity criteria described in the policy must be included in prior authorization requests, including the following:

  1. For initial unattended portable sleep studies, documentation of the following from the physician supervising the test:
     a. Signs/symptoms of sleep apnea; and
     b. Verification that there are no conditions present that would alter ventilation or require alternative treatment as described in policy statement;
  2. For repeat unattended portable sleep studies, documentation of indications for the repeat test included in policy statement IIB from the physician supervising the test
  3. For initial or repeat attended PSG, documentation supporting the medical necessity of the test as outlined in policy statements under III and IV
  4. For multiple sleep latency testing:
     a. Documentation of signs/symptoms of narcolepsy; AND
     b. Documentation that PSG has been performed and:
        - Interpretation indicates OSA has been ruled out; OR
        - Documentation of treatment duration with positive pressure airway therapy if symptoms persist in patients with OSA and suspected narcolepsy.

Abatacept (Orencia®)

- Abatacept may be considered MEDICALLY NECESSARY for treatment of the following:

  A. Rheumatoid Arthritis
     1. Intravenous or subcutaneous formulation as monotherapy or concomitantly with a non-biologic disease modifying antirheumatic drug (DMARD) when ALL of the following indications are met:
        a. Moderately to severely active rheumatoid arthritis in adults (e.g., swollen, tender joints with limited range of motion); and
        b. After consultation with a rheumatologist; and
        c. Failure, contraindication, or intolerance to at least one non-biologic disease modifying anti-rheumatic drug (DMARD); and
        d. Abatacept is not used in combination with another biologic DMARD;

     OR

     2. Moderately to severely active rheumatoid arthritis in adults when the patient has a history of beneficial response to abatacept.

  B. Polyarticular Juvenile Idiopathic Arthritis (JIA)
     1. Intravenous formulation as monotherapy or concomitantly with methotrexate when ALL of the following indications are met:
        a. Moderately to severely active polyarticular juvenile idiopathic arthritis (e.g., swollen, tender joints with limited range of motion); and
        b. Patient is six years of age or older; and
        c. After consultation with a rheumatologist; and
        d. Failure, contraindication, or intolerance to at least one non-biologic DMARD; and
        e. Abatacept is not used in combination with another biologic DMARD;

     OR

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2. Moderately to severely active polyarticular JIA when the patient has a history of beneficial response to abatacept.

- Abatacept is considered INVESTIGATIVE for all other indications, including but not limited to the following due to a lack of published clinical evidence establishing the role of abatacept in the treatment of these conditions.
  - A. Rheumatoid arthritis in patients under age 18
  - B. Juvenile idiopathic arthritis in patients under age 6
  - C. Concomitant administration of abatacept with a TNF antagonist
  - D. Ankylosing spondylitis
  - E. Behçet's disease
  - F. Crohn's disease
  - G. Giant cell arteritis
  - H. Graft versus host disease
  - I. Multiple sclerosis
  - J. Polymyalgia rheumatica
  - K. Psoriasis vulgaris
  - L. Psoriatic arthritis
  - M. Sarcoidosis
  - N. Scleroderma
  - O. Systemic lupus erythematosus
  - P. Systemic vasculitis (e.g., Wegener's granulomatosis and Takayasu's arteritis)
  - Q. Type I diabetes
  - R. Ulcerative colitis
  - S. Uveitis

Policies inactivated

None

There was no Medical and Behavioral Health Policy Activity for March 2015

Policies Effective: 06/15/15 Notification Posted: 04/23/15

Policies developed

Selected Treatments for Varicose Veins of the Lower Extremities

- **Endovenous Ablation**

A. Endovenous radiofrequency or laser ablation of the GSV or SSV may be considered MEDICALLY NECESSARY as a treatment of symptomatic varicose veins/venous insufficiency when ALL of the following criteria have been met:

1. Diameter of target vessel is 3.5 mm to no more than 15 mm;
   AND
2. Results of duplex ultrasound of the deep and superficial venous system performed while the patient is standing document reflux of 0.5 seconds or greater;
   AND

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3. Documentation of one or more of the following indications:
   a. Ulceration secondary to venous stasis that fails to respond to at least 3 months of compression therapy or recurrence of previously healed venous stasis ulcer despite ongoing use of compression therapy; OR
   b. Recurrent superficial thrombophlebitis that fails to respond to at least 3 months of compression therapy; OR
   c. Hemorrhage or recurrent bleeding episodes from a ruptured superficial varicosity; OR
   d. Symptoms characterized by severe, persistent pain, swelling, or heaviness and throbbing that interfere with activities of daily living (e.g. impaired mobility) after compression therapy for at least 3 months has not improved symptoms.

B. Endovenous radiofrequency or laser ablation of accessory saphenous veins may be considered MEDICALLY NECESSARY as a treatment of symptomatic varicose veins/venous insufficiency when ALL of the following criteria have been met:
   1. All the criteria in Section IA have been met;
      AND
   2. Incompetence of the accessory saphenous vein is isolated or the great or small saphenous veins have been previously eliminated.

C. Endovenous radiofrequency or laser ablation of perforator veins may be considered MEDICALLY NECESSARY as a treatment of leg ulcers associated with chronic venous insufficiency when:
   1. The incompetence of the perforator vein is isolated or the superficial veins (GSV, SSV, accessory or symptomatic varicose tributaries) have been previously eliminated;
      AND
   2. ALL of the following criteria are met:
      a. Diameter of target vessel is 3.5 mm to no more than 15 mm;
         AND
      b. Results of duplex ultrasound of the deep and superficial venous system performed while patient is standing documents perforator vein reflux of 0.5 seconds or greater;
         AND
      c. Ulceration secondary to venous stasis that fails to respond to at least 3 months of compression therapy;
         AND
      d. The venous insufficiency is not secondary to deep venous thromboembolism

- **Sclerotherapy**

Sclerotherapy may be considered MEDICALLY NECESSARY for initial or follow-up treatment of varicose tributaries, accessory or perforator veins when BOTH A and B are met:

A. Results of duplex ultrasound of the deep and superficial venous system performed while patient is standing documents ALL of the following:
   1. Venous diameter of target vessel is between 3 mm and 6 mm;
      AND
   2. Documented reflux of accessory or tributary veins of >0.5 seconds or at least 0.35 seconds if perforator veins are treated;
      AND
   3. Absence of reflux at the saphenofemoral and saphenopopliteal junctions or surgical ligation and division or endovenous ablation of a refluxing saphenofemoral and/or saphenopopliteal junction has been successfully performed.

B. Varicose veins with one or more of the following:
   1. A single significant hemorrhage from a ruptured superficial varicosity, especially if transfusion was required; OR

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2. More than one episode of minor hemorrhage from a ruptured superficial varicosity or after a single episode of hemorrhage if a varix remains in an area prone to trauma such as the pretibial area; OR
3. Venous ulcer (open or healed); OR
4. Two or more episodes of superficial symptomatic thrombophlebitis or persistent and symptomatic superficial thrombophlebitis that is unresponsive to conservative therapy including use of prescribed pressure gradient stockings of at least 3 months and NSAIDs if not contraindicated; OR
5. Symptoms characterized by severe, persistent pain, swelling or heaviness and throbbing that interfere with activities of daily living after conservative therapy including prescribed pressure gradient stockings for at least 3 months has not improved symptoms.

- **Transilluminated Powered Phlebectomy (TIPP)**

A. Transilluminated powered phlebectomy may be considered MEDICALLY NECESSARY for treatment of varicose accessory and tributary veins when performed the same time as surgical, radiofrequency or laser ablation of the great or small saphenous veins and ALL of the following are met:
1. Diameter of target vessel is 2.5 mm or greater;
AND
2. Results of duplex ultrasound of the deep and superficial venous system performed while the patient is standing document saphenous reflux of 0.5 seconds or greater;
AND
3. Documentation of one or more of the following indications:
a. Ulceration secondary to venous stasis that fails to respond to at least 3 months of compression therapy or recurrence of previously healed venous stasis ulcer despite ongoing use of compression therapy; OR
b. Recurrent superficial thrombophlebitis that fails to respond to at least 3 months of compression therapy; OR
c. Hemorrhage or recurrent bleeding episodes from a ruptured superficial varicosity; OR
d. Symptoms characterized by severe, persistent pain, swelling or heaviness and throbbing that interfere with activities of daily living (e.g. impaired mobility) after compression therapy for at least 3 months has not improved symptoms.

B. Transilluminated powered phlebectomy may be considered MEDICALLY NECESSARY when performed after the patient has undergone saphenous vein ablation, ligation or stripping and ALL of the following criteria are met:
1. Patient meets criteria in IIIA3 immediately above
AND
2. Duplex ultrasound confirms ablation of the saphenous vein or demonstrates no saphenous reflux;
AND
3. Reflux duration for the vein being treated must be greater than 0.5 seconds.

- The following are considered INVESTIGATIVE due to the lack of evidence on the effect on health outcomes:

A. Cyanoacrylate embolization
B. Endovenous radiofrequency or laser ablation of tributary veins
C. Endovenous cryoablation for all indications
D. Endovenous mechanochemical ablation
E. Sclerotherapy as the sole treatment of accessory or tributary veins without concurrent or prior successful treatment of saphenous veins
F. Sclerotherapy for treatment of veins < 3 mm or > 6 mm in diameter
G. Sclerotherapy for treatment of great or small saphenous veins
H. Sclerotherapy for treatment of veins in the presence of peripheral arterial disease
I. Transilluminated powered phlebectomy as sole treatment of great or small saphenous vein reflux

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J. Transilluminated powered phlebectomy treatment of perforator vein reflux

- Treatment of varicose veins of the lower extremities with any procedure is considered COSMETIC for the following:
  A. Treatment of symptomatic varicose veins not meeting the criteria in sections I-III above
  B. Treatment of asymptomatic varicose veins of the lower extremities
  C. Treatment of telangiectasias (e.g. spider veins, angiomata and hemangiomata)
- The following documentation may be requested:
  - Clinical history including duration and outcomes of conservative therapies;
  - Duplex ultrasound report demonstrating duration of reflux for the vein(s) being treated; and
  - High-resolution color photos documenting skin changes, dermatitis, and/or ulceration.

Policies revised

Islet Transplantation

- Autologous islet transplantation may be considered MEDICALLY NECESSARY as an adjunct to a total or near total pancreatectomy in patients with chronic pancreatitis.
- Allogeneic islet transplantation is considered INVESTIGATIVE for the treatment of type I diabetes due to lack of evidence demonstrating an impact on improved health outcomes.
- Autologous and allogeneic islet transplantation are considered INVESTIGATIVE for all other indications.

Wireless Capsule Endoscopy

- Wireless Wireless capsule endoscopy may be considered MEDICALLY NECESSARY for the following indications:
  A. Obscure gastrointestinal (GI) bleeding or iron deficiency anemia, suspected to be of small bowel origin, when evaluation by upper and lower endoscopies has been inconclusive;
  B. Initial diagnosis in patients with suspected Crohn's disease when conventional diagnostic tests (e.g., small bowel follow-through, lower endoscopy) have been inconclusive;
  C. Surveillance of the small bowel in patients with hereditary GI polyposis syndromes, including familial adenomatous polyposis and Peutz-Jeghers syndrome.
- The use of wireless capsule endoscopy is considered INVESTIGATIVE for all other indications, including, but not limited to:
  A. Initial diagnosis or follow-up of all other intestinal conditions (e.g., irritable bowel syndrome, celiac sprue, small bowel neoplasm, Lynch syndrome, portal hypertensive enteropathy, or unexplained chronic abdominal pain);
  B. Initial evaluation of acute upper GI bleeding;
  C. Evaluation of the extent of involvement of known Crohn's disease or ulcerative colitis;
  D. Evaluation of diseases involving the esophagus (e.g., chronic gastroesophageal reflux disease, Barrett's esophagus);
  E. Evaluation of the colon including, but not limited to, detection of colonic polyps or colon cancer.
- Use of the patency capsule prior to wireless capsule endoscopy is considered INVESTIGATIVE due to a lack of clinical evidence demonstrating its impact on improved health outcomes.

Transcranial Magnetic Stimulation

- Repetitive transcranial magnetic stimulation (rTMS) of the brain may be considered MEDICALLY NECESSARY as a treatment of major depressive disorder when all of the following (A-D) have been met:
  A. Confirmed diagnosis of severe major depressive disorder (single or recurrent) documented by standardized rating scales that reliably measure depressive symptoms (e.g., Hamilton Rating Scale for Depression or Montgomery-Asberg Depression Rating Scale).
  AND

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B. Any one of the following:
   1. Failure of 4 trials of psychopharmacologic agents including 2 different agent classes (e.g., selective serotonin reuptake inhibitors [SSRIs], serotonin–norepinephrine reuptake inhibitors [SNRIs], tricyclic antidepressants [TCAs] and two augmentation trials; OR
   2. Inability to tolerate a therapeutic dose of medication as evidenced by 4 trials of psychopharmacologic agents with distinct side effects; OR
   3. History of response to rTMS in a previous depressive episode (at least 3 months since the prior episode);

   AND

C. Ongoing active psychotherapy;

   AND

D. None of the following conditions are present:
   1. Seizure disorder or any history of seizure with increased risk of future seizure; OR
   2. Presence of acute or chronic psychotic symptoms or disorders (such as schizophrenia, schizophreniform or schizoaffective disorder) in the current depressive episode; OR
   3. Acute suicidal risk, catatonia or life-threatening inanition;
   4. Neurologic conditions that include epilepsy, cerebrovascular disease, dementia, increased intracranial pressure, having a history of repetitive or severe head trauma, or with primary or secondary tumors in the central nervous system (CNS); OR
   5. Presence of an implanted magnetic-sensitive medical device located 30 centimeters or less from the TMS magnetic coil or other implanted metal items, including but not limited to a cochlear implant, implanted cardioverter defibrillator (ICD), pacemaker, vagus nerve stimulator, or metal aneurysm clips or coils, staples, or stents.

- All other uses of TMS for treatment of the brain are considered INVESTIGATIVE including but not limited to the following. Evidence does not permit conclusion regarding effect on health outcome.

  A. Continued treatment with rTMS of the brain as maintenance therapy

  B. Treatment of all other psychiatric/neurologic disorders, including but not limited to bipolar disorder, schizophrenia, obsessive-compulsive disorder, or migraine headaches

Policies inactivated

Endoluminal Ablation for Treatment of Varicose Veins / Venous Insufficiency
Sclerotherapy for Varicose Veins of the Lower Extremities
Transilluminated Powered Phlebectomy for Treatment of Varicose Veins of the Lower Extremities

Policies reviewed with no changes in February 2015 – April 2015:

Advanced Therapies for Pharmacological Treatment of Pulmonary Hypertension

Allergy Testing and Treatment

Anesthesia Services for Gastrointestinal Endoscopic Procedures

Anesthesia-Assisted Opioid Withdrawal

Artificial Intervertebral Disc: Lumbar Spine

Automated Point-of-Care Nerve Conduction Tests

Balloon Catheter Therapy for Chronic Rhinosinusitis

Bone Growth Stimulators

Botulinum Toxin

BRAF Mutation Analysis

Cooling/Heating Devices Used in the Outpatient Setting

Cryoablation of Solid Tumors

Detection of Circulating Tumor Cells in the Management of Patients with Cancer

Dynesys Spinal System and Lumbar Dynamic Stabilization

Electrical Tumor Treatment Fields

Electrical/Electromagnetic Stimulation for Treatment of Arthritis

Gene Expression Testing for Cancers of Unknown Primary

Genetic Testing for FMR1 Mutations (Including Fragile X Syndrome)

Genetic Testing for Warfarin Dose

Growth Factors for Treatment of Wounds and Other Conditions

Hair Analysis

Hematopoietic Stem-Cell Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma

Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma

Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia

Hematopoietic Stem-Cell Transplantation for Miscellaneous Solid Tumors in Adults

Hematopoietic Stem-Cell Transplantation for Myelodysplastic Syndrome and Myeloproliferative Neoplasms

Hippotherapy

Immune Globulin Therapy

Implantable Cardioverter-Defibrillator

In Vitro Chemoresistance and Chemosensitivity Assays

Intra-Articular Hyaluronan Injections for Osteoarthritis

Intradiscal Electrothermal Annuloplasty (IDET), Percutaneous Radiofrequency Annuloplasty (PIRFT), and Intradiscal Biacuplasty

Intravenous Anesthetics for the Treatment of Chronic Pain

Laparoscopic and Percutaneous Techniques for the Myolysis of Uterine Fibroids

Metallothionein Protein (MT) Assessment and Treatment Protocol

Microwave Ablation of Solid Tumors

Mobile Cardiac Outpatient Telemetry

MRI-Guided High-Intensity Focused Ultrasound Ablation of Uterine Fibroids and other Tumors

Multigene Expression Assays for Predicting Recurrence in Colon Cancer

Occipital Nerve Stimulation

Oral Fentanyl for Cancer-Related Pain

Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Disorders in the Home

Photodynamic Therapy for Skin Conditions

Positron Emission Mammography

Pressure Reducing Support Surfaces

Prolotherapy

Proteomics-based testing Panels for the Evaluation of Ovarian (Adnexal) Masses

Proton Beam Radiation Therapy

Psychoanalysis

Quantitative Sensory Testing

Rhinoplasty

Saliva Hormone Tests

Scintimammography/Breast-Specific Gamma Imaging/Molecular Breast Imaging

Selected Treatments for Tinnitus

Spinal Fusion: Thoracic

Stem-Cell Therapy for Orthopedic Applications

Surface Electromyography (SEMG)

Traction Decompression of the Spine (VAX-D, Lordex, DRX9000)

Ventricular Assist Devices and Total Artificial Hearts

Wheelchairs

Provider Press is posted on our website quarterly for business office staff of multi-specialty clinics, physicians, public health agencies, DME providers, chiropractors, podiatrists, physical therapists, occupational therapists, optometrists and behavioral health professionals/providers. Direct inquiries to:

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Information in Provider Press is a general outline. Provider and member contracts determine benefits.

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