Provider Press

Provider information

Sept 2014 / Vol. 18, No. 3

BlueCross BlueShield Minnesota

BETTER CARE THROUGH QUALITY IMPROVEMENT

Every year, Blue Cross and Blue Shield of Minnesota (Blue Cross) reviews the care delivered to our subscribers. This review determines the goals for the quality program. The program currently has many goals to improve health services.

Making sure our subscribers receive preventive services and health screenings; making sure people with health problems, like heart disease, receive treatment; and improving the customer service experience are just a few of the goals in the program.

More detailed information is available about Blue Cross' process and outcomes in meeting quality improvement goals related to subscriber care and service. You can see more information about our quality improvement program at **bluecrossmn.com**. Enter "quality improvement program" in the search field. If you are unable to access the website please contact Eileen Johnson at **651-662-4224** to request information about the Quality Improvement Program.

UTILIZATION MANAGEMENT STATEMENT

Utilization management (UM) decision making is based only on appropriateness of care and service and on existing coverage provisions. Blue Cross does not compensate providers, practitioners or other individuals making UM decisions for denial of coverage or services. We do not offer incentives to decision makers to encourage denial of coverage or services that would result in less than appropriate care.

This statement is intended to inform and remind providers, practitioners, their employees and supervisors, upper management, medical directors, UM directors or managers, license UM staff and any other personnel who make UM decisions of this philosophy and practice.

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.	

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 June 2014 to August 2014 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
QP23-14	Communicating and Accessing Medical Policies
QP24-14	Preventive Care Coding Tips Brochure Now Available
QP25-14	Access to ProviderHub Is Changing
QP26-14	Clarification to Ambulatory Surgery Centers Pharmacotherapy and Chemotherapy Procedures and Services
QP27-14	Coding for Preventive Care Webinar Now Available
QP28-14	Risk Adjustment and Risk Adjustment Data Validation
QP29-14	Clarification to Expansion of Medical Policy Drug-related Prior Authorizations Bulletin
QP30-14	Reformatted Medical and Behavioral Health Policies
QP31-14	Community Paramedic Services for Minnesota Health Care Programs Subscribers
BULLETINS	**TITLE**
P13-14	Pre-certification/Pre-authorization Changes for Home Health Services for Commercial Subscribers
P14-14	Billing Chemical Dependency Room and Board Services for MHCP Subscribers
P15-14	Expansion of Medical Policy Drug-related Prior Authorizations
P16-14	July 2014 HCPCS code updates
P17-14	Pre-certification and Concurrent Review Changes for Medicare Skilled Nursing Facility Services for SecureBlue (MSHO) Subscribers
P18-14	Update to Attachment B: Definition of outpatient health services categories
P19-14	Discontinuation of the Advance Beneficiary Notices of Non-Coverage (ABN) Form
P20-14	Medical Necessity Criteria Update for MHCP Subscribers
P21-14	Upcoming Commercial Preventive Benefit Changes for 2014 and 2015
P22-14	Reminder: Chiropractic Services – Coding for Active/Corrective Treatment

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 June 2014 to August 2014. 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 2, Provider Agreements	Content change to Responsibilities of Participating Providers
Provider Policy and Procedure Manual	Chapter 3, Quality Improvement	Content change to Clinical Practice Guidelines
Provider Policy and Procedure Manual	Chapter 8, Claims Filing	Content change to Timely Filing
Provider Policy and Procedure Manual	Chapter 9, Reimbursement/ Reconciliation	Content changes to: • Payment Methodology • Reimbursement Reconciliation
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Chiropractic	Content change to Maintenance or Palliative Care
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Durable Medical Equipment (DME)	Added a new topic titled DME Rental for Public Programs
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Hospital and SNF Care	Content change to SNF Billing for Blue Plus Government Programs Products
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Laboratory	Deleted topic titled Genetic Testing Modifiers
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Pharmacy Services	Content change to Prior Authorizations
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Public Programs	Content change to Special Transportation
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Rehabilitative Services	Content change to Minnesota Health Care Programs (MHCP) Occupational Therapy, Physical Therapy, and Speech Therapy Authorization Process
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Surgical Services	Content change to Intra-Articular Hyaluronan Injections for Osteoarthritis
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Coding	Content changes to Preventive Care Services and a new topic titled Preventive Care Coding Tips
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Behavioral Health	Content change to MH-TCM Services to Minnesota Health Care Programs Eligibility of Dieticians/Nutritionists
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Medical Services	Content changes to: • Evaluation and Manangement (E/M) • Telephone Calls • Weight Management Care

2014 HOLIDAY SCHEDULE

Provider services will be closed on the following days in 2014:

Monday, September 1

Thursday, November 27

Friday, November 28

Thursday, December 25

Friday, December 26

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

UNITS REPORTING

Blue Cross follows the MN Uniform Companion Guides: (http://www.health.state.mn.us/auc/cg837pv8.pdf) for reporting units. The following is from Appendix A of the guide.

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.
- Report the number of units as the number of services performed for services with a measure in the description. For example, one unit equals: "per vertebral body;"
    - "each 30 minutes;"
    - "each specimen;"
    - "15 or more lesions;"
    - "initial."
- Follow all related AMA guidelines in CPT (e.g. "unit of service is the specimen" for pathology codes). Definition of "specimen": "A specimen is defined as tissue(s) that is (are) submitted for individual and separate attention, requiring individual examination and pathologic diagnosis."
- In the case of time as part of the code definition, more than half the time must be spent performing the service in order to report that code. Follow general rounding rules for reporting more than the code's time value. If the time spent results in more than one and one half times the defined value of the code and no additional time increment code exists, round up to the next whole number.
- Do not follow Medicare's rounding rules for speech, occupational, and physical therapy services. Each modality and unit(s) is reported separately by code definition. Do not combine codes to determine total time units.
- Anesthesia codes 00100-01999: 1 unit = 1 minute
- Decimals are accepted with codes that have a defined quantity in their description, such as supplies or drugs and biologicals. Units of service that are based on time are never reported with decimals.
- Drugs are billed in multiples of the dosage specified in the HCPCS Code.

SOFTWARE UPDATE

Our annual coding edit updates were implemented effective June 16, 2014. All claims submitted after the implementation date of this update, regardless of service date, will be processed according to the updated version.

Remember, we continue to review our past and present edits and will implement customizations as needed.

TRICK OR TREAT

The treat is that once again, in preparation for ICD-10, there are no new ICD-9-CM codes for October 1, 2014. The trick is wondering if more HCPCS codes will be issued effective October 1, 2014. CMS has released nine new codes and one revised code so far. We will be issuing a bulletin closer to October 1, 2014, with all coding additions and revisions before that effective date.

FYI

RISK ADJUSTMENT

Commercial Risk Adjustment is a piece of the Affordable Care Act (ACA) that provides a way to identify the difference in health care risk among patients which allows for a fair comparison between cost and quality of care across plans.

In accordance with the ACA, premiums are no longer tied to health history, rather subscribers now pay the same premium and are assigned a risk score based on their diagnoses. The risk score lets insurers know the overall health of their subscribers.

Inaccurate coding can undermine risk adjustment by misrepresenting the population of a plan, such as reflecting the subscriber is sicker or healthier than they actually are. This in turn provides inaccurate information about the amount of risk a health plan has. This is critical information that is utilized throughout the health plan to ensure that the subscriber is receiving the needed care for their conditions at affordable rates. It is in the patient as well as provider's best interest that diagnoses are coded correctly.

The implementation of risk adjustment allows insurers to shift their focus from levels of care, which vary greatly from visit to visit, to what is actually wrong (by ICD Code) with the patient. This information can drive analytics which predict future patient needs and plans for potential complications. In working together to improve our subscriber's risk scores, it is Blue Cross's belief that we can make a positive impact on our subscriber's health.

What is risk adjustment?

- Risk Adjustment is a facet of the Affordable Care Act that redistributes funds from plans with lower risk subscribers to plans with higher risk subscribers. It provides a way to identify a difference in risk among subscribers and plan population, which allows for a fair comparison between cost and quality of care.

Why is it important?

- Protects against adverse and risk selection by spreading the financial risk across the markets. A person can no longer be denied health care coverage in the individual and small group markets due to a pre-existing condition. Rather, all individuals that apply are gauranteed health care coverage at the same rate, because of this risk adjustment was created in order to balance the amount of risk a plan takes on.

How does this impact me as a provider?

- Accurate coding allows the health plans to represent their financial risk appropriately. This allows for the plan to continue to offer quality benefits at affordable rates.

CODING CORNER

THERE IS NO CCI EDIT

Yes, some of our coding edits are not supported by or found in CCI. However, we would like to remind you that we consider several sources when developing the edits we implement. As noted in the Blue Cross Provider Policy and Procedure Manual (PPPM), "The procedure code edits are based on CPT guidelines, a review of the Center for Medicare and Medicaid Services (CMS) Correct Coding Initiative policies and guidelines, specialty society guidelines, agreed upon industry practices and analysis by an extensive clinical consultant network. This automated review process is designed to apply the same industry criteria consistently across all professional claims." Additionally, our edits may reflect Blue Cross' Medical Coverage Guidelines, benefit plans and other Blue Cross policies.

Refer to Chapter 11, Coding section in the PPPM for additional edit information and guidance.

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 Minnesota 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

MEDICAL NECESSITY DECISIONS

All denial decisions are made by licensed, board-certified physician reviewers, licensed consulting psychologists, licensed chiropractors or other licensed peer reviewers as appropriate. Peer reviewers are available by telephone to discuss utilization review decisions based on medical necessity. To discuss a medical or behavioral health necessity decision with a physician or other reviewer, call the telephone number listed on the notification letter.

REVIEW UM CRITERIA

Blue Cross and Blue Plus utilization management (UM) programs use written utilization review criteria to make medical necessity determinations. Upon request, any Blue Cross or Blue Plus practitioner may review the clinical criteria used to evaluate an individual case. Medical and behavioral health policies are available for your use and review on the Blue Cross website at **providers.bluecrossmn.com.**

QUALITY IMPROVEMENT

CONTINUITY AND COORDINATION, KEYS TO EFFECTIVE CARE TRANSITIONS

It is well known across the industry that clear and useful communication is needed to help patients understand the care they receive and care they may need in the future. The health care system is complex and patients are often already struggling with stress and anxiety related to changes in health status by the time they seek care. This is especially true when patients need hospitalization. Today, patients likely leave the hospital with more self-care requirements and are expected to take a larger role in coordinating their own care.

There are ways that you can help your patients and support them through these difficult and often confusing transitions in care. The Minnesota RARE Campaign (Reducing Avoidable Readmissions Effectively) has many valuable resources related to improving communication and coordination at discharge. The campaign officially ended in June of 2014, but information is still available on their website www.rarereadmissions.org. The best practices listed below are pulled from an article focusing on comprehensive discharge planning.

Best Practices for Care Coordination at Discharge include:

- Work with patient and family using shared decision-making techniques to develop a comprehensive discharge care plan.
- Make sure discharge plan is easy-to-read; clear and straightforward, using plain language.
- Discharge plan needs to include the necessary information about care that was received and care that is recommended and is useful and relevant to both the patient and the entire care team working with the patient.
- Ensure that all care providers receive a copy of the discharge summary.
- Use the teach-back method to make sure that patient and/or caregiver understands and can act on discharge plan – medications, treatment, appointments, follow-up, etc.
- Make appointments for follow-up prior to patient leaving the hospital. Be sure to get their input regarding time and date.
- Review with the patient appropriate steps of what to do if a problem arises.

You may access the full article at: http://www.rarereadmissions.org/areas/compdischarge.html. Congratulations to all of you who have helped the RARE Campaign prevent nearly 8,000 readmissions representing a collective reduction in readmissions of 19 percent. Together we will help sustain these gains and foster continued improvement through our work together around continuity and coordination of care.

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 Blue Essentials (HMO-POS). 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: 07/21/14 Notification Posted: 05/29/14

Policies developed

Electrical Tumor Treatment Fields

- Pre-Certification/Pre-Authorization: Not applicable.
- The use of electrical tumor treatment fields (TTF) is considered INVESTIGATIVE for all indications including, but not limited to, treatment of glioblastoma multiforme, due to a lack of evidence demonstrating an impact on improved health outcomes.

Urine Drug Testing for Substance Abuse Treatment and Chronic Pain Management

- Pre-Certification/Pre-Authorization: No.
- Qualitative Urine Drug Testing

A. Qualitative urine drug testing for substance abuse treatment may be considered MEDICALLY NECESSARY under any of the following conditions:
   1. On initial entrance into a substance abuse treatment program when all of the following criteria are met:
      a. An adequate clinical assessment of patient history and risk of substance abuse is performed, including obtaining information from the state prescription drug monitoring program; AND
      b. Clinicians have knowledge of test interpretation; AND
      c. Clinical documentation specifies how the test result will be used to guide clinical decision making.
   2. During the stabilization phase of treatment no more frequently than once a week for a maximum of 4 weeks.
   3. During the maintenance phase of treatment no more frequently than once a month.

B. Qualitative urine drug testing for chronic pain management may be considered MEDICALLY NECESSARY under any of the following conditions:
   1. On initial entrance into a chronic pain management program when all of the following criteria are met:
      a. An adequate clinical assessment of patient history and risk of substance abuse is performed, including obtaining information from the state prescription drug monitoring program; AND
      b. Clinicians have knowledge of test interpretation; AND
      c. Clinical documentation specifies how the test result will be used to guide clinical decision making.
   2. During subsequent monitoring of treatment no more frequently than the following times according to the risk level of the individual, as determined by a validated screening tool for assessing the risk of aberrant drug-related behaviors (e.g., the Opioid Risk Tool [ORT] or the Screener and Opioid Assessment for Patients with Pain–Revised [SOAPP-R]):
      a. Twice a year for patients who are low or moderate risk;
      b. Four times a year for patients who are high risk OR receiving an opioid dose >120 mg MED/d;

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

c. At the time of the office visit for patients demonstrating aberrant behavior defined by one or more of the following:

i. Lost prescriptions;

ii. Requests for early refills;

iii. Obtained opioids from multiple providers;

iv. Unauthorized dose escalation;

v. Apparent intoxication.

C. Qualitative urine drug testing is considered NOT MEDICALLY NECESSARY in all other situations, including but not limited to routine testing and testing for non-medical purposes.

- Quantitative Urine Drug Testing

A. Quantitative urine drug testing for substance abuse treatment or chronic pain management may be considered MEDICALLY NECESSARY when ALL of the following criteria are met:

1. Qualitative urine drug testing was performed according to the medically necessary criteria described in section I;

AND

2. The result of qualitative urine drug testing was one or more of the following:

a. Positive for a non-prescribed drug with abuse potential; OR

b. Positive for an illicit drug (e.g., methamphetamine or cocaine); OR

c. Negative for prescribed medications;

AND

3. Clinical documentation specifies supporting rationale for each quantitative test ordered;

AND

4. Clinical documentation specifies how the test result will be used to guide clinical decision making.

B. Quantitative urine drug testing for substance abuse treatment or chronic pain management may be considered MEDICALLY NECESSARY when BOTH of the following criteria are met:

1. A qualitative test for the relevant drug(s) is not commercially available;
AND

2. The testing is performed according to the medically necessary criteria described in section I, with the exception that it is quantitative rather than qualitative testing.

C. Quantitative urine drug testing is considered NOT MEDICALLY NECESSARY in all other situations, including but not limited to routine testing and testing for non-medical purposes.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

Policies revised

Artificial Intervertebral Discs: Cervical Spine

- Pre-Certification/Pre-Authorization: No.
- Artificial intervertebral cervical discs may be considered MEDICALLY NECESSARY when ALL of the following criteria are met:

A. The device is approved by the U.S. Food and Drug Administration (FDA);
AND
B. Replacement is performed at one level from C3 to C7;
AND
C. Patient is skeletally mature;
AND
D. Patient has intractable radiculopathy and/or myelopathy due to herniated disc or osteophyte formation with ALL of the following:
1. Symptomatic nerve root and/or spinal cord compression documented by both of the following:
   a. Neck and/or arm pain;
   AND
   b. Functional and/or neurological deficit;

AND
2. Radiographic imaging (i.e., MRI or CT myelogram) demonstrates one or more of the following:
   a. Decreased disc height in comparison to a normal adjacent disc
   b. Degenerative spondylosis
   c. Disc herniation;

AND
3. Patient has failed at least six weeks of non-surgical therapy with at least two of the following:
   a. Active pain management program or protocol, under the direction of a physician, with pharmacotherapy that addresses neuropathic pain and other pain sources;
   OR
   b. Medical management with oral steroids and epidural steroid injections;
   OR
   c. Physical therapy.

OR
4. Patient has cervical nerve root compression verified by diagnostic imaging (i.e., MRI or CT myelogram) that results in severe pain (e.g., pain necessitating hospital admission for pain control) OR profound neuromotor or neurosensory deficit of the extremities AND ALL criteria for cervical disc arthroplasty except I.D.3 (six-week non-surgical therapy) are met.

- Artificial intervertebral cervical discs are considered INVESTIGATIVE for treatment of disorders of the cervical spine for all other indications including disc replacement in combination with cervical spinal fusion (whether performed concurrently or sequentially); or multi-level disc replacement There is a lack of clinical evidence demonstrating their impact on improved health outcomes.

Lung Cancer Screening Using Low-Dose Computed Tomography (LDCT)

- Pre-Certification/Pre-Authorization: No.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

- The use of low-dose computed tomography (LDCT) may be considered MEDICALLY NECESSARY as an annual screening technique for lung cancer in individuals who meet ALL of the following criteria:

  A. No signs or symptoms suggestive of underlying lung cancer; AND

  B. Age 55 - 80 years; AND

  C. History of cigarette smoking of at least 30 pack-years; AND

  D. If a former smoker, the individual has quit within the previous 15 years.

- The use of low-dose CT (LDCT) is considered INVESTIGATIVE as a screening technique for lung cancer in all other situations, due to a lack of evidence demonstrating an impact on improved health outcomes.

Cytochrome P450 Genotyping

- Pre-Certification/Pre-Authorization: No.
- Genotyping to determine cytochrome p450 (CYP450) genetic polymorphisms for the purpose of aiding in the choice of drug or dose to increase efficacy and/or avoid toxicity is considered INVESTIGATIVE due to the lack data on its impact on direct patient management and improved patient outcomes. This includes, but is not limited to the following applications:
  - Selection or dosing of selective serotonin reuptake inhibitor (SSRI) or tricyclic antidepressants:
  - Selection and dosing of selective norepinephrine reuptake inhibitors (e.g., atomoxetine HCL for treatment of attention-deficit/hyperactivity disorder)
  - Selection or dosing of antipsychotics drugs;
  - Aiding in the choice of clopidogrel versus alternative antiplatelet agents, or in determining the optimal dosing for clopidogrel;
  - Selection or dosing of beta blockers (e.g., metoprolol);
  - Selection or dosing of proton pump inhibitors in the treatment of H. pylori infection;
  - Management of treatment with tamoxifen in women at high risk for or with breast cancer;
  - Dosing and management of opioid analgesics (e.g., codeine, morphine sulfate, oxycodone hydrochloride) including deciding whether to prescribe codeine for nursing mothers;
  - Determining dose of efavirenz for treatment of HIV-1 infection;
  - Dosing and management of antituberculosis medications.

Cardiovascular Disease Risk Assessment and Management: Laboratory Evaluation of Non-Traditional Lipid and Nonlipid Biomarkers

- Pre-Certification/Pre-Authorization: Not applicable.
- Measurement of the following lipid or nonlipid biomarkers for risk assessment and/or management of cardiovascular disease is considered INVESTIGATIVE because these measurements have not been shown to provide clinical benefit beyond that provided by traditional lipid panels and therapies:

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

A. Low-density lipoprotein (LDL) particles (e.g., size or concentration);

B. Lipoprotein(a);

C. Apolipoprotein B;

D. Apolipoprotein E;

E. High-density lipoprotein (HDL) subclasses;

F. Lipoprotein-associated phospholipase A2 (Lp-PLA2);

G. Homocysteine;

H. B-type natriuretic peptide;

I. Cystatin C;

J. Fibrinogen;

K. Leptin.

Subcutaneous Hormone Pellets

- Pre-Certification/Pre-Authorization: No.
- Subcutaneous Administration of Testosterone

A. Use of the subcutaneous testosterone pellet Testopel™ may be considered MEDICALLY NECESSARY as replacement therapy in males for conditions associated with a deficiency or absence of endogenous testosterone when the following criteria are met:

1. Diagnosis of ONE of the following:

   a. Primary hypogonadism (congenital or acquired), OR

   b. Secondary hypogonadism (congenital or acquired), OR

   c. Delayed puberty

   AND

2. Oral, topical, and/or intramuscular testosterone replacement therapy have been tried and found to be ineffective or not tolerated.

B. Use of the subcutaneous testosterone pellet Testopel™ is considered NOT MEDICALLY NECESSARY for the treatment of male infertility, due to its adverse effect on sperm production and fertility.

C. Use of the subcutaneous testosterone pellet Testopel™ is considered INVESTIGATIVE for treatment of all other indications including, but not limited to symptoms associated with female menopause, due to lack of FDA approval of any other indications

D. The subcutaneous administration of formulations of testosterone other than Testopel™ is considered INVESTIGATIVE due to lack of FDA approval of any other products.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

- Subcutaneous Administration of Estrogen or Estrogen Combined with Testosterone
  Subcutaneous hormone pellets containing estrogen alone OR estrogen combined with testosterone (including bioidentical hormone formulations) are considered INVESTIGATIVE for all indications including, but not limited to, symptoms associated with female menopause because there are no FDA-approved formulations of these products.

Transilluminated Powered Phlebectomy for Treatment of Varicose Veins of the Lower Extremities

- Pre-Certification/Pre-Authorization: No.
- 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 the following criteria are met:

  A. Diameter of target vessel is 2.5 mm or greater; AND

  B. 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

  C. Documentation of one or more of the following indications:

     1. 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

     2. Recurrent superficial thrombophlebitis that fails to respond to at least 3 months of compression therapy; OR

     3. Hemorrhage or recurrent bleeding episodes from a ruptured superficial varicosity; OR

     4. 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.

- 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 are met:

  A. Patient meets criteria in section C above; AND

  B. Duplex ultrasound confirms ablation of the saphenous vein or demonstrates no saphenous reflux; AND

  C. Reflux duration for the vein being treated must be greater than 0.5 seconds.

- Transilluminated powered phlebectomy is considered INVESTIGATIVE for the following due to the lack of evidence on the effect on health outcomes:

  A. Sole treatment of great or small saphenous vein reflux;

  B. Treatment of perforator vein reflux.

- Transilluminated powered phlebectomy is considered COSMETIC for the following indications:

  A. Treatment of saphenous, accessory or tributary veins not meeting the criteria listed above;

  B. Treatment of asymptomatic varicose veins of the lower extremities;

  C. Treatment of telangiectasias (e.g. spider veins, angiomata and hemangiomata).

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Policies inactivated

Measurement of Lipoprotein-Associated Phospholipase A2 (Lp-PLA2) in Assessment of Cardiovascular Risk
Homocysteine Testing in Risk Assessment and Management of Cardiovascular Disease
Spider Veins/Dermal Telangiectasias
Genetic Testing for Helicobacter Pylori Treatment
Genetic Testing for Tamoxifen Treatment

Policies Effective: 08/18/14 Notification Posted: 06/26/14

Policies developed

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

- Pre-Certification/Pre-Authorization: No.
- 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. Karyotyping has been performed and results are non-diagnostic; AND

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

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

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

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

  F. 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

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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.

Policies revised

H.P. Acthar® Gel (Repository Corticotropin)

- Pre-Certification/Pre-Authorization: Yes.
- Intramuscular or subcutaneous injection of H.P. Acthar® Gel (repository corticotropin) may be considered MEDICALLY NECESSARY for patients who meet ALL of the following criteria:
  A. The patient does not have a contraindication to therapy (e.g., scleroderma, osteoporosis, systemic fungal infection, ocular herpes simplex, recent surgery, history or presence of a peptic ulcer, congestive heart failure, uncontrolled hypertension, sensitivity to proteins of porcine origin, concomitant use of live or live attenuated vaccines, suspected congenital infection in children under 2 years of age, primary adrenocortical insufficiency or adrenocortical hyperfunction).
  AND
  B. The patient has been diagnosed with ONE of the following conditions:
    1. Infantile spasms (West syndrome); AND
       a. The patient is under 2 years of age; AND
       b. The dose is within 150 IU/m^2 intramuscular in divided doses daily for 2 weeks, followed by a gradual taper (e.g., 30 IU/m^2 in the morning for 3 days, 15 IU/m^2 in the morning for 3 days, 10 IU/m^2 in the morning for 3 days, and 10 IU/m^2 every other morning for 6 days).
       Length of approval: 6 months
    OR
    2. Multiple sclerosis; AND
       a. The patient is an adult experiencing an acute exacerbation; AND
       b. The patient has failed an adequate trial of high-dose intravenous or oral corticosteroid therapy (e.g., 500-1000 mg intravenous or oral methylprednisolone daily for 3-7 days) within the last 30 days or has a contraindication to corticosteroid therapy; AND
       c. The patient is currently treated with a disease-modifying drug for multiple sclerosis (e.g., interferon beta-1b or glatiramer acetate) to control disease activity and progression; AND
       d. The dose is within 80-120 IU intramuscular or subcutaneous daily for 2-3 weeks.
       Length of approval: 1 month
- Intramuscular or subcutaneous injection of H.P. Acthar® Gel (repository corticotropin) is considered NOT MEDICALLY NECESSARY for diagnostic testing of adrenocortical function.
- Intramuscular or subcutaneous injection of H.P. Acthar® Gel (repository corticotropin) is considered INVESTIGATIVE for ALL other indications due to the lack of clinical evidence demonstrating effectiveness or an impact on improved health outcomes.

Organ Transplantation

- Pre-Certification/Pre-Authorization: Yes, except for kidney transplantation.
- The following organ transplant procedures may be considered MEDICALLY NECESSARY when the following criteria are met:
  A. Kidney

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1. Kidney transplantation (with either a living or cadaver donor) for carefully selected patients with end-stage renal disease who meet patient selection criteria established by the Organ Procurement and Transplantation Network (OPTN) and the United Network of Organ Sharing (UNOS)
2. Kidney retransplantation after a failed primary kidney transplant in patients who meet criteria for a kidney transplantation

B. Heart

1. Heart transplantation for carefully selected adult or pediatric patients with end-stage heart failure who meet patient selection criteria established by the Organ Procurement and Transplantation Network (OPTN) and the United Network of Organ Sharing (UNOS)
2. Heart retransplantation after a failed primary heart transplant in patients who meet criteria for heart transplantation

C. Heart/Lung

1. Heart/lung transplantation for carefully selected patients with end-stage cardiac and pulmonary disease who meet patient selection criteria established by the Organ Procurement and Transplantation Network (OPTN) and the United Network of Organ Sharing (UNOS)
2. Heart/lung retransplantation after a failed primary heart/lung transplantation in patients who meet criteria for heart/lung transplantation

D. Lung and Lobar Lung

1. Lung and lobar transplantation for carefully selected patients with irreversible, progressively disabling, end-stage pulmonary disease who meet patient selection criteria established by the Organ Procurement and Transplantation Network (OPTN) and the United Network of Organ Sharing (UNOS)
2. Lung or lobar lung retransplantation after a failed primary lung or lobar transplant in patients who meet criteria for lung transplantation

E. Small Bowel:

1. Small bowel transplantation for patients who meet the following criteria:
   a. Intestinal failure, characterized by loss of absorption and the inability to maintain protein-energy, fluid, electrolyte, or micronutrient balance; AND
   b. Established long-term dependency on total parenteral nutrition (TPN) and patient is developing or has developed severe complications due to TPN.
   Severe complications due to TPN include, but are not limited to: multiple and prolonged hospitalizations to treat TPN-related complications (especially repeated episodes of catheter-related sepsis) or the development of progressive liver failure. In the setting of progressive liver failure, small bowel transplant may be considered a technique to avoid end-stage liver failure related to chronic TPN, thus avoiding the necessity of a multivisceral transplant. In those receiving TPN, liver disease with jaundice (total bilirubin above 3 mg/dl) is often associated with development of irreversible progressive liver disease. The inability to maintain venous access and great vein damage are additional reasons to consider small bowel transplant in those who are dependent on TPN.
2. Small bowel retransplantation after a failed primary small bowel transplant in patients who meet criteria for small

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bowel transplantation

F. Small Bowel/Liver and Multivisceral

1. Small bowel/liver or multivisceral transplantation for patients who meet the following criteria:

   a. Intestinal failure characterized by loss of absorption and the inability to maintain protein-energy, fluid, electrolyte, or micronutrient balance; AND

   b. Established long-term dependency on total parenteral nutrition (TPN) and evidence of impending end-stage liver failure

2. Small bowel/liver retransplantation or multivisceral retransplantation after a failed primary small bowel/liver transplant or multivisceral transplant in patients who meet criteria for small bowel/liver or multivisceral transplantation

G. Allogeneic Pancreas

1. Combined pancreas-kidney transplantation in diabetic patients with end-stage renal disease;

2. Pancreas transplantation after a prior kidney transplantation in patients with insulin-dependent diabetes;

3. Pancreas transplantation alone in patients with severely disabling and potentially life-threatening complications due to hypoglycemia unawareness or labile diabetes that persists despite optimal medical management;

4. Pancreas retransplantation after a failed primary pancreas transplantation in patients who meet criteria for pancreas transplantation

H. Liver

1. Liver transplantation with either a cadaver or living donor, in carefully selected patients with end-stage liver failure due to irreversible damage to the liver. Conditions causing end-stage liver disease include, but are not limited to, the following:

   a. Hepatocellular disease

      - Alcoholic cirrhosis;
      - Viral hepatitis (A, B, C);
      - Autoimmune hepatitis;
      - Alpha-1 antitrypsin deficiency;
      - Hemochromatosis;
      - Non-alcoholic steatohepatitis (NASH);
      - Protoporphyria;
      - Wilson's disease

   b. Cholestatic liver disease

      - Primary biliary cirrhosis;

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- Primary sclerosing cholangitis with development of secondary biliary cirrhosis;
- Biliary atresia

c. Vascular disease
- Budd-Chiari syndrome

d. Primary hepatocellular carcinoma

e. Inborn errors of metabolism

f. Trauma and toxic reactions

g. Polycystic disease of the liver in patients who have massive hepatomegaly causing obstruction or functional impairment of other organs

h. Familial amyloid polyneuropathy

i. Unresectable hilar cholangiocarcinoma

j. Nonmetastatic hepatoblastoma in pediatric patients

2. Liver retransplantation in patients with the following indications:

a. Primary graft non-function

b. Hepatic artery thrombosis

c. Chronic rejection

d. Ischemic-type biliary lesions

e. Recurrent non-neoplastic disease causing late graft failure

- All other indications for organ transplantation are considered INVESTIGATIVE, due to a lack of evidence demonstrating an impact on improved health outcomes. Those indications include, but are not limited to:

A. Liver transplantation

1. Intrahepatic cholangiocarcinoma

2. Extrahepatic malignancy, other than unresectable hilar cholangiocarcinoma

3. Hepatocellular carcinoma extending beyond the liver

4. Neuroendocrine tumors metastatic to the liver

Genetic Testing for Hereditary Breast and/or Ovarian Cancer Syndrome (BRCA1 and BRCA2 Genes)

- Pre-Certification/Pre-Authorization: Yes.
- Genetic testing of BRCA1 and BRCA2 may be considered MEDICALLY NECESSARY for an individual with a personal history of breast cancer including invasive cancer or ductal carcinoma in situ who meets ANY of the following:

A. Diagnosed with breast cancer at age 45 or younger with or without family history of breast or other cancers

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B. Diagnosed with breast cancer at age 50 or younger with unknown or limited family history (e.g., fewer than two first-or second-degree female relatives or female relatives surviving beyond 45 years in either lineage, may have an underestimated probability of a familial mutation)

C. Diagnosed with breast cancer at age 60 or younger with breast cancer that is triple negative (estrogen receptor, progesterone receptor and HER2 negative).

D. Diagnosed with breast cancer at any age with one or more of the following:

1. Male gender
2. Primary tumors in both breasts or clearly defined multiple tumors in one breast when first breast cancer diagnosis occurred at or younger than age 50
3. One or more close blood relatives with breast cancer at or before age 50
4. One or more close blood relatives with ovarian, fallopian tube, or primary peritoneal cancer at any age
5. Two or more close blood relatives from the same side of the family with breast cancer at any age
6. Two or more close blood relatives from the same side of the family with pancreatic cancer at any age
7. Two or more close blood relatives from the same side of the family with prostate cancer (Gleason score of 7 or greater) at any age
8. Close male blood relative with breast cancer
9. Of an ethnicity associated with founder mutations with higher BRCA1 and/or BRCA2 mutation frequency (e.g., Ashkenazi Jewish, Icelandic, Swedish, Dutch, or Hungarian descent)

- Genetic testing of BRCA1 and BRCA2 may be considered MEDICALLY NECESSARY for an individual with a personal history of one or more of the following cancers:

A. Ovarian cancer

B. Fallopian tube cancer

C. Primary peritoneal cancer

D. Pancreatic cancer at any age with two or more close blood relatives from the same side of the family with one or more of the following cancers breast, ovarian, fallopian tube, primary peritoneal, pancreatic or prostate cancer (Gleason score of 7 or greater) at any age. If patient is of Ashkenazi Jewish ancestry, only one additional relative affected by these cancers is needed.

E. Prostate cancer (Gleason grade of 7 or greater) at any age with two or more close blood relatives from the same side of the family with breast, ovarian, fallopian tube, primary peritoneal, pancreatic or prostate cancer (Gleason score of 7 or greater) at any age. If patient is of Ashkenazi Jewish ancestry, only one additional relative affected by these cancers is needed.

- Genetic testing of BRCA1 and BRCA2 may be considered MEDICALLY NECESSARY in an individual 18 years of age or older with no personal history of cancers listed in section I or II above who has received pre-test genetic counseling as defined above, by a healthcare professional who has the appropriate genetics training and experience and is independent of the laboratory performing the test; AND who meets one or more of the following:

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A. Is a member of a family with a known deleterious BRCA1 and/or BRCA2 mutation in a close blood relative. Individuals who meet this criterion are candidates for BRCA single-site analysis;

OR

B. Patient has a reasonable likelihood of a mutation based on pre-test genetic counseling AND an appropriate affected family member is unavailable for testing (e.g., affected relative refuses testing or relative is deceased);

AND

1. A first-or second-degree blood relative meets any of the criteria in section I or II;

OR

2. A third-degree blood relative with breast cancer and/or ovarian, fallopian tube or primary peritoneal cancer with two or more close blood relatives from the same side of the family with breast cancer (at least one with breast cancer diagnosed at age 50 or younger); AND/OR two or more close blood relatives from the same side of the family with ovarian, fallopian tube or primary peritoneal cancer.

- Testing for rearrangements of the BRCA1 and BRCA2 genes may be considered MEDICALLY NECESSARY for individuals who:

A. Meet one or more of the criteria in sections I, II, or III for BRCA1 and/or BRCA2 testing;

AND

B. Have tested negative for mutations in BRCA1 and/or BRCA2 sequencing.

- BRCA1 and/or BRCA2 testing is considered INVESTIGATIVE for all other indications, including but not limited to the following due to a lack of clinical evidence demonstrating its impact on improved health outcomes:

A. Testing in individuals younger than age 18 without a personal history of cancers addressed in this policy;

B. Laboratory testing for mutations in BRCA1 and/or BRCA2 in the general population;

C. Genetic testing for hereditary breast and/or ovarian cancer syndrome using next generation sequencing panels.

- Documentation supporting the medical necessity criteria described in the policy must be included in the prior authorization. In addition, the following documentation must be submitted:

1. Diagnosis of individual with personal history of cancer (policy sections I and II);

OR

2. For a patient without a personal history of cancer (policy section III) verification of pre-test genetic counseling, as defined above, by a healthcare professional who has the appropriate genetics training and experience and is independent of the laboratory performing the test.

Spinal Fusion: Lumbar

- Pre-Certification/Pre-Authorization: Yes.
- Lumbar spinal fusion may be considered MEDICALLY NECESSARY for any of the following indications when confirmed by imaging studies (e.g., x-ray, CT, MRI):

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A. Epidural compression or vertebral destruction from a tumor;

B. Neural compression after spinal fracture;

C. Instability after debridement for infection;

D. Spinal infections (e.g., osteomyelitis, spinal tuberculosis);

E. Severe or rapidly progressive symptoms of motor loss, neurogenic claudication or cauda equina syndrome;

F. Idiopathic scoliosis when EITHER of the following criteria are met:

1. Scoliotic curve with a Cobb angle > 45 degrees in children who are skeletally immature; OR

2. Scoliotic curve with a Cobb angle > 50 degrees resulting in functional impairment in skeletally mature individuals;

G. Symptomatic pseudarthrosis.

- Lumbar spinal fusion, alone or in conjunction with a primary decompression surgery, may be considered MEDICALLY NECESSARY for treatment of degenerative conditions with spinal instability when ALL the following criteria are met:

A. ONE of the following conditions are present:

1. Post-laminectomy instability; OR

2. Degenerative scoliosis or kyphosis; OR

3. Spondylolisthesis, OR

4. Spinal stenosis with spondylolisthesis;

AND

B. Documented unremitting pain and disability refractory to intensive conservative therapy for three (3) months. Intensive conservative therapy must have occurred within the previous six (6) months AND must include ALL of the following:

1. An active, organized, and progressive strength and flexibility program;
NOTE: If a patient is unable to complete physical therapy (PT) due to progressively worsening pain and disability, the case will be reviewed on an individual basis by an internal physician reviewer (See Documentation Submission section); AND

2. A minimum of two sessions per week over the 3-month period; AND

3. Functional assessment, as measured by the Oswestry Disability Index (ODI), demonstrating ONE of the following:

a. Less than 30% improvement in the ODI score between the first and last physical therapy session; OR

b. Continued ODI score of greater than or equal to 40% at the conclusion of physical therapy

AND

4. An educational component that deals with patient expectations and perceptions, as well as the anatomic sources of back pain

AND

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C. Diagnostic imaging (e.g., x-ray, CT, MRI), obtained within the previous six (6) months, demonstrates spinal instability (> 3mm of translation and/or 10 degrees or more of angulation of one vertebra compared to the adjacent vertebra in a spinal motion segment).

- Lumbar spinal fusion in conjunction with a decompression surgery may be considered MEDICALLY NECESSARY in the treatment of certain degenerative conditions without existing instability when ALL the following criteria are met:

A. ONE of the following conditions are present:

1. Spinal stenosis; OR
2. Recurrent spinal stenosis at the same segment; OR
3. Recurrent disc herniation with failed laminectomy

AND

B. Documented unremitting pain and disability refractory to intensive conservative therapy for three (3) months. Intensive conservative therapy must have occurred within the previous six (6) months AND must include ALL of the following:

1. An active, organized, and progressive strength and flexibility program;
   NOTE: If a patient is unable to complete physical therapy (PT) due to progressively worsening pain and disability, the case will be reviewed on an individual basis by an internal physician reviewer (See Documentation Submission section);

   AND

2. A minimum of two sessions per week over the 3-month period; AND
3. Functional assessment, as measured by the Oswestry Disability Index (ODI), demonstrating ONE of the following:
   a. Less than 30% improvement in the ODI score between the first and last physical therapy session; OR
   b. Continued ODI score of greater than or equal to 40% at the conclusion of physical therapy

   AND

4. An educational component that deals with patient expectations and perceptions, as well as the anatomic sources of back pain

AND

C. Diagnostic imaging (e.g., CT, MRI), obtained within the previous six (6) months demonstrates spinal cord compression.

- Lumbar spinal fusion may be considered MEDICALLY NECESSARY for chronic (present for at least 6 – 12 months) discogenic back pain without instability when ALL the following criteria are met:

A. Documented unremitting pain and disability refractory to intensive conservative therapy for at least three (3) months. Intensive conservative therapy must have occurred within the previous six (6) months AND must include ALL of the following:

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1. Anti-inflammatory medication and analgesics, unless contraindicated; AND
2. Therapeutic injections; AND
3. An active, organized, and progressive strength and flexibility program
   NOTE: If a patient is unable to complete physical therapy (PT) due to progressively, worsening pain and disability, the case will be reviewed on an individual basis by an internal physician reviewer (See Documentation Submission section);

   AND
4. A minimum of two sessions per week over the 3-month period; AND
5. Functional assessment, as measured by the Oswestry Disability Index (ODI), demonstrating ONE of the following:
   a. Less than 30% improvement in the ODI score between the first and last physical therapy session; OR
   b. Continued ODI score of greater than or equal to 40% at the conclusion of physical therapy

   AND
6. An educational component that deals with patient expectations and perceptions, as well as the anatomic sources of back pain

   AND

B. Absence of untreated, underlying, contributory mental health conditions or psychosocial issues including, but not limited to, depression or drug or alcohol abuse;

   AND

C. Diagnostic imaging (e.g. MRI, CT), obtained within the previous six (6) months, demonstrates degenerative disc disease limited to 1 – 2 disc levels.

- Documentation supporting the medical necessity criteria described in the policy must be included in the prior authorization. In addition, the following documentation must also be submitted:

1. Written report describing findings from spinal diagnostic imaging studies.
2. Intensive conservative therapy:
   - Documentation from the physical therapist must include Oswestry Disability Index (ODI) scores
   - If a patient is unable to complete physical therapy (PT) due to progressively, worsening symptoms of pain and disability, the case will be reviewed on an individual basis by an internal physician reviewer. Documentation must be submitted from the physical therapist describing the patient's inability to complete PT.
3. For patients with chronic discogenic back pain without instability (policy section IV), documentation regarding the absence of untreated, underlying, contributory mental health conditions or psychosocial issues including, but not limited to, depression or drug or alcohol abuse must be submitted by the patient's primary care physician or a Mental Health Professional. The Mental Health Professional must meet the Minnesota Department of Human Services qualifications, as set forth in Minn.Stat. §245.462, subd. 18 (2013) and Minn.Stat. §245.4871, subd. 27 (2013).

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Treatment of Obstructive Sleep Apnea and Snoring in Adults

- Pre-Certification/Pre-Authorization: Yes, ONLY for surgical procedures.
- Medical Management

A. Oral appliances (e.g., mandibular advancing/positioning devices or tongue-retaining devices) may be considered MEDICALLY NECESSARY in patients with OSA confirmed by polysomnography.

B. Continuous positive airway pressure (CPAP) may be considered MEDICALLY NECESSARY in patients with confirmed OSA with:

1. An AHI of 15 or greater;

   OR

2. An AHI between 5 and 14 with any of the following associated symptoms:

   a. Excessive daytime sleepiness

   b. Impaired cognition

   c. Mood disorders

   d. Insomnia

   e. Documented hypertension

   f. Ischemic heart disease

   g. History of stroke

C. Bi-level Positive Airway Pressure (BiPAP) may be considered MEDICALLY NECESSARY in patients who:

1. Meet the criteria for CPAP; AND

2. Have failed a prior trial of CPAP; OR

3. For whom BiPAP is found to be more effective than CPAP in the sleep laboratory.

D. Auto-Adjusting PAP (APAP) may be considered MEDICALLY NECESSARY in patients who:

1. Meet the criteria for CPAP above; AND

2. Have a contraindication to CPAP, have failed a prior trial of CPAP OR are undergoing a trial of APAP to titrate CPAP;

   AND

3. Have no evidence by history or physical examination of the following conditions:

   a. Central sleep apnea

   b. Congestive heart failure

   c. Chronic pulmonary disease such as chronic obstructive pulmonary disease

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d. Pulmonary hypertension

e. Obesity hypoventilation syndrome or other condition which may cause nocturnal arterial oxyhemoglobin desaturation

E. Expiratory Positive Airway Pressure (EPAP) (ie, Provent®) is considered INVESTIGATIVE due to the lack of clinical evidence demonstrating its impact on improved health outcomes.

F. Oral pressure therapy devices, including but not limited to the Winx™ system, are considered INVESTIGATIVE due to the lack of clinical evidence demonstrating their impact on improved health outcomes.

G. Atrial pacing is considered INVESTIGATIVE in the treatment of obstructive sleep apnea due to the lack of clinical evidence demonstrating its impact on improved health outcomes.

- Surgical Management

A. Uvulopalatopharyngoplasty (UPPP) may be considered MEDICALLY NECESSARY when all the following criteria are met:

1. Presence of significant, unexplained cor pulmonale or cardiac arrhythmia resulting from documented OSA; OR

2. An AHI of 15 events per hour or greater; or an AHI between 5 and 14 with documented hypertension, ischemic heart disease, or history of stroke;

AND

a. BMI less than 40;

AND

b. Patient has not responded to or does not tolerate CPAP, BiPAP, or APAP following a minimum of 4 hours per night for three (3) months of PAP usage.

B. Maxillofacial surgical procedures, such as inferior sagittal mandibular osteotomy and genioglossal advancement with or without hyoid myotomy and suspension or mandibular-maxillary advancement (MMA) may be considered MEDICALLY NECESSARY when the following criteria are met:

1. Presence of significant, unexplained cor pulmonale or cardiac arrhythmia resulting from documented OSA;

OR

2. an AHI of 15 events per hour or greater; or an AHI between 5 and 14 with documented hypertension, ischemic heart disease, or history of stroke;

AND

a. Objective evidence of hypopharyngeal obstruction documented by either fiberoptic examination or cephalometric radiographs;

AND

b. Patient has not responded to or does not tolerate CPAP, BiPAP, or APAP following a minimum of 4 hours per night for three (3) months of PAP usage.

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C. All other surgical procedures are considered INVESTIGATIVE for the sole or adjunctive treatment of obstructive sleep apnea/upper airway resistance syndrome, including, but not limited to:

1. Uvulectomy
2. Laser-assisted uvulopalatoplasty (LAUP)
3. Radiofrequency volumetric reduction of the palatal tissues
4. Radiofrequency volumetric tissue reduction of the tongue, with or without radiofrequency reduction of the palatal tissues
5. Palatal stiffening procedures, including but not limited to, cautery-assisted palatal stiffening operation and the implantation of palatal implants
6. Tongue base suspension
7. Implantable hypoglossal nerve stimulators

- Treatment of snoring is considered NOT MEDICALLY NECESSARY because simple snoring in the absence of documented obstructive sleep apnea is not considered a medical condition. Therefore, all procedures for the sole or adjunctive treatment of snoring are considered NOT MEDICALLY NECESSARY, including but not limited to:

A. Uvulectomy

B. Laser-assisted uvulopalatoplasty (LAUP)

C. Radiofrequency volumetric reduction of the palatal tissues

D. Radiofrequency volumetric tissue reduction of the tongue, with or without radiofrequency reduction of the palatal tissues

E. Palatal stiffening procedures, including but not limited to, cautery-assisted palatal stiffening operation, and the implantation of palatal implants

F. Tongue base suspension

Epidermal Growth Factor Receptor (EGFR) Analysis for Non-Small Cell Lung Cancer

- Pre-Certification/Pre-Authorization: No.
- Except as noted below, analysis of two types of somatic mutations within the EGFR gene – small deletions in exon 19 and a point mutation in exon 21 (L858R) – may be considered MEDICALLY NECESSARY to predict treatment response to erlotinib or afatinib in patients with advanced NSCLC.
- Analysis of two types of somatic mutations within the EGFR gene – small deletions in exon19 and a point mutation in exon 21 (L858R) – is considered INVESTIGATIVE for patients with advanced NSCLC of squamous cell-type due to a lack of clinical evidence indicating the impact of these tests on improved health outcomes.
- Analysis for other mutations within exons 18-24, or other applications related to NSCLC, is considered INVESTIGATIVE due to a lack of clinical evidence indicating the impact of these tests on improved health outcomes.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

Policies inactivated

None

There was no Medical and Behavioral Health Policy Activity for July 2014.

Policies reviewed with no changes in May 2014 and June 2014:

Acupuncture

Bariatric Surgery

Belimumab

Cellular Immunotherapy for Prostate Cancer

Chelation Therapy

Compassionate Use

Computerized Dynamic Posturography

Continuous or Intermittent Glucose Monitoring in Interstitial Fluid

Cranial Electrotherapy Stimulation

Digital Breast Tomosynthesis

Electrocardiographic (ECG) Body Surface Mapping

Endoscopic Radiofrequency Ablation or Cryoablation for Barrett's Esophagus

Fecal Calprotectin Testing

Gene Therapy

Gene-based Tests for Screening, Detection, and/or Management of Prostate Cancer

Hematopoietic Stem Cell Transplantation for Primary Amyloidosis

Hematopoietic Stem-Cell Transplantation for Non-Hodgkin Lymphomas

Hematopoietic Stem-Cell Transplantation for Waldenstrom Macroglobulinemia

Hematopoietic Stem-Cell Transplantation in the Treatment of Germ-Cell Tumors

Image-Guided Minimally Invasive Lumbar Decompression for Spinal Stenosis

Ketamine for Treatment of All Mental Health and Substance-Related Disorders

Liposuction

Mastopexy

Microprocessor-Controlled Prostheses for the Lower Limb

Multianalyte Assays with Algorithmic Analyses for Assessing Risk of Type 2 Diabetes

Myoelectric Prostheses for the Upper Limb

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Percutaneous and Endoscopic Techniques for Disc Decompression

Peripheral Nerve Stimulation of the Trunk or Limbs for Treatment of Pain

Psychoanalysis

Respiratory Syncytial Virus Prophylaxis

Rhinomanometry and Acoustic/Optical Rhinometry

Sleep Studies / Polysomnograms in Children and Adolescents

Spinal Unloading Devices: Patient-Operated

Squeeze Machine for Autistic Spectrum Disorders

Stem-Cell Therapy for Peripheral Arterial Disease

Surgical Interruption of Pelvic Nerve Pathways for Treatment of Pelvic Pain (Primary and Secondary Dysmenorrhea)

Surgical Treatment of Femoroacetabular Impingement

Systems Pathology Testing for Predicting Risk of Recurrence in Prostate Cancer

Tobacco Cessation Treatments

Wireless Gastric Motility Monitoring

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

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Network Management R317
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