Provider Press

Provider information

June 2014 / Vol. 18, No. 2

BlueCross BlueShield Minnesota

ACCESS TO PROVIDERHUB IS CHANGING

The access on ProviderHub will be changing for our users to be compliant with HIPAA 5010. The eligibility functionality and the claims functionality will be transitioning completely to Availity on August 2, 2014. If you have not already registered with Availity, please do so at this time to be prepared for the access and functionality changes that will be happening on ProviderHub.

To register for access to the Availity Web Portal, go to **Availity.com** and click on the 'Get Started' button on the top left of the home page. Once you log into the secure portal, you'll have access to free live training, frequently asked questions, comprehensive help topics and other resources to help ensure you get the most out of your Availity experience.

PREADMISSION NOTIFICATION (PAN) FOR INPATIENT ADMISSIONS

The Blue Cross and Blue Shield of Minnesota (Blue Cross) Provider Policy and Procedure Manual requires that providers notify Blue Cross when subscribers require an inpatient admission. This notification can be entered in ProviderHub for Minnesota subscribers.

Subscribers receiving services in Minnesota that are covered by other Blue Cross plans may also have preadmission notification requirements. To obtain required PAN information for these subscribers go to **providers.bluecrossmn.com** and select Medical Policy and Pre-Certification/Authorization Router.

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

ProviderHub / 1
FYI / 1-3, 7, 9-10
Coding Corner / 4-5
Quality Improvement / 6, 8
Health Literacy / 11
Medical and Behavioral Health Policy Update / 12-36

FYI

PUBLICATIONS AVAILABLE ONLINE

The following is a list of Quick Points and Bulletins published from March 2014 to May 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
QP8-14	2014 Healthcare Effectiveness Data Information Set (HEDIS) Provider Notification
QP9-14	What's New on the Availity Web Portal?
QP10-14	2014 Adolescent and Adult Chemical Depenedency/Substance Abuse Treatment Clarification
QP11-14	Taft Hartley Third Party Administrators to begin EFT Provider Payments
QP12-14	Reminder of claims submission for Platinum Blue (Cost) plan
QP13-14	99214 and 99215 selection reminder
QP14-14	ICD-10 Delay: Impact to Network Providers
QP15-14	Better health for all mothers and their babies enrolled in MHCP after birth initiative- Birth notification for PMAP & MinnesotaCare
QP16-14	Provider cost data update
QP17-14	Adult Day Service Bath Legislative Changes
QP18-14	Verifying Eligibility for Minnesota Health Care Program Transportation Subscribers
QP19-14	Delay of Effective Date until June 1, 2014, for Expansion of Drug-related Prior Authorization Categories
QP20-14	Vulnerable Persons Mandated Reporting
QP21-14	Blue Plus Reward Program for PMAP and MinnesotaCare Subscribers
QP22-14	Update: Sequestration and impacts to processing of claims for services under Medicare programs
BULLETINS	**TITLE**
P3R1-14	Edit Clarification to post-operative pain block procedures
P4-14	Chiropractic Services – Coding for Active/Corrective Treatment and Prior Authorization Changes
P4R1-14	Update: Chiropractic Services – Coding for Active/Corrective Treatment, Prior Authorization Changes and Contract Renewals
P5-14	Expansion of Drugs-related Prior Authorization Categories and Services
P6-14	Women's preventive contraceptive benefit updates and claims reprocessing
P7-14	Pre-certification/Pre-authorization Changes for Home Health Services for Government Programs Subscribers
P8-14	Skilled Nursing Facility (SNF) Services – Pre-certification Changes for Subscribers with Commercial Groups
P9-14	Provider Service Agreement Renewal for 2014
P10-14	Home Health Provider Reimbursement
P11-14	Change to MHCP and MSC+ subscribers pre-certification requirements for lift chair and seat lift mechanism
P12-14	Minnesota Senior Health Options Model of Care Requirements

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 2014 to May 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 Required Notification
Provider Policy and Procedure Manual	Chapter 10, Appeals	Multiple content changes throughout
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines	Content change to Helpful Coding tips
Provider Policy and Procedure Manual	Chapter 11, Anesthesia	Content change to Epidural or Injection Anesthesia for Post-Operative Pain Management
Provider Policy and Procedure Manual	Chapter 11, Optometric/ Optical Services	Content change to Eyewear Billing and Reimbursement
Provider Policy and Procedure Manual	Chapter 11, Surgical	Content change to Knee Arthroplasty Pre-certification Review
Blue Plus	Chapter 3, Government Programs	Changes made to Timely Filing Exception description and Model of Care Section

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.

2014 HOLIDAY SCHEDULE

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

Friday, July 4

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

SOME GLOBAL PACKAGE REMINDERS

There are extensive guidelines and policies around billing surgical packages but we wanted to touch on what is included in the global package, split billing modifiers and the unrelated E/M modifier.

So what is included in the global package?
The global surgical package, also called global surgery, includes all necessary services normally furnished by a surgeon before, during, and after a procedure. Payment for the surgical procedure includes the pre-operative, intra-operative and post-operative services routinely performed by the surgeon or by members of the same group. Physicians in the same group practice must bill and be paid as though they were a single physician.

When the physician who furnishes the surgery also furnishes the following services, they are included in the global surgery payment:

- Pre-operative visits after the decision is made to operate. For major procedures, this includes pre-operative visits the day before the day of surgery. For minor procedures, this includes pre-operative visits the day of surgery;
- Intra-operative services that are normally a usual and necessary part of a surgical procedure;
- All additional medical or surgical services required of the surgeon during the post-operative period of the surgery because of complications, which do not require additional trips to the operating room;
- Follow-up visits during the post-operative period of the surgery that are related to recovery from the surgery;
- Post-surgical pain management by the surgeon;
- Supplies and miscellaneous services, such as dressing changes and related post-surgical care.

Some split-billing modifier reminders
More than one physician may furnish services included in the global surgical package. When splitting the global package, for instance, when the surgeon furnishes only the surgery and a physician other than the surgeon furnishes pre-operative and post-operative inpatient care. Modifiers are key to communicating what part of the surgical package was performed so appropriate payment is applied.

First, split global-care billing does not apply to procedure codes with a zero day post-operative period. For 10 and 90 day post-op procedures, where physicians agree on the transfer of care during the global period, services will be distinguished by the use of the appropriate modifier:

continued to page 5

CODING CORNER

SOME GLOBAL PACKAGE REMINDERS continued from page 4

- Surgical care only (modifier "-54"); or
- Post-operative management only (modifier "-55").

For global surgery services billed with modifiers "-54" or "-55," the same CPT code must be billed. The same date of service and surgical procedure code should be reported on the bill for the surgical care only and post-operative care only. The date of service is the date the surgical procedure was furnished. Physicians must keep copies of the written transfer agreement in the beneficiary's medical record.

- Modifier "-54" indicates that the surgeon is relinquishing all or part of the post-operative care to a physician.
- The physician, other than the surgeon, who furnishes post-operative management services, bills with modifier "-55."

Modifiers "-54" and "-55" do not apply to assistant-at-surgery services or to an Ambulatory Surgical Center (ASC's) facility fees.

And reporting unrelated E/M Service during the post-operative period
Another important modifier is "-24" (Unrelated E/M service by the same physician during a post-operative period). The physician may need to indicate that an E/M service was furnished during the post-operative period of an unrelated visit or procedure. An E/M service billed with modifier "-24" must be supported by documentation that the service is not related to the post-operative care of the procedure.

THE CODES KEEP ON COMING

Several HCPCS codes revisions and additions have already been published by the Centers for Medicare and Medicaid Services (CMS) with more anticipated.

The effective date for both code sets will be July 1, 2014, and all revised and added codes will be recognized and accepted by this date. A bulletin will be issued before the effective date with details, along with the new and revised HCPCS codes.

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

CLINICAL PRACTICE GUIDELINES

Updated Clinical Practice Guidelines are now available in Chapter Three of the Blue Cross Provider Policy and Procedure Manual. To access the manual go to **providers.bluecrossmn.com.**

Blue Cross' updated Clinical Practice Guidelines cover the full range of medical services:

- Prevention and Screening
- Prenatal Care
- Behavioral Health
- Medical Health

continued to page 8

FYI

PREVENTIVE CARE

Blue Cross recognizes the importance of preventive care for our subscribers. The preventive care you provide helps people stay healthy, avoids the onset of disease, and reduces healthcare costs. Our goal is to ensure our subscribers are receiving appropriate preventive care. To further that goal, Blue Cross would like to clarify information around the cost of preventive care and inform you of a new subscriber rewards program.

Most Blue Cross plans cover preventive services such as well child checks, adult preventive visits, annual wellness visits, immunizations and certain screening tests with no out-of-pocket costs to the subscribers. Subscribers in those plans will not incur a cost for many preventive services if they use an in-network provider, and if the provider does not bill an additional problem-based office visit code. Because there is often confusion about appropriate coding for preventive care, Blue Cross put together a brochure with tips to help providers navigate this area.

The preventive care coding brochure is available at **providers.bluecrossmn.com** under tools and resources.

A small percent of self-insured and fully insured commercial plans were not required to cover all preventive services mandated by the Affordable Care Act. Subscribers should be encouraged to call the customer service number on the back of their insurance cards in order to understand exactly what their plan covers.

Blue Cross is also excited to announce a new Member Rewards Program. Starting in May, 2014, Blue Advantage Prepaid Medical Assistance Program (PMAP) and Minnesota Care subscribers of Blue Plus can earn reward cards for receiving preventive care. Rewards are available for several preventive services, including childhood immunizations, prenatal care, postpartum care, cervical cancer screening and diabetic eye exams. To earn a reward, eligible subscribers must complete the applicable voucher (including obtaining the appropriate provider's signature) and send it into Blue Cross by December 31, 2014. The incentives range from $25 to $75. New subscribers will receive the voucher packet in their Blue Cross Welcome Packet. Subscribers can also download and print vouchers at **bluecrossmn.com/rewardcards.**

QUALITY IMPROVEMENT

RESULTS FROM 2013 COORDINATION OF CARE PROVIDER SURVEY

Blue Cross recognizes the importance of coordination of care between medical professionals as a way to provide a seamless and positive experience for our subscribers as well as ensuring that care is delivered at the right time, in the right place and at the right amount. Blue Cross annually reviews efforts related to improving coordination and continuity of medical care.

Survey content was designed by a Blue Cross team representing Medical Affairs, Provider Quality and Market Research incorporating feedback obtained during qualitative analysis. Representatives from the Provider Quality Advisory Group and the Behavioral Health Quality Advisory Group were provided an electronic link to the survey and asked to distribute the link to 10-15 members of their organization, creating a convenience sample of 85 respondents from a variety of specialties.

The new survey focused on key care transitions and handoffs between primary care, specialty care, inpatient care, emergency department, behavioral health care and retail care settings.

Listed below are some key findings from the survey results:

- Only 15% of respondents reported being "very satisfied" with the overall continuity and coordination of care for their patients.
- Four hand-off points had less than 70% overall satisfaction
- Emergency department to primary care represented one of the lowest scoring hand-off points
- Only 1% of respondents reported "always" receiving communication from walk-in/retail care, while 44% reported either "rarely" or "never" receiving communication.
- In addition to being received less often, respondents also rated information they do receive from walk-in or retail care as least effective, with only 5% rating communication as "very effective".

Based on the results from the 2013 provider survey, key opportunities for improving continuity and coordination of medical care will be as follows:

1. to continue to support improvement in overall coordination
2. gather qualitative data related to lowest scoring hand-offs
3. facilitate dialogue around best practices for key care hand-offs
4. increase sample size for 2014 provider survey

Coordination and continuity of care is critical to achieving improved health outcomes, reduction of unnecessary procedures and improved member experience of care received.

CLINICAL PRACTICE GUIDELINES

continued from page 6

Blue Cross believes that the use of clinical practice guidelines is a key component of Quality Improvement. Each year, Blue Cross' Clinical Practice Quality Committee (a designee of the Quality Council) approves the adoption of select guidelines that are used to support various programs and initiatives.

The guidelines do not substitute for sound clinical judgment; however, they are intended to assist clinicians in understanding key processes for improvement efforts.

Please note that some treatment and management options recommended in clinical practice guidelines may not be covered benefits under a Blue Cross and Blue Shield of Minnesota and Blue Plus Subscriber's health plan.

FYI

WOMEN'S PREVENTIVE CONTRACEPTIVE BENEFIT UPDATES AND CLAIMS REPROCESSING

The Affordable Care Act requires coverage of certain preventive services with no cost to the member at the in-network level, including certain contraceptive medications, devices and services for women as prescribed (referred to in this document as "preventive contraceptive benefits").* The coverage requirements for preventive contraceptive benefits apply to Blue Cross and Blue Shield of Minnesota (Blue Cross) commercial market non- grandfathered plans and certain other plans that adopted the benefit.

Blue Cross has updated its preventive contraceptive benefits to align with new guidance. For more information about what is covered under this benefit, see the document entitled **"Health Care Reform: Women's Preventive Contraceptive Benefits,"** available at: **www.bluecrossmn.com**.

This coverage is effective for plans or policy years and renewals beginning on their effective date that is on or after August 1, 2012. Blue Cross will reprocess affected medical claims and, for members with Prime Therapeutics as their pharmacy benefits manager, Prime Therapeutics will adjust affected pharmacy claims.** As a result of the claims reprocessing/adjustments, refunds will be issued as appropriate.

Who is affected?

This change may impact female members with individual, non-grandfathered commercial coverage or those who have coverage through an affected commercial group, whether fully- or self-insured. However, some groups, including without limitation, groups who use a pharmacy benefit manager other than Prime Therapeutics, may have a different set of preventive contraceptive pharmacy benefits than discussed here.

Certain organizations, including religious employers, temporary safe harbor and eligible organizations, may be exempt or eligible for accommodation from the requirement to cover preventive contraceptive benefits.

Important note: Some services and devices are only covered under the medical benefit, while others may be covered under either the medical or pharmacy benefit, as noted in the document entitled "Women's Preventive Contraceptive Benefits," available at: **www.bluecrossmn.com**. Items indicated as over-the-counter (OTC), pharmacy, or pharmacy only are only eligible for coverage when a member has a prescription and the item is purchased in-network at the pharmacy or pharmacy counter and the pharmacy benefit card is presented. Members and providers are not eligible for reimbursement of OTC, pharmacy, or pharmacy only items submitted with claim forms or receipts.

continued on page 10

FYI

WOMEN'S PREVENTIVE CONTRACEPTIVE BENEFIT UPDATES AND CLAIMS REPROCESSING continued from page 9

To be eligible for payment as a preventive contraceptive benefit, a medical contraceptive type/method must have been submitted and coded correctly by a provider appropriately credentialed to perform the service.

How will members be refunded for medical claims?

- ❑ Blue Cross will be reprocessing impacted medical claims between August 1, 2012 and December 31, 2013.
- ❑ Blue Cross is working on a process and plan for refunding members for impacted medical claims.

How will members be refunded for pharmacy claims?

- ❑ Pharmacy claims will be reviewed and adjusted as necessary, and refunds will be issued as appropriate.
- ❑ For OTC pharmacy methods, a record of a prescription must exist to be eligible for a refund.

Questions?

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

*Certain religious employers and eligible organizations may be, respectively, exempt or eligible for accommodation from the requirement to cover these contraceptive benefits. Women enrolled through eligible organizations may have a separate ID card for preventive contraceptive benefits. Individual policy holders may not claim exemption.

**Prime Therapeutics LLC is an independent company providing pharmacy benefit management services.

HEALTH LITERACY

FEDERAL POLICY EFFORTS RELATED TO HEALTH LITERACY

Today the health industry is changing faster than ever before. Policymakers are looking for ways to expand insurance coverage, improve care, and control costs. Leaders across the nation recognize that a key element to reaching these goals will be to adopt programs and activities that help organizations become more adept in health literacy best practices.

Plain Writing Act of 2010

This legislation requires all federal government agencies, including all health agencies, to use "plain writing" guidelines in both print and electronic documents. The purpose is to improve the effectiveness of agencies and provide communication that the "public can understand and use".

Healthy People 2020

The first goal listed under the Health Communication and Health Information Technology section of Healthy People 2020, is "to improve the health literacy of the population". Measurement focuses on increasing the proportion of persons who report the following:

- their health care provider always gave them easy-to-understand instructions about what to do to take care of their illness or health condition
- their health care provider always asked them to describe how they will follow the instructions
- their health care providers' office always offered help in filling out a form

Affordable Care Act (ACA)

There are four explicit references to health literacy in the law. The provisions are represented in issues relating to research dissemination, shared decision-making, medication labeling and workforce development. They support the importance of and need for effective and clear communication between health professionals at all levels, patients and the public.

To learn more about building a culture of health literacy and using plain language at your practice, please send an email to **Alisha_Ellwood@bluecrossmn.com**

To access more information on the Federal policy efforts listed above, click on the links below.

Plain Writing Act of 2010

Healthy People 2020

Health literacy Implications of the ACA

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: 04/21/14 Notification Posted: 02/27/14

Policies developed

None

Policies revised

Spinal Fusion: Thoracic

- Pre-Certification/Pre-Authorization: Yes, for Government Programs products ONLY: Secure Blue, Blue Advantage (PMAP), Blue Plus (MNCare), Blue Advantage (MSC+).
- Thoracic spinal fusion may be considered MEDICALLY NECESSARY for ANY of the following indications:

A. Acute traumatic spinal injury resulting in thoracic spinal instability; OR

B. Osteomyelitis resulting in vertebral body destruction; OR

C. Primary or metastatic bone tumor resulting in fracture instability or spinal cord compression; OR

D. Thoracic nerve root compression verified by diagnostic imaging (i.e., MRI or CT myelogram) and resulting in severe pain (e.g., pain necessitating hospital admission for pain control) OR profound weakness of the extremities; OR

E. Symptomatic pseudarthrosis; OR

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;

OR

G. Severe kyphosis when EITHER of the following criteria are met:

1. Thoracic spondylosis with kyphosis, resulting in spinal cord compression; OR

2. Kyphotic curve > 75 degrees that has either progressed over time OR is refractory to bracing;

OR

H. Spondylotic radiculopathy when BOTH of the following criteria are met:

1. Persistent or progressive radicular pain or weakness secondary to nerve root compression despite eight (8) weeks of conservative therapy with at least two (2) of the following, within the last six (6) months:

a. Active pain management program or protocol, under the direction of a physician, with pharmacotherapy that addresses neuropathic pain and other pain sources (e.g., a prescription oral analgesic [preferably anti-inflammatory], muscle relaxant, or tricyclic anti-depressant medication); OR

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

b. Medical management with oral steroids and epidural steroid injections; OR

c. Physical therapy

AND

2. Diagnostic imaging (i.e., MRI or CT myelogram), performed within the last year, demonstrates thoracic nerve root compression

OR

I. Spondylotic myelopathy when BOTH of the following criteria are met:

1. Clinical signs and/or symptoms of myelopathy, as demonstrated by at least ONE of the following:

a. Upper and/or lower extremity weakness, numbness, or pain; OR

b. Bladder or bowel incontinence; OR

c. Increased tone or spasticity; OR

d. Gait abnormalities consistent with thoracic myelopathy OR

e. Over active or overresponsive reflexes; OR

f. Hoffman's sign; OR

g. Positive Babinski sign; OR

h. Hand incoordination or clumsiness

AND

2. Diagnostic imaging (i.e., MRI or CT myelogram), performed within the last year, demonstrates spinal cord compression.

Advanced Therapies for Pharmacological Treatment of Pulmonary Hypertension

- Pre-Certification/Pre-Authorization: Yes, ONLY for Sildenafil (Revatio®) and Tadalafil (Adcirca™).
- Advanced Therapies for Pharmacological Treatment of Pulmonary Arterial Hypertension (PAH; WHO Group 1)

A. Advanced therapies for PAH may be considered MEDICALLY NECESSARY for patients who meet ALL of the following criteria:

1. Mean pulmonary artery pressure greater than 25 mm Hg; AND

2. Pulmonary capillary wedge pressure, left atrial pressure, or left ventricular end-diastolic pressure less than or equal to 15 mm Hg; AND

3. Pulmonary vascular resistance greater than 3 Wood units; AND

4. Confirmation of PAH by complete right heart catheterization; AND

5. Exclusion of significant chronic hypoxemic lung disease or chronic thromboembolic disease; AND

6. A negative response to acute pulmonary vasodilator testing OR a contraindication to calcium-channel antagonists.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

B. The following advanced therapies for PAH may be considered MEDICALLY NECESSARY when used as monotherapy for patients diagnosed with PAH (as described in section A above):

1. Epoprostenol (Flolan® or Veletri®) continuous intravenous infusion;
2. Treprostinil (Remodulin®) continuous subcutaneous or intravenous infusion;
3. Treprostinil (Tyvaso®) inhalation via nebulizer;
4. Treprostinil (Orenitram™) extended-release oral;
5. Iloprost (Ventavis®) inhalation via nebulizer;
6. Bosentan (Tracleer®) oral;
7. Ambrisentan (Letairis®) oral;
8. Macitentan (Opsumit®) oral;
9. Sildenafil (Revatio®) oral;
10. Tadalafil (Adcirca®) oral;
11. Riociguat (Adempas®) oral.

C. Combination therapy (i.e., two or more advanced therapies) for PAH may be considered MEDICALLY NECESSARY when ALL of the following conditions are met:

1. The patient has failed to demonstrate an adequate response to monotherapy; AND
2. Drugs are from different therapeutic classes, excluding the combination of a soluble guanylate cyclase inhibitor (e.g., riociguat [Adempas®]) and a phosphodiesterase type 5 inhibitor (e.g., sildenafil [Revatio®] or tadalafil [Adcirca®]), which are contraindicated as combined treatment; AND
3. Each drug may be considered medically necessary for the treatment of PAH (as described in section B above).

D. Combination therapy (i.e., two or more advanced therapies) for PAH is considered INVESTIGATIVE as first-line treatment.

- Advanced Therapies for Pharmacological Treatment of Non-PAH Pulmonary Hypertension (PH; WHO Groups 2-5)

A. The use of riociguat may be considered MEDICALLY NECESSARY for the treatment of chronic thromboembolic pulmonary hypertension (CTEPH; WHO Group 4) in patients with either of the following conditions:

1. Persistent or recurrent pulmonary hypertension after surgical thrombectomy; OR
2. Inoperable CTEPH.

B. The use of riociguat is considered INVESTIGATIVE for the treatment of all other non-PAH pulmonary hypertension conditions, including but not limited to:

1. Pulmonary hypertension associated with left heart diseases (WHO Group 2);
2. Pulmonary hypertension associated with lung diseases and/or hypoxemia (including chronic obstructive pulmonary disease) (WHO Group 3);

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

3. Miscellaneous conditions (i.e., sarcoidosis, histocytosis X and lymphangiomatosis) (WHO Group 5)

C. The use of epoprostenol, treprostinil, iloprost, bosentan, ambrisentan, macitentan, sildenafil, or tadalafil is considered INVESTIGATIVE for the treatment of non-PAH pulmonary hypertension conditions, including but not limited to:

1. Pulmonary hypertension associated with left heart diseases (WHO Group 2);

2. Pulmonary hypertension associated with lung diseases and/or hypoxemia (including chronic obstructive pulmonary disease) (WHO Group 3);

3. Pulmonary hypertension due to chronic thrombotic and/or embolic disease (WHO Group 4);

4. Miscellaneous conditions (i.e., sarcoidosis, histocytosis X and lymphangiomatosis) (WHO Group 5)

- Other Advanced Therapies

The use of tadalafil 10 mg (Cialis®) and vardenafil 10 mg (Levitra®) is considered INVESTIGATIVE for the treatment of PAH (WHO Group 1) and non-PAH pulmonary hypertension (WHO Groups 2-5).

Hematopoietic Stem-Cell Transplantation for Multiple Myeloma and POEMS Syndrome

- Pre-Certification/Pre-Authorization: Yes.
- Hematopoietic Stem-Cell Transplantation (HSCT) for Multiple Myeloma

A. Autologous HSCT (i.e., single, tandem, or second [salvage]) may be considered MEDICALLY NECESSARY to treat multiple myeloma.

B. Tandem transplantation with an initial round of autologous HSCT followed by allogeneic HSCT using a reduced-intensity conditioning (RIC) regimen may be considered MEDICALLY NECESSARY to treat newly diagnosed multiple myeloma patients.

C. Allogeneic HSCT, myeloablative or nonmyeloablative, as upfront therapy of newly diagnosed multiple myeloma or as salvage therapy, is considered INVESTIGATIVE.

- Hematopoietic Stem-Cell Transplantation (HSCT) for POEMS Syndrome

A. Autologous HSCT (single transplant) may be considered MEDICALLY NECESSARY to treat disseminated POEMS syndrome (i.e., disseminated bone marrow involvement or diffuse sclerotic bone lesions).

B. Tandem autologous HSCT is considered INVESTIGATIVE in the treatment of POEMS syndrome.

C. Allogeneic HSCT (i.e., myeloablative and nonmyeloablative) is considered INVESTIGATIVE in the treatment of POEMS syndrome.

Intra-Articular Hyaluronan Injections for Osteoarthritis

- Pre-Certification/Pre-Authorization: No.
- Intra-articular hyaluronan injections may be considered MEDICALLY NECESSARY for the treatment of painful osteoarthritis of the knee in patients who meet all of the following criteria:

A. There is documentation of a diagnosis of osteoarthritis of the knee supported by radiologic evidence including one or more of the following:

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

1. Joint space narrowing,
2. Subchondral sclerosis,
3. Osteophytes and sub-chondral cysts;

AND

B. There is documentation that pain due to osteoarthritis of the knee interferes with functional activities (e.g., walking, prolonged standing);

AND

C. Pain has persisted despite use of BOTH of the following within the previous 6 months:

1. Medical management with acetaminophen, nonsteroidal anti-inflammatory agents (NSAIDS) or other analgesic medications for a minimum of 3 months unless there is a contraindication to use;

AND

2. Physical therapy, 4 week course;

AND

D. There is no evidence of other joint disease (e.g., rheumatoid or psoriatic arthritis);

AND

E. There is no active joint infection, bleeding disorder or skin infection at the injection site and no prior allergic reaction following injection of a hyaluronan product.

- A repeat course of intra-articular hyaluronan injections may be considered MEDICALLY NECESSARY when both all of the following criteria have been met:

A. The individual met all of the criteria for an initial course of treatment;

AND

B. At least 6 months have passed since the conclusion of the prior treatment course;

AND

C. Significant pain relief was achieved with the prior course of injections.

- Use of ultrasound guidance for intra-articular hyaluronan injection is considered INVESTIGATIVE.
- Injection of corticosteroids concomitantly with hyaluronan is considered INVESTIGATIVE.
- The use of intra-articular hyaluronan injections for the following indications is considered INVESTIGATIVE:

A. Injection into joints other than the knee including but not limited to the foot, ankle, hip, shoulder, elbow and hand.

B. Injection for chondromalacia patella (patellofemoral syndrome) or osteochondritis dissecans.

BRAF Mutation Analysis

- Pre-Certification/Pre-Authorization: No.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

- BRAFV600 mutation analysis in tumor tissue of patients with unresectable or metastatic melanoma may be considered MEDICALLY NECESSARY to select patients for treatment with vemurafenib, dabrafenib, and/or trametinib.
- BRAFV600 mutation analysis for all other patients with melanoma is considered INVESTIGATIVE due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- BRAF mutation analysis is considered INVESTIGATIVE for all other pharmacogenetic indications, including analysis to predict non-response to monoclonal antibodies cetuximab and panitumumab in the treatment of metastatic colorectal cancer, due to the lack of clinical evidence demonstrating its impact on improved health outcomes.

Policies inactivated

Biomarker Genes for the Detection of Lymph Node Metastases in Breast Cancer
Suprachoroidal Delivery of Pharmacological Agents
Full Body CT Scanning
Low-Density Lipid (LDL) Apheresis

Policies Effective: 05/19/14 Notification Posted: 03/27/14

Policies developed

None

Policies revised

Photodynamic Therapy for Skin Conditions

- Pre-Certification/Pre-Authorization: No.
- Photodynamic therapy may be considered MEDICALLY NECESSARY for the treatment of the following conditions:
  - A. Actinic keratoses;
  - B. Superficial basal cell skin cancer only when surgery and radiation are contraindicated;
  - C. Bowen's disease (squamous cell carcinoma in situ) only when surgery and radiation are contraindicated.
- Photodynamic therapy is considered INVESTIGATIVE for all other dermatologic applications, including but not limited to:
  - A. Acne vulgaris
  - B. Non-superficial basal cell carcinomas
  - C. Sebaceous gland hyperplasia
  - D. Hidradenitis suppurativa
  - E. Mycoses
- Photodynamic therapy as a technique for hair removal and skin rejuvenation is considered COSMETIC.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

Immune Globulin Therapy

- Pre-Certification/Pre-Authorization: Yes, for all indications except pre- and post-transplantation of solid organs and hematopoietic stem-cell transplantation.
- INTRAVENOUS IMMUNE GLOBULIN

The use of intravenous immune globulin may be considered MEDICALLY NECESSARY in the treatment of the following conditions:

A. Primary Immunodeficiencies

1. X-linked agammaglobulinemia (X-LA or Bruton's disease);

2. Common variable immune deficiency when the following criteria are met;

   a. Significant and clearly documented recurrent infections (e.g., recurrent pneumonias, frequent episodes of bacterial sinusitis, and not just isolated chronic sinusitis); AND

   b. Onset of symptoms after two (2) years of age; AND

   c. Abnormally low serum levels of IgM and/or IgA (2 standard deviations below the age-adjusted mean) IN ADDITION TO abnormally low serum levels of IgG, as demonstrated by EITHER of the following:

      - Total serum IgG level < 200mg/dL; OR
      - Total serum IgG level ≥ 200 and < 400mg/dL OR at least 2 standard deviations below the normal age-adjusted mean AND
        - A demonstrated impaired response to immunization with protein AND/OR polysaccharide antigens:
          - For protein antigens: Serum antibody titers to tetanus and/or diphtheria should be obtained before immunization with tetanus and/or diphtheria vaccine and then three to four weeks after immunization. An abnormal response is defined as less than a four-fold rise in antibody titer
          - For polysaccharide antigens: Serum antibody titers to pneumococcus should be obtained before immunizations and then three to six weeks after immunization with a polyvalent pneumococcal polysaccharide vaccine (such as Pneumovax). An abnormal response is defined as less than a four-fold rise in titer;

          AND

        - Exclusion of other possible causes of hypogammaglobulinemia;

        AND

   d. Documentation must include the patient's serum immunoglobulin levels AND the age-adjusted reference ranges for the laboratory performing the tests.

3. IgG subclass deficiencies

   a. Significant and clearly documented recurrent infections (e.g., recurrent pneumonias, frequent episodes of bacterial sinusitis, and not just isolated chronic sinusitis); AND

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

b. Abnormally low levels of one or more IgG subclasses (2 standard deviations below the age-adjusted mean) in patients with normal levels of total IgG and IgM; AND

c. A demonstrated impaired response to immunization with protein AND/OR polysaccharide antigens:

- For protein antigens: Serum antibody titers to tetanus and/or diphtheria should be obtained before immunization with tetanus and/or diphtheria vaccine and then three to four weeks after immunization. An abnormal response is defined as less than a four-fold rise in antibody titer
- For polysaccharide antigens: Serum antibody titers to pneumococcus should be obtained before immunization and then three to six weeks after immunization with a polyvalent pneumococcal polysaccharide vaccine (such as Pneumovax). An abnormal response is defined as less than a four-fold rise in titer;

AND

d. Documentation must include the patient's serum immunoglobulin levels AND the age-adjusted reference ranges for the laboratory performing the tests.

4. X-linked immunodeficiency with hyper IgM;
5. Immunodeficiency with thrombocytopenia and eczema (Wiscott-Aldrich syndrome);
6. Hyperimmunoglobulin E syndrome;
7. Severe combined immune deficiency;
8. Cellular immunodeficiency with immunoglobulins (Nezelof syndrome);
9. Thymic hypoplasia (DiGeorge's syndrome);
10. Pediatric human immunodeficiency virus (HIV) infection;
11. Kawasaki disease (mucocutaneous lymph nodes syndrome);
12. Acquired hypogammaglobulinemia caused from either of the following two malignancies:
    a. Chronic lymphocytic leukemia
    b. Multiple myeloma.

B. Hematologic Disorders

1. Idiopathic thrombocytopenic purpura;
2. Neonatal alloimmune thrombocytopenia - as antenatal treatment in women who have previously had an infant with alloimmune thrombocytopenia or as neonatal treatment for the infant;
3. Warm antibody autoimmune hemolytic anemia, refractory to cortocosteroids and splenectomy;
4. Pure red cell aplasia due to parvovirus B19.

C. Musculoskeletal System and Connective Tissue Disorders

1. Dermatomyositis that has not responded to treatment with prednisone and immunosuppressant therapy (e.g., azathioprine, methotrexate);

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

2. Polymyositis that has not responded to treatment with prednisone and immunosuppressant therapy (e.g., azathioprine, methotrexate).

D. Nervous System Disorders

1. Acute inflammatory demyelinating polyneuropathy (Guillain-Barré syndrome);

2. Chronic inflammatory demyelinating polyneuropathy (CIDP);

3. Myasthenia gravis

a. Myasthenic crisis (i.e., an acute episode of respiratory muscle weakness);

b. Myasthenia gravis in patients with chronic debilitating disease (e.g., restricted daily activities and symptomatic at rest or worse) despite treatment with cholinesterase inhibitors, or complications from or failure of steroids a nd /or azathioprine;

4. Multifocal motor neuropathy in patients with conduction block and anti-GM1 antibodies.

E. Organ and Stem-Cell Transplantation

1. Prior to solid organ transplantation, for treatment of patients at high risk of antibody-mediated rejection, including highly sensitized patients and those receiving an ABO incompatible organ;

2. Following organ transplantation, for treatment of antibody-mediated rejection;

3. Following hematopoietic stem-cell transplantation, for treatment of related immunodeficiencies.

F. Dermatologic Disorders

1. Autoimmune Mucocutaneous Blistering Diseases

Treatment of the following conditions in patients with severe, progressive disease despite treatment with conventional medical therapy (e.g., corticosteroids, azathioprine, cyclophosphamide):

a. Pemphigus vulgaris;

b. Pemphigus foliaceus;

c. Bullous pemphigoid;

d. Mucous membrane pemphigoid;

e. Bullous systemic lupus erythematosus (SLE);

f. Epidermolysis bullosa acquisita

2. Toxic epidermal necrolysis (TEN)

- SUBCUTANEOUS IMMUNE GLOBULIN

The use of subcutaneous immune globulin (SCIg) therapy may be considered MEDICALLY NECESSARY for the treatment of primary immunodeficiencies (FDA-labeled indications), including the following:

A. Congenital agammaglobulinemia;

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

B. Severe combined immunodeficiency;

C. Wiskott-Aldrich syndrome;

D. X-linked agammaglobulinemia (XLA);

E. Common variable immune deficiency (CVID) when the following criteria are met:

1. Significant and clearly documented recurrent infections (e.g., recurrent pneumonias, frequent episodes of bacterial sinusitis, and not just isolated chronic sinusitis); and

2. Onset of symptoms after two (2) years of age; and

3. Abnormally low serum levels of IgM and/or IgA (2 standard deviations below the age-adjusted mean) IN ADDITION TO abnormally low serum levels of IgG, as demonstrated by EITHER of the following:

   a. Total serum IgG level < 200mg/dL; OR

   b. Total serum IgG level ≥ 200 and < 400mg/dL OR at least 2 standard deviations below the normal age-adjusted mean AND

   - A demonstrated impaired response to immunization with protein AND/OR polysaccharide antigens:
     - For protein antigens: Serum antibody titers to tetanus and/or diphtheria should be obtained before immunization with tetanus and/or diphtheria vaccine and then three to four weeks after immunization. An abnormal response is defined as less than a four-fold rise in antibody titer
     - For polysaccharide antigens: Serum antibody titers to pneumococcus should be obtained before immunizations and then three to six weeks after immunization with a polyvalent pneumococcal polysaccharide vaccine (such as Pneumovax). An abnormal response is defined as less than a four-fold rise in titer;

   AND

   - Exclusion of other possible causes of hypogammaglobulinemia

   AND

4. Documentation must include the patient's serum immunoglobulin levels AND the age-adjusted reference ranges for the laboratory performing the tests.

- DOCUMENTATION FOR RENEWAL REVIEW

Renewal of pre-authorization for all medical necessity indications for intravenous AND subcutaneous immune globulin must include documentation supporting sustained treatment-related response, such as substantial improvement in disease condition or a reduction in disease progression.

- INVESTIGATIVE INDICATIONS

The use of intravenous immune globulin OR subcutaneous immune globulin is considered INVESTIGATIVE in ALL other circumstances, including the following conditions:

A. Chronic fatigue syndrome;

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

B. Multiple sclerosis (relapsing-remitting and chronic, progressive);

C. Recurrent fetal loss;

D. Chronic sinus infections *(unless the sinus infection is a symptom of one of the primary immunodeficiencies listed above. Chronic sinus infection is common in most primary immunodeficiencies listed, especially antibody deficiency with normal or near-normal immunoglobulins);

E. Inclusion body myositis;

F. Asthma;

G. POEMS syndrome (polyneuropathy, organeomegaly, endocrinopathy, monoclonal gammopathy, and skin changes);

H. Autistic spectrum disorders;

I. PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections);

J. Fisher syndrome;

K. Opsoclonus-myoclonus.

Botulinum Toxin

- Pre-Certification/Pre-Authorization: Yes, ONLY for chronic migraine headaches. Initial approval will be a for 6 month trial. Continued treatment beyond 6 months will require additional authorization.
- The use of botulinum toxin (A or B serotypes) may be considered MEDICALLY NECESSARY for the following:

A. Cervical dystonia (spasmodic torticollis) to decrease the severity of abnormal head position and neck pain*

B. Strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII (facial) nerve disorders in patients 12 years of age and above*

C. Upper limb spasticity*

D. Dystonia/spasticity in patients with any of the following diseases of the central nervous system:

1. Focal dystonias:

a. Focal upper limb dystonia (e.g., organic writer's cramp)

b. Oromandibular dystonia (e.g., orofacial dyskinesia, Meige syndrome)

c. Laryngeal dystonia (adductor spasmodic dysphonia)

d. Idiopathic (primary or genetic) torsion dystonia

e. Symptomatic (acquired) torsion dystonia

2. Spastic conditions:

a. Cerebral palsy

b. Spasticity related to stroke

c. Acquired spinal cord or traumatic brain injury

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

d. Hereditary spastic paraplegia

e. Spastic hemiplegia

f. Neuromyelitis optica

g. Multiple sclerosis or Schilder's disease

E. Esophageal achalasia in patients who have not responded to dilation therapy or who are considered poor surgical candidates

F. Sialorrhea (drooling) associated with Parkinson's disease

G. Chronic anal fissure

H. Prevention (treatment) of chronic migraine headache in the following situations*

1. Initial 6-month trial in adult patients who

a. Meet International Headache Classification (ICHD-2) diagnostic criteria for chronic migraine headache:

- migraine headaches lasting at least 4 hours on at least 15 days per month; and
- migraine headaches for at least 3 months

AND

b. Have symptoms that persist despite adequate trials of at least 2 agents from different classes of medications used in the treatment of chronic migraine headaches, e.g. antidepressants, antihypertensives and antiepileptics.

- Patients who have contraindications to preventive medications are not required to undergo a trial of these agents.

2. Continuing treatment beyond 6-months:

a. Migraine headache frequency reduced by at least 7 days per month compared to pre-treatment level;

OR

b. Migraine headache duration reduced at least 100 hours per month compared to pre-treatment level.

I. Urinary incontinence due to detrusor overactivity associated with a neurologic condition [e.g., spinal cord injury (SCI), multiple sclerosis (MS)] in adults who have an inadequate response to or are intolerant of an anticholinergic medication.*

J. Overactive bladder with symptoms of urge urinary incontinence, urgency, and frequency, in adults who have an inadequate response to or are intolerant of an anticholinergic medication.*

* FDA-approved indication for at least one of the agents.

- The use of all botulinum toxin agents is considered COSMETIC for the treatment of glabellar lines or wrinkles and other indications solely to improve appearance.
- All other uses of botulinum toxin are considered INVESTIGATIVE including, but not limited to:

A. Benign prostatic hyperplasia

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

B. Chronic low back pain

C. Chronic motor tic disorder, and tics associated with Tourette syndrome (motor tics)

D. Depressive disorders

E. Detrusor sphincteric dyssynergia

F. Essential tremor

H. Facial wound healing

I. Headaches, except as noted above for prevention (treatment) of chronic migraine headache

J. Hirschsprung's disease

K. Internal anal sphincter (IAS) achalasia

L. Interstitial cystitis

M. Joint pain

N. Lateral epicondylitis

O. Mechanical neck disorders

P. Myofascial pain syndrome

Q. Neuropathic pain after neck dissection

R. Pain after hemorrhoidectomy or lumpectomy

S. Prevention of pain associated with breast reconstruction after mastectomy

T. Raynaud's disease/Raynaud's phenomenon

U. Sialorrhea (drooling), unless secondary to Parkinson's disease

V. Tinnitus

- The use of assays to detect antibodies to botulinum toxin is considered INVESTIGATIVE due to a lack of evidence demonstrating a beneficial impact on health outcomes.

Mobile Cardiac Outpatient Telemetry (MCOT)

- Policy title has been changed from Ambulatory Event Monitors and Mobile Cardiac Outpatient Telemetry to Mobile Cardiac Outpatient Telemetry
- Previous policy statements pertaining to other types of ambulatory event monitors have been removed; this policy is now specific to MCOT.
- Pre-Certification/Pre-Authorization: Not applicable.
- Mobile cardiac outpatient telemetry (MCOT) is considered INVESTIGATIVE for all indications due to a lack of evidence demonstrating an impact on improved health outcomes.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

Pneumatic Compression Devices in the Home Setting

- Pre-Certification/Pre-Authorization: No.
- Lymphedema

  The use of pneumatic compression devices may be considered MEDICALLY NECESSARY for the treatment of lymphedema in the home setting when ALL of the following criteria are met:

  A. The patient has undergone a four-week trial of conservative therapy which includes:

     1. Use of an appropriate compression bandage system or compression garment,

     2. Exercise, and

     3. Elevation of the limb;

  AND

  B. The treating physician determines that no significant improvement has occurred or significant symptoms remain following the four-week trial.

- Chronic Venous Insufficiency

  The use of pneumatic compression devices in the home setting may be considered MEDICALLY NECESSARY for the treatment of chronic venous insufficiency of the lower extremities when ALL of the following criteria are met:

  A. The patient has one or more venous stasis ulcers;

  AND

  B. The patient has undergone a trial of conservative therapy for a minimum of six months which includes ALL of the following:

     1. The use of an appropriate compression bandage system or compression garment,

     2. Appropriate dressings for the wound,

     3. Exercise, and

     4. Elevation of the limb.

  AND

  C. The treating physician determines that the venous stasis ulcer has failed to heal.

- Post-Surgical Venous Thromboembolism (VTE) Prophylaxis

  A. The use of pneumatic compression devices in the home setting may be considered MEDICALLY NECESSARY in patients who have undergone surgery when ALL of the following criteria are met:

     1. The patient has undergone surgery that requires post-surgical VTE prophylaxis (e.g., major orthopedic surgery such as such a total hip arthroplasty, total knee arthroplasty or hip fracture repair);

     AND

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

2. The patient has a contraindication to pharmacologic anticoagulants, such as being at high-risk for bleeding. Risk factors for bleeding include:

   a Bleeding disorder such as hemophiliab.

   b. Active liver disease

   c. Severe renal failure

   d. Previous major bleed (and previous bleeding risk similar to current risk)

   e. Concomitant antiplatelet agent

   f. History of or difficult-to-control surgical bleeding during the current operative procedure, extensive surgical dissection, and revision surgery.

B. Home use of pneumatic compression devices for post-surgical VTE prophylaxis is considered INVESTIGATIVE for all other indications.

- The use of pneumatic compression devices in the home setting is considered INVESTIGATIVE for all other indications, including but not limited to treatment of restless legs syndrome.

Policies inactivated

Phototherapy for Seasonal Affective Disorder
Methadone Maintenance Treatment for Chronic Opioid Dependence
Replacement of Amalgams
Skin Contact Monochromatic Infrared Energy Therapy

Policies Effective: 06/16/14 Notification Posted: 04/24/14

Policies developed

None

Policies revised

Intra-articular Hyaluronan Injections for Osteoarthritis

- Pre-Certification/Pre-Authorization: No.
- This policy was previously posted in April 2014. The following statement has been removed from the medical necessity criteria. No other changes have been made.
  - There is no active joint infection, bleeding disorder or skin infection at the injection site and no prior allergic reaction following injection of a hyaluronan product.

Wireless Capsule Endoscopy

- Pre-Certification/Pre-Authorization: No.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

- Wireless capsule endoscopy may be considered MEDICALLY NECESSARY for the following indications:
  - A. Obscure bleeding of the small intestine 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, or Lynch syndrome);
  - 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.

Growth Factors for Treatment of Wounds and Other Conditions

- Pre-Certification/Pre-Authorization: Yes.
- Recombinant Platelet-Derived Growth Factor
  - A. Use of recombinant platelet-derived growth factor (i.e., becaplermin) may be considered MEDICALLY NECESSARY when it is used as an adjunct to standard wound management for the following indications:
    1. Treatment of neuropathic diabetic ulcers extending into the subcutaneous tissue; AND
    2. Treatment of pressure ulcers extending into the subcutaneous tissue.
  - B. Other applications of recombinant platelet-derived growth factor (i.e., becaplermin) are considered INVESTIGATIVE, including, but not limited to:
    1. Ischemic ulcers; AND
    2. Ulcers related to venous stasis, AND
    3. Ulcers not extending through the dermis into the subcutaneous tissue.
- Autologous Blood-Derived Preparations
  - A. Use of autologous blood-derived preparations (i.e., platelet-rich plasma) is considered INVESTIGATIVE for ANY treatment (e.g., primary treatment, adjunct to surgical treatment) of ALL indications, including but not limited to:
    1. Acute wounds or chronic, non-healing wounds;

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

2. Osteoarthritis of any joint;
3. Soft tissue injuries and disorders, including but not limited to:
   a. Plantar fasciitis;
   b. Epicondylitis (tennis elbow);
   c. Dupuytren's contracture;
   d. Tendinopathy;
   e. Anterior cruciate ligament tears;
   f. Rotator cuff disorders.
4. Long bone nonunion

Endoluminal Ablation for Treatment of Varicose Veins/Venous Insufficiency

- Pre-Certification/Pre-Authorization: No
- Great Saphenous Vein (GSV) or Small Saphenous Vein (SSV)

Endoluminal 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 the following criteria have been 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 the patient is standing document 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.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

- Accessory Saphenous Veins

  Endoluminal radiofrequency or laser ablation of accessory saphenous veins may be considered MEDICALLY NECESSARY as a treatment of symptomatic varicose veins/venous insufficiency when:

  A. All the criteria in Section I have been met;

  AND

  B. Incompetence of the accessory saphenous vein is isolated or the great or small saphenous veins have been previously eliminated.

- Perforator Veins

  Endoluminal radiofrequency or laser ablation of perforator veins may be considered MEDICALLY NECESSARY as a treatment of leg ulcers associated with chronic venous insufficiency when:

  A. The incompetence of the perforator vein is isolated or the superficial veins (GSV, SSV, accessory or symptomatic varicose tributaries) have been previously eliminated;

  AND

  B. ALL of the following criteria are 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 patient is standing documents perforator vein reflux of 0.5 seconds or greater;

     AND

     3. Ulceration secondary to venous stasis that fails to respond to at least 3 months of compression therapy;

     AND

     4. The venous insufficiency is not secondary to deep venous thromboembolism.

- Endovenous radiofrequency or laser ablation of tributary veins is considered INVESTIGATIVE.
- Endoluminal cryoablation is considered INVESTIGATIVE for all indications.
- Endoluminal radiofrequency or laser ablation is considered COSMETIC for the following indications:
  - Treatment of the GSV, SSV, accessory or perforator veins not meeting the criteria listed above
  - Treatment of asymptomatic varicose veins of the lower extremities
  - Treatment of telangiectasias (e.g. spider veins, angiomata and hemangiomata)
- Documentation: 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

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

- High-resolution color photos documenting skin changes, dermatitis, and/or ulceration.

Cryoablation of Solid Tumors

- Pre-Certification/Pre-Authorization: No.
- Cryoablation may be considered MEDICALLY NECESSARY for the following indications:

A. Treatment of liver tumors under the following circumstances:

1. Treatment of hepatocellular carcinoma (HCC) when all the following criteria are met:
   a. The patient is not a candidate for surgical resection (e.g., due to location of the tumor(s) and/or comorbid conditions); AND
   b. Presence of three (3) lesions or less; AND
   c. Tumor size is ≤ 5 cm in diameter; AND
   d. All tumor foci can be adequately treated by ablation.
2. Treatment of hepatic metastases from colorectal cancer when all the following criteria are met:
   a. The patient is not a candidate for surgical resection (e.g., due to location of the tumor(s) and/or comorbid conditions); AND
   b. Absence of extrahepatic metastatic disease; AND
   c. Tumor size is ≤ 5 cm in diameter; AND
   d. All tumor foci can be adequately treated by ablation.
3. Treatment of hepatic metastases from neuroendocrine tumors when all the following criteria are met:
   a. The patient is not a candidate for surgical resection (e.g., due to location of the tumor(s) and/or comorbid conditions); AND
   b. Systemic therapy has failed to control symptoms; AND
   c. All tumor foci can be adequately treated by ablation.

B. Treatment of prostate cancer under the following circumstances:

1. Primary treatment for clinically localized prostate cancer; OR
2. Salvage treatment for recurrent prostate cancer following failed radiation therapy

C. Treatment of localized renal cell carcinoma when tumor size is ≤ 4 cm and either of the following criteria are met:

1. Preservation of kidney function is necessary (i.e., the patient has one kidney or renal insufficiency, defined as a glomerular filtration rate [GFR] of < 60 mL/min/m2) and standard surgical approaches would compromise kidney function; OR
2. Patient is not considered a surgical candidate due to co-morbid disease

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

- Cryoablation is considered INVESTIGATIVE for treatment of all other solid tumors or metastases including, but not limited to, the following:

  A. Benign breast tumors (e.g., fibroadenomas);

  B. Malignant breast tumors;

  C. Renal cell carcinomas in patients who are surgical candidates;

  D. Pancreatic cancer;

  E. Lung cancer;

  F. Subtotal prostate ablation.

Bone Growth Stimulators

- Pre-Certification/Pre-Authorization: Yes.
- Electrical Bone Growth Stimulators (20974, 20975, E0747, E0748, E0749)

  A. Noninvasive electrical bone growth stimulators may be considered MEDICALLY NECESSARY as a treatment of fracture nonunions or congenital pseudarthroses in the appendicular skeleton (the appendicular skeleton includes bones of the shoulder girdle, upper extremities, pelvis, and lower extremities). The diagnosis of fracture nonunion must meet ALL the following criteria:

  1. At least three months have passed since the date of fracture; AND

  2. Serial radiographs or other diagnostic imaging (e.g., CT or MRI), if clinically appropriate, have confirmed that no progressive signs of healing have occurred; AND

  3. The fracture gap is one (1) cm or less; AND

  4. The patient can be adequately immobilized and is of an age likely to comply with non-weight bearing

  B. Noninvasive electrical bone growth stimulators may be considered MEDICALLY NECESSARY as a treatment of patients with failed lumbar spinal fusion. Failed spinal fusion is defined as a spinal fusion that has not healed at a minimum of six months after the original surgery, as evidenced by serial radiographs, or other diagnostic imaging (e.g., CT or MRI) if clinically appropriate, showing no progression of healing for 3 months during the latter portion of the 6-month period.

  C. Invasive or noninvasive electrical bone growth stimulators may be considered MEDICALLY NECESSARY as an adjunct to lumbar and/or lumbosacral spinal fusion surgery in patients at high risk for fusion failure, defined as ANY ONE of the following criteria:

  1. One or more previous failed spinal fusion(s); OR

  2. Grade III or worse spondylolisthesis; OR

  3. Fusion to be performed at two levels; OR

  4. Current smoking habit; OR

  5. Diabetes; OR

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

6. Renal disease; OR
7. Alcoholism; OR
8. Chronic steroid use.

D. All other applications of invasive or noninvasive electrical bone growth stimulators are considered INVESTIGATIVE including, but not limited to:

1. Noninvasive or invasive electrical bone growth stimulators for treatment of a fresh fracture (less than seven days old);
2. Noninvasive or invasive electrical bone growth stimulators for treatment of delayed union fractures;
3. Noninvasive or invasive electrical bone growth stimulators for any non-lumbar fusion/arthrodesis or failed arthrodesis (e.g., as an adjunct to cervical or thoracic fusion; for failed cervical or thoracic spinal surgery; as an adjunct to ankle arthrodesis; for failed ankle arthrodesis)
4. Noninvasive electrical bone growth stimulators for immediate post-surgical treatment after appendicular skeletal surgery (e.g., femoral osteotomy).
5. Noninvasive or invasive bone growth stimulators for treatment of stress fractures.

E. The use of semi-invasive electrical bone growth stimulators is considered INVESTIGATIVE for all applications.

- Ultrasound Bone Growth Stimulators (20979, E0760)

A. Low-intensity ultrasound bone growth stimulators may be considered MEDICALLY NECESSARY when used as an adjunct to conventional management (i.e., closed reduction and cast immobilization) for the treatment of fresh (less than seven days old), closed fractures in skeletally mature individuals who are at high risk for nonunion due to any one of the following risk factors:

1. Comorbidities:
   a. Current smoking habit; OR
   b. Diabetes; OR
   c. Renal disease; OR
   d. Osteoporosis; OR
   e. Alcoholism; OR
   f. Chronic steroid use.

OR

2. Fracture characteristics:
   a. Jones/5th metatarsal fracture; OR
   b. Carpal navicular fracture (also called the scaphoid); OR
   c. Fractures associated with extensive soft tissue or vascular damage.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

B. Low-intensity ultrasound bone growth stimulators may be considered MEDICALLY NECESSARY as a treatment of fracture nonunions of bones, excluding the skull and vertebra, when ALL of the following criteria are met:

1. At least three months have passed since the date of fracture; AND
2. Serial radiographs, or other diagnostic imaging (e.g., CT or MRI) if clinically appropriate, have confirmed that no progressive signs of healing have occurred; AND
3. The fracture gap is one (1) cm or less; AND
4. The patient can be adequately immobilized and is of an age likely to comply with non-weight bearing

C. All other applications of low-intensity ultrasound bone growth stimulators are considered INVESTIGATIVE including, but not limited to:

1. Treatment of delayed union fractures
2. Congenital pseudarthroses;
3. Treatment of open fractures [e.g., as an adjunct (applied at the time of surgery or within 3 months) to open reduction internal fixation or osteotomy];
4. Stress fractures.
5. Arthrodesis or failed arthrodesis.

- Documentation from the ordering physician supporting the use and medical necessity of the bone growth stimulator must be included in the prior authorization and must include the following:

1. For treatment of nonunion, a written report from a radiologist documenting EITHER of the following:

   a. For nonhealing fractures: at least two radiographs or other diagnostic imaging (e.g., CT or MRI), if clinically appropriate, taken 30 days or more apart during the 3 months following the date of the acute fracture, and validating the fracture gap distance; OR

   b. For nonhealing spinal fusion: at least two radiographs or other diagnostic imaging (e.g., CT or MRI), if clinically appropriate, over the course of the latter three months of the six-month period following the original surgery.

2. Documentation must support the medical necessity criteria pertaining to the specific indication(s) described in the policy. As appropriate, this information should include the date of fracture, location of fracture, fracture characteristics, co-morbidities, and other relevant data indicated in the policy statement.

Selected Treatments For Tinnitus

- Pre-Certification/Pre-Authorization: Not applicable.
- Treatment of tinnitus with any of the following is considered INVESTIGATIVE due to the lack of clinical evidence demonstrating an impact on improved health outcomes:
  - electrical stimulation
  - electromagnetic energy
  - tinnitus maskers

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

- tinnitus retraining
- transcranial magnetic stimulation
- transmeatal laser irradiation

Policies inactivated

Eye Movement Desensitization and Reprocessing for Posttraumatic Stress Disorder (PTSD)

Policies reviewed with no changes in February 2014 – April 2014:

Abatacept (Orencia®)
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
Cooling/Heating Devices Used in the Outpatient Setting
Detection of Circulating Tumor Cells in the Management of Patients with Cancer
Dynesys® Spinal System and Lumbar Dynamic Stabilization
Electrical/Electromagnetic Stimulation for Treatment of Arthritis
Endovascular Procedures (Angioplasty and/or Stenting) for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)
Extended Hours Home Care Skilled (Private Duty) Nursing
Genetic Testing for FMR1 Mutations (including Fragile X Syndrome)
Genetic Testing for Helicobacter Pylori Treatment
Genetic Testing for Tamoxifen Treatment
Genetic Testing for Warfarin Dose
Hair Analysis
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 CNS Embryonal Tumors and Ependymoma
Hematopoietic Stem-Cell Transplantation for Miscellaneous Solid Tumors in Adults
Hematopoietic Stem-Cell Transplantation for Myelodysplastic Syndrome and Myeloproliferative Neoplasms
Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood
Hippotherapy
Humanitarian Use Devices
Implantable Cardioverter-Defibrillator
In Vitro Chemoresistance and Chemosensitivity Assays
Intradiscal Electrothermal Annuloplasty (IDET), Percutaneous Radiofrequency Annuloplasty (PIRFT), and Intradiscal Biacuplasty
Intravenous Anesthetics for the Treatment of Chronic Pain
Islet Transplantation

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

Ketamine for Treatment of All Mental Health and Substance-Related Disorders
Laparoscopic and Percutaneous Techniques for the Myolysis of Uterine Fibroids
Microwave Ablation of Solid Tumors
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
Pfeiffer Treatment Center / Health Research Institute Metallothionein Protein (MT) Assessment and Treatment
Positron Emission Mammography
Pressure-Reducing Support Surfaces
Prolotherapy
Proteomics-based Testing Panels for the Evaluation of Ovarian (Adnexal) Masses
Proton Beam Radiation Therapy
Quantitative Sensory Testing
Rhinoplasty
Saliva Hormone Tests
Scintimammography/Breast-Specific Gamma Imaging/Molecular Breast Imaging
Stem-Cell Therapy for Orthopedic Applications
Surface Electromyography (SEMG)
Tesamorelin (Egrifta)
Traction Decompression of the Spine
Transcranial Magnetic Stimulation
Treatment of Hereditary Angioedema
Ventricular Assist Devices and Total Artificial Hearts

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:

Network Management R317
Editor: Holly Batchelder
P.O. Box 64560
St. Paul, MN 55164-0560
(651) 662-2014
toll free: 1-800-382-2000, ext. 22014

Advisors/Faith Bauer, CPC, CPC-H, CPC-P; Jeannie Harp, CPC; Janine Utecht, CPC, CPC-H, CPC-P, CPMA; and Karen Kiemele, MPH

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

CPT-4 codes noted are AMA copyrighted.

6/14

Blue Cross® and Blue Shield® of Minnesota and Blue Plus® are nonprofit independent licensees of the Blue Cross and Blue Shield Association

Network Management R317
P.O. Box 64560
St. Paul, MN 55164-0560