# Provider **Press**

Provider information

March 2014 / Vol. 18, No. 1

BlueCross BlueShield Minnesota

## PHARMACY UPDATE

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) will be expanding prior authorization (PA) of pharmaceuticals under its pharmacy and medical benefits. Policies that apply to drugs under the medical benefit will continue to be published as they are today. Upcoming pharmacy program descriptions will be available in one convenient location within the provider section of the Blue Cross website 45 days prior to their active implementation dates.

New PA's will be available for initial viewing online at **providers.bluecrossmn.com**:

- Under Tools & Resources select Medical Policy, then acknowledge the Acceptance statement
- Select View All Active Policies
- Select Upcoming Pharmacy Utilization Management (UM) Programs

# FYI

## 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.

### 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 December 2013 to February 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 |
|---|---|
| QP27-13 | Regions Hospital scheduled to become nonparticipating effective January 1, 2014 |
| QP28-13 | Chiropractic network structure changes |
| QP1-14 | Blue Cross reaches agreement with Regions Hospital |
| QP2-14 | Quality Improvement Project for SecureBlue℠ (HMO SNP) Subscribers: Decreasing High Risk Medication Use |
| QP3-14 | 2014 Hospice Pharmacy Education |
| QP4-14 | Split Fill Program for Selected, Orally Administered Oncology Medications |
| QP5-14 | Clarification to independent clinical lab claim submission through BlueCard |
| QP6-14 | Transportation changes back to BlueRide for MHCP subscribers |
| QP7-14 | Pre-Certification and Pre-Authorization Request Form Updates |
| **BULLETINS** | **TITLE** |
| P1-14 | January 2014 HCPCS code updates |
| P2-14 | Update to Attachment B: Definitions of outpatient health services categories |
| P3-14 | Clarification to post-operative pain block recovery request and edit removal notification |

### 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

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

# FYI

## PROVIDER MANUAL UPDATES

The following is a list of Blue Cross and Blue Shield of Minnesota provider manuals that have been updated from December 2013 to February 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 4, Care Management | Content change to Pre-Certification/Pre-Authorization |
| Provider Policy and Procedure Manual | Chapter 11, Coding Policies and Guidelines, Behavioral Health | The following topics had changes:<br>• Eligible Groups for ARMHS<br>• Intensive Residential Treatment Services (IRTS) for Medicaid Government Programs only<br>• Adult Non-Residential Crisis Services (MHCP members only)<br>• Psychiatric Consultation to Primary Care Practitioners<br>• Extended Care and Halfway House Room and Board (Medicaid Government Programs only)<br>• Children' Residential Mental Health (Medicaid Government Programs only) |
| Provider Policy and Procedure Manual | Chapter 11, Coding Policies and Guidelines, Durable Medical Equipment | The following topics had changes:<br>• Hearing Aids<br>• Coding Modifiers<br>The following new topics were added:<br>• CPAP and Bi-Pap Billing for Public Programs<br>• Medicare Guidelines for DME in a SNF or NF |
| Provider Policy and Procedure Manual | Chapter 11, Coding Policies and Guidelines, Home Health, Home Infusion, Hospice | The following topics had changes:<br>• Elderly Waiver Program<br>• Referrals and Prior Authorization<br>• RAP Claim Submission<br>• Hospice Billing for Medicare Products |
| Provider Policy and Procedure Manual | Chapter 11, Coding Policies and Guidelines, Medical Services | Content change to Ear Wax Removal |
| Provider Policy and Procedure Manual | Chapter 11, Coding Policies and Guidelines, Public Programs | The following topics had changes:<br>• Newborn Circumcision<br>• PCA Billing<br>• Chiropractic, Physical, Occupational and Speech Therapy Authorization<br>• MHCP changes in Pre-Authorization<br>• Special Transportation |

## 2014 HOLIDAY SCHEDULE

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

Monday, May 26

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

## SIGN HERE PLEASE

It's been said before, but worth repeating. The documentation for a service or visit is part of the patient's permanent legal record. Signatures are an important element of documentation. Blue Cross requires that medical record entries for services provided/ordered be authenticated by the author. The accepted method is a handwritten or electronic signature. Stamp signatures are not acceptable. Patient identification, date of service, and provider of the service should be clearly identified on the submitted documentation.

Medical records sent without signatures are not acceptable. Providers should verify that all signatures are being printed on their medical records when sending copies from electronic medical record systems or vendors.

## CODE EDITS UPDATE REMINDER

Blue Cross' coding edits are not updated and loaded at the same time as the coding changes are available. While we are reviewing potential edits at this time, until implemented, coding edits will not be applied to the new 2014 codes. This does not mean that the codes are invalid. All new HCPCS/CPT codes effective January 1, 2014, have been loaded to our claims system.

Once the new and revised edits are implemented, all claims submitted after the implementation date of the update, regardless of service date, will be processed according to that updated version or instituted edit.

## E/M BASED ON TIME

CPT indicates that when counseling and/or coordination of care dominates more than 50 percent of the face-to-face physician time then time shall be considered the key or controlling factor for a particular level of E/M. CPT also stipulates that the extent of counseling and/or coordination of care must be documented in the medical record.

While the actual time of additional counseling and/or coordination must be part of the medical record, the details – *the extent* - the "who", "what" and "why" of that counseling and/or coordination must **also** be part of the medical record for consideration.

## FUN WITH ICD-10

So how do you code for the headaches from ICD-10 code training?

- G44.209 Tension-type headache, unspecified, not intractable; and
- Z56.6 Other physical and mental strain related to work

Don't forget to code what caused that headache.

# 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

# CODING CORNER

## PROVIDER POLICY AND PROCEDURE MANUAL UPDATES

The manual has or is being updated with coding changes that were effective January 1, 2014, so be sure to check out the updates to the various coding sections of Chapter 11. Access the manual through the Blue Cross website at **providers.bluecrossmn.com**. Manuals are found under the Forms & publications section.

# 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: 01/20/14 Notification Posted: 11/27/13

### Policies developed

***Intravenous Human Epidermal Growth Factor Receptor 2 (HER2) Targeted Agents***

- Pre-Certification/Pre-Authorization: No.
- Breast Cancer

  A. Trastuzumab (Herceptin), ado-trastuzumab emtansine (Kadcyla), and pertuzumab (Perjeta) may be considered MEDICALLY NECESSARY for treatment of patients with breast cancer only when tumor overexpression of HER2 has been confirmed by testing in accordance with current ASCO/CAP or NCCN guidelines.

  B. Trastuzumab (Herceptin), ado-trastuzumab emtansine (Kadcyla), and pertuzumab (Perjeta) are considered INVESTIGATIVE for treatment of breast cancer for which tumor overexpression of HER2 has not been confirmed.
- Gastric, Esophageal, and Gastroesophageal Junction Adenocarcinoma

  A. Trastuzumab (Herceptin) may be considered MEDICALLY NECESSARY for treatment of patients when tumor overexpression of HER2 has been confirmed by testing in accordance with current ASCO/CAP or NCCN guidelines in the following instances:

  1. Metastatic gastric or gastroesophageal junction adenocarcinoma;

  OR

  2. Palliative care of patients with advanced gastric, esophageal or gastroesophageal junction adenocarcinoma with a Karnofsky performance score of 60% or greater (Unable to work; able to live at home and care for most personal needs; varying amount of assistance needed, or able to carry on normal activity and to work; no special care needed) OR Eastern Cooperative Oncology Group (ECOG) performance score of 2 or less in combination with systemic chemotherapy. An ECOG score of 2 or less indicates that the patient is ambulatory more that 50% of waking hours and capable of self-care.

  B. Trastuzumab (Herceptin) is considered INVESTIGATIVE for treatment of advanced or metastatic gastric, esophageal or gastroesophageal junction adenocarcinoma for which tumor overexpression of HER2 has not been confirmed.

  C. Ado-trastuzumab emtansine (Kadcyla) and pertuzumab (Perjeta) are considered INVESTIGATIVE for treatment of gastric, esophageal, or gastroesophageal junction adenocarcinoma.
- Other Cancers

  Trastuzumab (Herceptin), ado-trastuzumab emtansine (Kadcyla), and pertuzumab (Perjeta) are considered INVESTIGATIVE for treatment of all other cancers including but not limited to colorectal, endometrial, esophageal (except as stated in IIA above), gastric (except as stated in IIA above), head and neck, non-small cell lung, osteosarcoma, ovarian, pancreatic, peritoneal, prostate, salivary gland, and urothelial.
- Assessment of HER2 expression

  Assessment of HER2 expression in tumor tissue that is not in accordance with current ASCO/CAP or NCCN guidelines, including but not limited to by quantitative total HER2 expression or HER2 homodimer measurement, is considered INVESTIGATIVE.

# MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

## Policies revised

***Autologous Chondrocyte Implantation of Focal Articular Cartilage Lesions***

- Pre-Certification/Pre-Authorization: No.
- Autologous chondrocyte implantation (ACI)

A. ACI may be considered MEDICALLY NECESSARY for the treatment of disabling full-thickness articular cartilage defects of the knee caused by acute or repetitive trauma, in patients who have had an inadequate response to a prior surgical procedure (e.g., debridement, subchondral drilling, abrasion arthroscopy, microfracture), when all of the following criteria are met:

1. Patient is an adult OR a skeletally mature adolescent with documented closure of growth plates (e.g., 15 years or older);
2. Total area of the cartilage lesion (i.e. length x width, in centimeters or cm) is greater than 1.5 cm2 (centimeters squared);
3. Focal, full-thickness (Outerbridge grade III or IV) unipolar lesions on the weight bearing surface of the femoral condyles or trochlea;
4. Documented minimal to absent degenerative changes in the surrounding articular cartilage (Outerbridge Grade II or less), and normal-appearing hyaline cartilage; surrounding the border of the defect;
5. Presence of persistent symptoms (e.g., pain, swelling and catching/locking) that significantly limit activities of daily living;
6. Presence of stable ligaments (if ligaments are unstable, documentation should be provided as to how this condition will be addressed);
7. No malalignment present (if malalignment is present, documentation should indicate planned concurrent correction of alignment).

B. ACI for treatment of all other articular cartilage defects of the knee (i.e., defects that do not meet the criteria outlined under I.A.) are considered INVESTIGATIVE, due to a lack of evidence demonstrating an impact on improved health outcomes.

C. ACI for all other indications is considered INVESTIGATIVE due to a lack of evidence demonstrating an impact on improved health outcomes. Those investigative indications include, but not limited to:

1. Lesions in joints other than the knee (e.g., talus);
2. Lesions of the patella or tibia.

D. Matrix-induced autologous chondrocyte implantation is considered INVESTIGATIVE for all indications due to a lack of evidence demonstrating an impact on improved health outcomes.

***Osteochondral Allografts and Autografts in the Treatment of Focal Articular Cartilage Lesions***

- Pre-Certification/Pre-Authorization: No.

# MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

- Osteochondral Allograft

A. Osteochondral allograft transplantation may be considered MEDICALLY NECESSARY for the treatment of symptomatic full-thickness articular cartilage defects of the knee caused by acute or repetitive trauma, in patients who have had an inadequate response to a prior surgical procedure (e.g., debridement, subchondral drilling, abrasion arthroscopy, microfracture), when all the following criteria are met:

1. Patient is an adult OR a skeletally mature adolescent with documented closure of growth plates (e.g., 15 years or older);
2. Total area of the cartilage lesion (i.e. length x width, in centimeters or cm) is greater than 1.5 cm2 (centimeters squared);
3. Focal full-thickness (Outerbridge grade III or IV) cartilage lesions on the weight-bearing surface of the femoral condyles (medial or lateral) or trochlea;
4. Documented minimal to absent degenerative changes in the surrounding articular cartilage (Outerbridge grade II or less) and normal-appearing hyaline cartilage surrounding the border of the defect;
5. Presence of persistent symptoms (e.g., pain, swelling and catching/locking) that significantly limit activities of daily living;
6. Presence of stable ligaments (if ligaments are unstable, documentation should be provided as to how this condition will be addressed);
7. No malalignment present (if malalignment is present, documentation should indicate planned concurrent correction of alignment).

B. Osteochondral allograft transplantation for treatment of all other articular cartilage defects of the knee (i.e., defects that do not meet the criteria outlined under I.A.) is considered INVESTIGATIVE, due to a lack of evidence demonstrating an impact on improved health outcomes.

C. Osteochondral allograft transplantation for all other indications and in all other joints is considered INVESTIGATIVE due to a lack of evidence demonstrating an impact on improved health outcomes. Those investigative indications include, but not limited to:

1. Lesions in joints other than the knee (e.g., talus);
2. Lesions of the patella or tibia.

D. Allograft minced cartilage procedures are considered INVESTIGATIVE for all indications and in all joints, due to a lack of evidence demonstrating an impact on improved health outcomes.

- Osteochondral Autografts

A. Osteochondral autograft transplantation (OATS or autologous mosaicplasty), using one or more cores of osteochondral tissue may be considered MEDICALLY NECESSARY for the treatment of symptomatic full-thickness cartilage defects of the knee caused by acute or repetitive trauma, in patients who have had an inadequate response to a prior surgical procedure (e.g., debridement, subchondral drilling, abrasion arthroscopy, microfracture), when all the following criteria are met:

# MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

1. Patient is an adult OR a skeletally mature adolescent with documented closure of growth plates (e.g., 15 years or older);

2. Total area of the cartilage lesion (i.e. length x width, in centimeters or cm) is ≥ 1.0 cm2 (centimeters squared) and ≤ 2.0 cm2;

3. Focal full-thickness (Outerbridge grade III or IV) cartilage lesions on the weight-bearing surface of the femoral condyles (medial or lateral) or trochlea;

4. Documented minimal to absent degenerative changes in the surrounding articular cartilage (Outerbridge grade II or less) and normal-appearing hyaline cartilage surrounding the border of the defect;

5. Presence of persistent symptoms (e.g., pain, swelling and catching/locking) that significantly limit activities of daily living;

6. Presence of stable ligaments (if ligaments are unstable, documentation should be provided as to how this condition will be addressed);

7. No malalignment present (if malalignment is present, documentation should indicate planned concurrent correction of alignment).

B. Osteochondral autograft transplantation for treatment of all other articular cartilage defects of the knee (i.e., defects that do not meet the criteria outlined under II.A.) is considered INVESTIGATIVE, due to a lack of evidence demonstrating an impact on improved health outcomes.

C. Osteochondral autograft transplantation for all other indications and in all other joints is considered INVESTIGATIVE due to a lack of evidence demonstrating an impact on improved health outcomes. Those investigative indications include, but not limited to:

1. Lesions in joints other than the knee (e.g., talus);

2. Lesions of the patella or tibia.

D. Autograft minced cartilage procedures are considered INVESTIGATIVE for all indications and in all joints, due to a lack of evidence demonstrating an impact on improved health outcomes.

***Bone Morphogenetic Protein (BMP)***

- Pre-Certification/Pre-Authorization: No.
- Use of recombinant human bone morphogenetic protein-2 (rhBMP-2), may be considered MEDICALLY NECESSARY for the following indications:

A. As an adjunct to an anterior lumbar interbody fusion procedure when use of an autograft is unfeasible (e.g., need for a greater quantity of autograft than is available); OR

B. For instrumented posterolateral intertransverse spinal fusion when use of an autograft is unfeasible (e.g., need for a greater quantity of autograft than is available); OR

C. As an adjunct to treatment of open fracture of the tibial shaft, when use of an autograft is unfeasible (e.g., need for a greater quantity of autograft than is available).

# MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

- Use of recombinant human bone morphogenetic protein-7 (rhBMP-7) may be considered MEDICALLY NECESSARY for the following indications:

  A. In recalcitrant long bone non-unions where use of an autograft is unfeasible (e.g., need for a greater quantity of autograft than is available) and alternative treatments have failed; OR

  B. For revision posterolateral intertransverse spinal fusion procedures in compromised patients when use of an autograft is unfeasible (e.g., need for a greater quantity of autograft than is available).

- Use of recombinant human bone morphogenetic protein-2 (rhBMP-2) or recombinant human bone morphogenetic protein-7 (rhBMP-7) is considered INVESTIGATIVE for all other indications, including but not limited to:

  A. As an adjunct to thoracic and cervical fusion procedures;

  B. As initial treatment or revision of posterolateral spinal fusion, except as indicated above;

  C. As management of early stages of osteonecrosis of the vascular head or femoral shaft;

  D. As an adjunct to distraction osteogenesis (Iliazarov procedure)

  E. Craniofacial applications including, but not limited to, periodontal defect regeneration, cleft palate repair, cranial defect repair, sinus augmentation, and localized alveolar ridge augmentations for defects associated with extraction sockets.

***Treatment of Urinary Dysfunction***

- Pre-Certification/Pre-Authorization: Yes, ONLY for Percutaneous Tibial Nerve Stimulation (PTNS).

- Botulinum Toxin Therapy

  Botulinum toxin may be considered MEDICALLY NECESSARY for incontinence due to detrusor overactivity, incontinence of neurogenic origin (e.g., spinal cord injury, multiple sclerosis),or overactive bladder in adults who have had an inadequate response to or are intolerant of an anticholinergic medication.

- Magnetic Stimulation

  Use of magnetic stimulation of the pelvic floor muscles [Extracorporeal Magnetic Innervation (ExMI™), NeoControl® Pelvic Floor System] as treatment for urinary incontinence is considered INVESTIGATIVE due to lack of clinical evidence indicating its impact on improved health outcomes.

- Pelvic Floor Electrical Stimulation

  Use of pelvic floor electrical stimulation (i.e., pelvic TENS) may be considered MEDICALLY NECESSARY as treatment for stress and/or urge incontinence in patients who have undergone a documented trial of pelvic muscle exercises for a period of at least six (6) months with no significant improvement in incontinence.

- Percutaneous Tibial Nerve Stimulation (PTNS)

  A. Percutaneous tibial nerve stimulation may be considered MEDICALLY NECESSARY for treatment of urinary dysfunction (i.e., incontinence, urgency frequency, and non-obstructive urinary retention) in patients who meet all the following criteria:

# MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

1. Absence of neurologic disease associated with detrusor hyperreflexia; AND
2. Absence of outlet obstruction; AND
3. Symptoms have resulted in significant disability (e.g., the frequency and/or severity of leakages are limiting the patient's ability to work or participate in activities outside the home); AND
4. Conservative forms of treatment have been tried for at least one year and have failed.

B. The use of percutaneous tibial nerve stimulation for any other indication is considered INVESTIGATIVE.

- Periurethral Bulking Agents

A. Use of the following periurethral bulking agents may be considered MEDICALLY NECESSARY to treat stress urinary incontinence:

1. Collagen implants (e.g., Contigen Bard collagen implants);
2. Carbon-coated spheres (e.g., Durasphere);
3. Calcium hydroxylapatite (e.g., Coaptite®);
4. Polydimethylsiloxane (e.g., Macroplastique®);

B. Use of these periurethral bulking agents as treatment for any other type of urinary incontinence is considered INVESTIGATIVE.

C. Use of autologous cellular therapy (e.g., myoblasts, fibroblasts, muscle-derived stem cells, or adipose-derived stem cells), autologous fat, and autologous ear chondrocytes is considered INVESTIGATIVE.

D. Use of any other periurethral bulking agents for urinary incontinence is considered INVESTIGATIVE.

- Personal Use Ultrasound Devices

A. Use of a portable personal use ultrasound device to non-invasively measure bladder volume (e.g., BladderManager®) may be considered MEDICALLY NECESSARY only for spinal cord-injury patients with autonomic dysreflexia.

B. All other uses are considered INVESTIGATIVE.

- Transurethral Radiofrequency Micro-Remodeling

Use of transurethral radiofrequency micro-remodeling (e.g., Renessa) for treatment of stress urinary incontinence is considered INVESTIGATIVE due to a lack of published evidence supporting its impact on improved health outcomes.

- Transvaginal Radiofrequency Bladder Neck Suspension
- Use of transvaginal radiofrequency bladder neck suspension for treatment of stress urinary incontinence is considered INVESTIGATIVE due to a lack of published evidence supporting its impact on improved health outcomes.

## Policies inactivated

**T-Wave Alternans**
**Uterine Activity Monitoring (Home Ambulatory)**

# MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

Policies Effective: 03/17/14 Notification Posted: 01/23/14

## Policies developed

**None**

## Policies revised

***Spinal Fusion: Cervical***

- Pre-Certification/Pre-Authorization: Yes.
- Cervical spinal fusion may be considered MEDICALLY NECESSARY for ANY of the following indications:

A. Acute traumatic spinal injury resulting in cervical 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. Cervical 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 (e.g., profound deltoid biceps, triceps, or hand weakness; OR

E. Nontraumatic atlantoaxial (C1-C2) subluxation related to ONE of the following conditions:

1. Congenital abnormality of the C1-C2 vertebrae; OR
2. Os odontoideum; OR
3. Rheumatoid arthritis

OR

F. Symptomatic pseudarthrosis; OR

G. 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:
   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
   b. Medical management with oral steroids and epidural steroid injections; OR
   c. Physical therapy

AND

2. Diagnostic imaging (i.e., MRI or CT myelogram) demonstrates cervical nerve root compression

# MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

OR

H. 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/lower extremity weakness, numbness, or pain; OR

   b. Bladder or bowel incontinence; OR

   c. Increased tone or spasticity; OR

   d. Gait abnormalities consistent with cervical 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) demonstrates spinal cord compression;

OR

I. Degenerative spinal segment adjacent to a prior decompression or fusion procedure* when at least ONE of the following criteria are met:

1. Symptoms of radiculopathy (as described under G above) associated with the adjacent level of the cervical spine AND conservative nonsurgical treatment (as described under G above) has failed; OR

2. Symptoms of myelopathy (as described under H above) associated with the adjacent level of the cervical spine

   *NOTE: Any request that would result in more than two (2) cervical fusions in a person's lifetime requires Medical Director review.

OR

J. Other causes of nontraumatic instability or cervical spondylosis, when documentation demonstrates ALL of the following:

1. Moderate to severe neck pain despite eight (8) weeks of conservative therapy with at least two (2) 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 (e.g., a prescription oral analgesic [preferably anti-inflammatory], muscle relaxant or tricyclic anti-depressant medication); OR

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

   c. Physical therapy

   AND

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2. Clinically significant function limitation resulting in impaired, age-appropriate activities of daily living and diminished quality of life; AND

3. Diagnostic imaging by x-ray demonstrates ONE of the following:

   a. Instability by flexion and extension x-rays

      - Sagittal plane translation >3mm; OR

      - Sagittal plane translation >20% of vertebral body width

   OR

   b. Relative sagittal plane angulation >11 degrees.

***Genetic Testing and Counseling for Heritable Disorders***

- Pre-Certification/Pre-Authorization: No.
- Testing For Carrier Status

A. Carrier testing in a parent or prospective parent may be considered MEDICALLY NECESSARY when the parent or prospective parent is at high risk of being a carrier of a specific genetic disorder based upon family history as defined by meeting one or more of the following conditions in section I.A and all of the criteria in section IB:

   1. An affected child is identified with an autosomal recessive or X-linked disorder and genetic testing is performed to guide subsequent reproductive decisions;

      OR

   2. One or both parents or prospective parents have a first or a second degree relative who is affected by a specific genetic disorder, or the first degree relative has an affected child with an autosomal recessive or X-linked disorder and genetic testing is performed to guide subsequent reproductive decisions or to guide medical management;

      OR

   3. One parent or prospective parent is known to be a carrier of a clinically significant autosomal recessive condition;

      OR

   4. The parents or prospective parents are members of a racial or ethnic group with a high risk of a specific genetic disorder with an autosomal recessive pattern of inheritance.

B. If one or more of the criteria in Section A (above) are met, parents or prospective parents must meet ALL of the following criteria:

   1. For each disorder, a specific causative mutation, or set of mutations, has been established in the population being tested;

      AND

   2. A clinical association between the mutation detected and the severity of the disorder has been validated in the peer-reviewed medical literature; AND

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3. The test will identify or rule out heritability of the condition and will provide information that established biochemical or other testing cannot provide; AND

4. Genetic testing is performed to facilitate decisions surrounding reproduction;

   AND

5. Testing is accompanied by genetic counseling.

C. Genetic testing for carrier status is considered INVESTIGATIVE when the criteria above are not met. There is a lack of clinical evidence demonstrating its impact on improved health outcomes.

D. Expanded carrier screening panels are considered INVESTIGATIVE. These include but are not limited to the following:

- 23andMe
- Counsyl™
- GoodStart Select™
- Inherigen™
- InherigenPlus™
- Inheritest™
- NateraOne™

- Presymptomatic Genetic Testing To Predict Risk of a Disorder

A. Presymptomatic genetic testing may be considered MEDICALLY NECESSARY in individuals with a reasonable expectation that the condition exists or may arise based on family history and a pedigree analysis and who have no signs or symptoms of a genetic disorder when ALL of the following criteria are met:

1. A specific causative mutation, or set of mutations, has been established for the disorder being evaluated;

   AND

2. A clinical association between the mutation detected and the severity of the disorder has been validated in the peer-reviewed medical literature;

   AND

3. The results of the genetic test will impact disease prevention, surveillance, or medical management of the individual;

   AND

4. Testing is accompanied by genetic counseling.

B. Presymptomatic genetic testing to predict risk of a disorder is considered INVESTIGATIVE when the criteria above are not met. There is a lack of clinical evidence demonstrating its impact on improved health outcomes. Examples of these tests include but are not limited to the following:

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- 23andMe
- deCODE T2™
- deCODE AF™
- deCODE MI™
- deCODE Glaucoma™

C. Genetic testing of children to predict adult onset of disease is considered NOT MEDICALLY NECESSARY unless test results will guide current decisions concerning prevention and this benefit would be lost by waiting until the child has reached adulthood.

- Diagnostic Testing

A. Genetic testing may be considered MEDICALLY NECESSARY to diagnose a genetic disorder in individuals with signs or symptoms who meet ALL of the following criteria:

1. The test used has been established in the peer-reviewed medical literature to reliably detect a specific causative mutation or set of mutations or a chromosome variant associated with a specific disease;

AND

2. A biochemical or other test is identified but the results are indeterminate, or the genetic disorder cannot be identified through biochemical or other testing (e.g. serum cholesterol testing for familial hypercholesterolemia or ultrasound screening for aortic disease in Marfan syndrome);

AND

3. The results of the genetic test will impact the medical management of the individual;

AND

4. Testing is accompanied by genetic counseling.

B. Genetic testing for diagnostic purposes in individuals not meeting the above criteria is considered INVESTIGATIVE. There is a lack of clinical evidence demonstrating its impact on improved health outcomes.

C. Genetic testing of an individual's entire genome or exome for any indication in the absence of genetic counseling with pedigree analysis as defined in this policy is considered INVESTIGATIVE. There is a lack of clinical evidence that this type of testing improves health outcomes.

***Knee Arthroplasty (Knee Replacement)***

- Pre-Certification/Pre-Authorization: Yes, ONLY when BOTH of the following criteria are met:

1. The provider performing the knee arthroplasty is located in Minnesota or a bordering county; AND
2. The member is less than 60 years of age OR 80 years of age or older.

This policy does not apply to the following lines of business:

1. Federal Employee Plan (FEP); OR

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2. Government Programs products; OR
3. Medicare Primary products.

- Total knee arthroplasty (also known as total knee replacement) for the treatment of advanced knee joint disease may be considered MEDICALLY NECESSARY for EITHER of the following indications:

A. Imaging and/or arthroscopic evidence of complete cartilage destruction (i.e., modified Outerbridge grade IV or Kellgren-Lawrence grade 4) AND both of the following:

1. Moderate to severe persistent knee pain; AND
2. Clinically significant functional limitation resulting in impaired, age-appropriate activities of daily living and diminished quality of life.

OR

B. Imaging and/or arthroscopic evidence of cartilage damage (i.e., modified Outerbridge grade III or Kellgren-Lawrence grade 3) when ALL of the following criteria are met:

1. Moderate to severe persistent knee pain despite use of BOTH of the following:

a. Medical management with nonsteroidal anti-inflammatory agents (NSAIDS) or other analgesic medications;

AND

b. Physical therapy, including strengthening exercises: 6 week course;

AND

2. Clinically significant functional limitation resulting in impaired, age-appropriate activities of daily living and diminished quality of life.

- Unicompartmental knee arthroplasty (also known as partial knee replacement) for the treatment of advanced knee joint disease limited to a single compartment (i.e., medial, lateral, or patellofemoral) may be considered MEDICALLY NECESSARY for EITHER of the following indications:

A. Imaging and/or arthroscopic evidence of complete cartilage destruction (i.e., modified Outerbridge grade IV or Kellgren-Lawrence grade 4) AND ALL of the following

1. Moderate to severe persistent knee pain localized to the affected compartment (i.e., medial, lateral, or patellofemoral); AND
2. Clinically significant functional limitation resulting in impaired, age-appropriate activities of daily living and diminished quality of life; AND
3. Involved knee demonstrates adequate alignment and ligamentous stability

OR

B. Imaging and/or arthroscopic r evidence of cartilage damage (i.e., modified Outerbridge grade III or Kellgren-Lawrence grade 3) AND ALL of the following:

1. Moderate to severe persistent knee pain localized to the affected compartment (i.e., medial, lateral, patellofemoral)

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despite use of BOTH of the following:

a. Medical management with nonsteroidal anti-inflammatory agents (NSAIDS) or other analgesic medications AND

b. Physical therapy, including strengthening exercises: 6 week course

AND

2. Clinically significant functional limitation resulting in impaired, age-appropriate activities of daily living and diminished quality of life.

AND

3. Involved knee demonstrates adequate alignment and ligamentous stability.

- Revision of knee arthroplasty may be considered MEDICALLY NECESSARY for any of the following indications:

A. Instability of the prosthetic components or aseptic loosening; OR

B. Periprosthetic fractures; OR

C. Fracture or dislocation of the patella; OR

D. Infection of the implant.

- The following knee procedures are considered INVESTIGATIVE due to a lack of evidence demonstrating an impact on improved health outcomes:

A. Bicompartmental knee arthroplasty and bi-unicompartmental knee arthroplasty;

B. Unicondylar interpositional spacer.

- Documentation: The following documentation must be submitted for initial knee arthroplasty:

1. Written report describing the extent of cartilage damage as determined by arthroscopy and/or diagnostic imaging, using the Modified Outerbridge classification system or the Kellgren-Lawrence grading system

2. Clinical notes describing:

a. Level of knee pain;

b. Functional limitations related to knee symptoms;

c. Medical management with nonsteroidal anti-inflammatory agents (NSAIDS) or other analgesics; and

d. Physical therapy.

3. For unicompartmental knee arthroplasty: an orthopedic assessment of knee alignment and ligamentous stability

***Gene Expression Testing for Cancers of Unknown Primary***

- Pre-Certification/Pre-Authorization: Not applicable.

- Gene expression testing is considered INVESTIGATIVE to evaluate the site of origin of a tumor of unknown primary

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or to distinguish a primary from a metastatic tumor due to a lack of evidence supporting its impact on improved health outcomes.

### Policies inactivated

**None**

## Policies reviewed with no changes in November 2013 – January 2014:

**Allogeneic Hematopoietic Stem-Cell Transplantation for Genetic Diseases and Acquired Anemias**

**Actigraphy**

**Anterior Eye Segment Scanning Computerized Imaging**

**Autism Spectrum Disorders: Assessment**

**Axial (Percutaneous) Lumbar Interbody Fusion**

**Bioimpedance Spectroscopy Devices for Detection and Management of Lymphedema**

**Breast Implant, Removal or Replacement**

**Communication Assist Devices**

**CT Colonography (Virtual Colonoscopy)**

**Electromagnetic Navigation Bronchoscopy**

**Extracorporeal Shock Wave Treatment for Plantar Fasciitis and Other Conditions**

**Functional Neuromuscular Electrical Stimulation Device**

**Genetic Testing for Familial Alzheimer's Disease**

**Growth Hormone Treatment**

**Hematopoietic Stem-Cell Transplantation for Hodgkin Lymphoma**

**Implantation of Intrastromal Corneal Ring Segments**

**Infliximab**

**Low-Level Laser Therapy and Deep Tissue Laser Therapy**

**Lysis of Epidural Adhesions**

**Neurofeedback/Electroencephalogram (EEG) Biofeedback**

**Occlusion of Uterine Arteries**

**Orthognathic Surgery**

**PathfinderTG® Molecular Testing**

**Pegloticase (Krystexxa)**

**Percutaneous Electrical Nerve Stimulation (PENS) or Percutaneous Neuromodulation Therapy (PNT)**

**Percutaneous Facet Joint Denervation**

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**Percutaneous Vertebroplasty, Kyphoplasty, and Sacroplasty**

**Phototherapy for the Treatment of Psoriasis**

**Psychological and Neuropsychological Testing**

**Scanning Laser Technologies for Glaucoma Testing and Monitoring**

**Spinal Cord Stimulation**

**Subtalar Arthroereisis**

**Treatment for Temporomandibular Disorder (TMD)**

**Tumor Markers, Urinary**

**Thrombopoietin Mimetic Agents for Treatment of Thrombocytopenia**

**Ultrasound-Guided High-Intensity Focused Ultrasound Ablation for Treatment of Prostate Cancer and Other Tumors**

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

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