Provider Press

September 2013 / Vol. 17, No. 3

For the health of all.

Utilization Management – we ask, you answer, we act

Every year, Blue Cross and Blue Shield of Minnesota (Blue Cross) conducts an electronic survey asking for provider feedback on our utilization management processes. In 2012, over 1,000 providers responded to this survey. Here are some of the results:

- 75% of respondents were satisfied with the prior authorization process for medical procedures
- 77% of respondents were satisfied with the prior authorization process for behavioral health procedures
- 65% of respondents were satisfied with the appeal process for utilization management denials
- 73% of respondents were satisfied with the quality of the clinical interaction they experienced with the utilization management reviewer
- 80% of respondents were satisfied with the services received from Blue Cross

In addition to multiple choice questions, survey respondents were able to write in opportunities for improvement. Based upon results of the survey and additional information collected, Blue Cross is working on the following actions to improve utilization management processes:

- Enhancing education to our provider representatives on prior authorizations, pre-certifications and pre-admission notifications for hospital stay requests
- Educating providers on the clinical information required for prior authorization requests in an effort to reduce the amount of appeals made because the initial request had insufficient clinical information
- Providing ongoing education on BlueCard requirements for appeals
- Continuing to make enhancements to the provider portals

We greatly appreciate everyone who responded to our 2012 survey. Last year, we gathered the overall responses and looked at each individual comment before planning actions to improve our utilization management processes.

We know your time is valuable and keep our survey to a limited number of questions. If you have not received the survey in the past and would like to complete one, please email Susan Nelsen at Susan_A_Nelsen@bluecrossmn.com.

Provider Press

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

Inside preview

FYI

Publications available online

The following is a list of Quick Points and Bulletins published from June 2013 to August 2013 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
QP13-13	Discontinuation of FluStop℠ program
QP14-13	U1 modifier for PCA services
QP15-13	IHM enhanced process for case and disease management
QP16-13	Effective July 1, 2013, newest version of the InterQual criteria being utilized
QP17-13	Medicare guidelines for processing of oxygen and oxygen equipment
Bulletins	**Title**
P4R2-13	Revised: Changes to the National Drug Code submission on Minnesota Health Care Programs (MHCP) claims
P15-13	Advance Beneficiary Notices of Noncoverage (ABN)
P16-13	Change in Certification of Need requirements for special transportation providers
P17-13	Update to Attachment B: Definition of Outpatient Health Services Categories
P18-13	July 2013 HCPCS code updates
P19-13	Pre-certification and concurrent review for residential substance use disorder services
P20-13	Pre-certification and concurrent review for eating disorder residential services
P21-13	Pre-certification and concurrent review for children's and adolescent residential mental health services
P22-13	Change in billing policy for child and teen checkups
P23-13	Number of allowed visits increases for family protocols for MHCP subscribers

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 June 2013 to August 2013. 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 6, Blue Plus	Content change made to Referral Required topic
Provider Policy and Procedure Manual	Chapter 8, Claims Filing	New topic added titled Mid Level Reduction Exemption
Provider Policy and Procedure Manual	Chapter 9, Reimbursement/ Reconciliation	Clarifications made to MNCare Tax
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Hospital/SNF Care section	Content change made to SNF Billing for Blue Plus Government Program Products
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Public Services section	Content change made to Interpretive Services topic
Blue Plus Manual	Chapter 1, Introduction to Blue Plus	Care Management Numbers and Addresses topic: Added clarification that prior authorization is only required for MSC+
Blue Plus Manual	Chapter 3, Government Programs	Long Term Care topic: • Changed nursing home care from 90 days to 180 days • Added clarification that a referral or a communication form is required for SecureBlue subscribers
Blue Plus Manual	Chapter 4, Referrals	Referrals Required topic: Removed requirement for a referral for SNF services

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: chemical dependency
- 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.

FYI

Minnesota Department of Health Awarded Innovations Grant

The Cancer Control Section at the Minnesota Department of Health (MDH) was awarded a five-year, $5.8 million Innovations Grant to increase cancer screening in the Minnesota Health Care Program (MHCP) population. The grant is a collaborative effort between MDH and the Minnesota Department of Human Services (DHS).

MDH plans to:

1. Develop and implement an innovative, cost-effective approach to increase breast, cervical and colorectal cancer screening rates among MHCP beneficiaries.
2. Develop highly effective, innovative and evocative direct mail materials coupled with a small ($20) financial incentive to increase age- and gender-appropriate screening for these cancers.
3. Work to sustain the effort and expand it to other states and organizations.

MDH will spend the first year working to increase colorectal cancer screening. They plan to start sending materials out to MHCP members this fall. The table below provides additional information on the MDH plan for this project.

Cancer site	Age and gender-appropriate MHCP enrollees	Estimated screening rate	Estimated intervention size	Tentative date of first mailing
Colorectal	142,000	48%	74,000	Fall 2013
Breast	131,000	51%	64,000	Early 2014
Cervical	299,000	67%	99,000	2015

Please note that the mailings from MDH will inform MHCP members that they will receive a $20 incentive for completing an appropriate cancer screen. Members will receive the $20 incentive after the claim has been processed.

If you have questions or concerns, please email Laura Friedenberg, Innovations Grant Coordinator, at Laura.Friedenberg@state.mn.us.

2013 Holiday schedule

Provider services will be closed on the following days in 2013:

Monday, September 2

Thursday, November 28

Friday, November 29

Wednesday, December 25

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

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.
Route 4-72
P.O. Box 64179
St. Paul, MN 55164-0179

Utilization management statement

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

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

Coding Corner

E/M appeal documentation reminder

On appeal, we need all records to support the level of service (evaluation and management or E/M) that was denied. The final medical record ("draft" documentation is not accepted) should be complete and legible and documentation should always include the following:

- patient's name
- date of service
- reason for the encounter and relevant history
- physical examination findings
- plan of care
- practitioner's signature

Additional information on appeal documentation can be found in the online Blue Cross and Blue Shield of Minnesota Provider Policy and Procedure Manual, Chapter 10, Appeals.

Assist at surgery

We need to know surgically what the assist did to warrant separate reimbursement. Denied assist at surgery services may be appealed with documentation to support separate reimbursement of assistant surgeon claims. The documentation/operative report should include the following:

- Name and credentials of assistant
- The specific activities the assistant surgeon performed. A separate operative note by the assistant surgeon* or specific documentation of the assistant's activities clearly identified within the primary surgeon's operative note is required.

  * A separate operative note will require the signature of the assistant surgeon

Stent edit update

Blue Cross has reviewed our edits involving urological stents and have since removed several edits effective August 1, 2013. The code 52332 will no longer deny against the following codes:

52325	52327	52330	52334	52341	52342	52344
52345	52346	52352	52353	52354	52355	

Coding Corner

October changes

October brings some of nature's finest days, crisp and cool with vivid colors. Oh, and it also brings not one, but two, medical coding updates. First, the HCPCS codes. Several HCPCS code revisions and additions have already been published by the Centers for Medicare & Medicaid Services (CMS) with more anticipated. Second are the ICD-9-CM procedures for 2014. There are no new ICD-9-CM diagnosis codes.

The effective date for both code sets will be October 1, 2013, and all revised and added codes will be recognized and accepted by this date. A Provider Bulletin will be issued before the effective date with details, along with the new and revised HCPCS and ICD-9-CM procedure codes.

A little more on signatures

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. If the signature requirements are not met, we will deny the claim appeal without considering the documentation with the missing or illegible signature.

And speaking of ICD

Blue Cross is diligently working and on course for full ICD-10 implementation, but providers need to ready themselves, also. Remember that October 1, 2014, is fast approaching and use of ICD-10 by that date is not optional. All "covered entities" — as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) — are required to adopt ICD-10 codes for use in all HIPAA transactions with dates of service on or after the October 1, 2014, compliance date.

Unlisted code reminder

Unlisted codes are an effective and valid way to report services or procedures where there is no other code that defines that service or procedure. However, the use of any unlisted code will be subject to review. When submitting a code that is by definition unlisted, not otherwise classified or not elsewhere classified, a narrative and/or documentation must be submitted describing the service or item. Your claim could be rejected or denied if this information is not submitted. Additionally, if on review we find there is a definitive code available, the unlisted code will be rejected.

Quality Improvement

Measuring Care Coordination

Defining care coordination is challenging. In 2007, researchers conducted a systemic review and found over 40 different definitions of "care coordination." They concluded, "care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshaling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care" (McDonald KM, Sundaram V, Bravata DM, et al. Care coordination. In : Shojania KG, McDonald KM, Wachter RM, and Owens DK, eds. Closing the quality gap: A critical analysis of quality improvement strategies. Vol. 7. Rockville, MD: Agency for Healthcare Research and Quality, June 2007.)

Communication is a key ingredient to facilitate care coordination. In 2012, Blue Cross surveyed over 1,000 providers to learn more about communication received by providers from other care sites. Here are results from that survey:

- 35% of responders chose "sometimes" or "usually" when asked **how often** they receive verbal or written communications from other care sites
- 84% of responders chose "sometimes useful" or "usually useful" when asked **how useful** they find the information in the verbal or written communications from specific types of care sites

The Agency for Healthcare Research and Quality has released The Care Coordination Measures Atlas, a resource for persons interested in measuring care coordination. The Care Coordination Measures Atlas is available online and for download (**http://www.ahrq.gov/professionals/systems/long-term-care/resources/coordination/atlas/care-coordination-measures-atlas.pdf**.)

This free resource:

- Provides a list of existing measures of care coordination (including over 15 measures for provider communication)
- Includes measures of patient and caregiver experiences with care coordination, as well as those of health care professionals and health system managers
- Features measures that are mapped to a conceptual framework linked to key domains, which are important in measuring care coordination
- Contains a five-step Jumpstart Guide users can follow to identify existing measures of care coordination that may meet their particular needs

Blue Cross is always looking for ways to improve continuity and coordination of care for patients and providers. If you would like to provide suggestions or participate in a survey about care coordination, please email Susan Nelsen at Susan_A_Nelsen@bluecrossmn.com.

Medical necessity decisions

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

Review UM criteria

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

FYI

New imaging management program for Sprint members

Your participating provider agreement with Blue Cross and Blue Shield of Minnesota supports the delivery of health services to members covered by other Blue Cross and Blue Shield plans across the country. One such plan, Blue Cross and Blue Shield of Illinois (BCBSIL), has partnered with American Imaging Management (AIM) Specialty Health℠ to offer a quality improvement and cost management program for members employed by Sprint. The program, Radiology Quality Initiative (RQI), is a prospective clinical review program for outpatient advanced diagnostic imaging services. Participating Sprint members can be identified by the alpha prefixes **("SKL," "SXX," "SKP," "SHM," "SPW," "SMT")** that appear on their Blue Cross and Blue Shield member ID cards. The diagnostic imaging studies covered under this program are:

- Computed tomography (CT/CTA)
- Magnetic resonance imaging (MRI/MRA)
- Nuclear cardiology
- Positron emission tomography (PET)

Imaging studies performed in conjunction with emergency room services, inpatient hospitalization, outpatient surgery at hospitals and surgery centers, urgent care centers, or observations are not part of this program.

How the process works

Providers are encouraged to contact AIM for an order number before scheduling one of the outpatient advanced diagnostic imaging procedures listed above for a Sprint member. Imaging providers are also encouraged to verify that an order number has been obtained before scheduling and performing diagnostic imaging exams.

Physicians can contact AIM by calling **1-866-455-8415** or using the online ProviderPortal at **americanimaging.net/goweb**.

The physician will need to give AIM the member's ID number and alpha prefix from the BCBSIL member ID card along with the following information:

✓ Member's identification number, name, date of birth and health plan

✓ Ordering physician information (name, location)

✓ Imaging provider information (name, location)

✓ Imaging exam(s) being requested (body part, right, left or bilateral)

✓ Patient diagnosis (suspected or confirmed)

✓ Clinical symptoms/indications (intensity/duration)

For complex cases, more information may be required, such as results of past treatment history.

This initiative began...

on August 1, 2013, and is designed to support the highest quality and affordable care for the members of Sprint. Blue Cross and Blue Shield of Minnesota and BCBSIL appreciate and thank our provider partners in their efforts to support this initiative.

If you have any questions or require additional information, please contact the number on the back of the member's ID card.

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 **45** 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 45 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 – Noridian, Part B – Wisconsin Physician Services, Home Health and Hospice – HHH MAC, Durable Medical Equipment Medicare Administrative Contractor – DME MAC, 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: 7/8/13 Notification Posted: 5/23/13

Policies developed

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

- The policy statements are as follows:
- The use of multianalyte assays with algorithmic analysis (MAAA) for the prediction of type 2 diabetes is considered INVESTIGATIVE due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Not applicable.

Policies revised

Stem-Cell Therapy for Orthopedic Applications

- The policy statements are as follows:
- Mesenchymal stem-cell therapy is considered INVESTIGATIVE for all orthopedic applications, including use in repair or regeneration of musculoskeletal tissue, due to a lack of evidence demonstrating an impact on improved health outcomes.
- Use of allograft bone products containing viable stem cells, including but not limited to demineralized bone matrix (DBM) with stem cells, is considered INVESTIGATIVE for all orthopedic applications, due to a lack of evidence demonstrating an impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Not applicable.

Bariatric Surgery

- The policy statements have been updated as follows:
- I. PATIENT SELECTION CRITERIA
  - A. The surgical treatment of morbid obesity may be considered MEDICALLY NECESSARY for patients 18 years of age or older who meet ALL the following criteria:
    1. The patient must have a Body Mass Index (BMI) of ≥ 40. Patients with a BMI of 35-40 will be considered when there is documentation of a co-morbid condition, such as hypertension refractory to standard drug regimens, cardiovascular disease, degenerative joint disease, documented obstructive sleep apnea, severe persistent asthma, or diabetes (See attached Body Mass Index [BMI] table at the end of this policy. This table was adapted from the NIH "Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults").
       AND
    2. The condition of morbid obesity must be of at least two years duration and must be present during the two years prior to surgery. Because attempts to lose weight over this two-year time period may cause small fluctuations around the required levels for the patient's BMI, the two-year time period will not necessarily start over, or be prolonged if small fluctuations occur.
       AND
    3. Over the last year prior to surgery, the patient has actively participated in a structured, nonsurgical weight loss program (i.e., a program that provides diet, exercise, and behavior modification strategies through individual or group counseling), for a total of six months with failure to achieve weight loss goals or maintain weight loss. Participation in one of these programs must be at least 3 consecutive months in duration. Participation must be monitored by the primary care physician providing medical oversight for the patient and must be documented

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in the medical record.
AND

4. The patient must be evaluated preoperatively by an eligible licensed Mental Health Professional[1] to ensure the absence of significant psychopathology that would hinder the ability of an individual to understand the procedure and comply with medical/surgical recommendations.

[1]The "Mental Health Professional" must meet the Minnesota Department of Human Services qualifications, as set forth in Minn.Stat.245.462, subd. 18 (2012)

AND

5. The physician requesting authorization for the surgery must confirm that the patient's treatment plan includes a surgical preparatory program addressing all the following components in order to improve outcomes related to the surgery and to establish the member's ability to comply with post-operative medical care and dietary restrictions:
   a. Pre-operative and post-operative dietary plan; AND
   b. Behavior modification strategies; AND
   c. Counseling and instruction on exercise and increased physical activity; AND
   d. Ongoing support for lifestyle changes necessary to make and maintain appropriate choices that will reduce health risk factors and improve overall health.

- II. SURGICAL PROCEDURES

A. The following surgical procedures may be considered MEDICALLY NECESSARY in the treatment of morbid obesity when the previous patient selection criteria have been met:
   1. Open gastric bypass using a Roux-en-Y anastomosis with an alimentary or Roux limb of ≤ 150 cm;
   2. Laparoscopic gastric bypass using a Roux-en-Y anastomosis;
   3. Open vertical banded gastroplasty;
   4. Adjustable gastric banding, consisting of an adjustable external band placed around the stomach (i.e., Lap-Band® and REALIZE Band);
   5. Open or laparoscopic biliopancreatic bypass (i.e., Scopinaro procedure) with duodenal switch;
   6. Open or laparoscopic sleeve gastrectomy.

B. Any other surgical or minimally invasive procedure is considered INVESTIGATIVE as a treatment of morbid obesity, including but not limited to:
   1. Laparoscopic vertical banded gastroplasty;
   2. Gastric bypass using a Billroth II type of anastomosis, known as the mini-gastric bypass;
   3. Biliopancreatic bypass (i.e., the Scopinaro procedure) without duodenal switch;
   4. Long-limb gastric bypass procedure (i.e., > 150 cm);
   5. Endoluminal (also called endosurgical, endoscopic, sclerosing endotherapy or natural orifice transluminal endoscopic) procedure as a primary bariatric procedure or as a revision procedure (e.g., to treat weight gain after bariatric surgery or to remedy large gastric stoma or large gastric pouches), by any method (e.g., insertion of the StomaphyX™ device);
   6. Bariatric surgery (any procedure) solely as a cure for type 2 diabetes mellitus.

- III. Reoperation Criteria

A. Revision bariatric surgery OR conversion of one type of bariatric surgery to a different procedure may be considered MEDICALLY NECESSARY using one of the procedures identified under II.A for EITHER of the following indications:
   1. Treatment of surgical complications following the original bariatric surgery. Complications may include, but are

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not limited to: staple-line failure, obstruction, stricture, malnutrition, erosion or band slippage, pouch dilation, or stoma ulcer:

OR

2. Inadequate weight loss following the original surgery when ALL the following criteria are met:
   a. Documentation shows the patient was compliant with the postoperative dietary and exercise program described in I.A.5; AND
   b. Patient currently has a BMI ≥ 40 OR a BMI of 35-40, with documentation of an obesity-related co-morbid condition as described in I.A.1; AND
   c. At least two (2) years have elapsed since the original bariatric surgery.

- Pre-Certification/Pre-Authorization: Yes.

Policies inactivated

Corneal Topography/Computerized Corneal Topography
Measurement of Long Chain Omega-3 Fatty Acids as a Cardiac Risk Factor
Mechanical Embolectomy for Treatment of Acute Stroke
Nociceptive Trigeminal Inhibition – Tension Suppression System (NTI-tss) for Treatment of Headache
Unicondylar Interpositional Spacer (Unispacer)
NOTE: This policy has been combined with the policy on Knee Arthroplasty (Knee Replacement), IV-122

Policies Effective: 08/12/13 Notification Posted: 06/27/13

Policies developed

None

Policies revised

Treatment of Obstructive Sleep Apnea and Snoring in Adults

- The policy statements have been updated as follows:
- I. Medical Management
  A. Oral Appliances
  Oral appliances (e.g., mandibular advancing/positioning devices or tongue-retaining devices) may be considered MEDICALLY NECESSARY in patients with OSA confirmed by polysomnography.
  B. Continuous Positive Airway Pressure (CPAP)
  Continuous positive airway pressure (CPAP) may be considered MEDICALLY NECESSARY in patients with confirmed OSA with:
  1. An AHI of 15 or greater;
  OR
  2. An AHI between 5 and 14 with any of the following associated symptoms:
     a. Excessive daytime sleepiness
     b. Impaired cognition
     c. Mood disorders
     d. Insomnia

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e. Documented hypertension
f. Ischemic heart disease
g. History of stroke

C. Bi-level Positive Airway Pressure (BiPAP)

BiPAP may be considered MEDICALLY NECESSARY in patients

1. Who meet the criteria for CPAP;

AND

2. Who have failed a prior trial of CPAP;

OR

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

D. Auto-Adjusting PAP (APAP)

APAP may be considered MEDICALLY NECESSARY in patients who:

1. Meet the criteria for CPAP above;

AND

2. Have failed a prior trial of CPAP or for whom CPAP is contraindicated or who are undergoing a trial of APAP to titrate CPAP;

AND

3. Patient has no evidence by history or physical examination of the following conditions:
   a. Central sleep apnea
   b. Congestive heart failure
   c. Chronic pulmonary disease such as chronic obstructive pulmonary disease
   d. Pulmonary hypertension
   e. Obesity hypoventilation syndrome or other condition which may cause nocturnal arterial oxyhemoglobin desaturation

E. Expiratory Positive Airway Pressure (EPAP)

An EPAP device (ie, Provent®) is considered INVESTIGATIVE due to the lack of clinical evidence demonstrating its impact on improved health outcomes.

F. Oral Pressure Therapy Devices

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

G. Atrial Pacing

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

- II. Surgical Management

A. Uvulopalatopharyngoplasty (UPPP)

UPPP may be considered MEDICALLY NECESSARY when all the following criteria are met:

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

OR

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

AND

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a. BMI less than 40

AND

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

B. Maxillofacial Procedures

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

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

OR

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

AND

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

AND

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

C. Other Surgical Procedures

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

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

- II. Treatment of Snoring

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

A. Uvulectomy

B. Laser-assisted palatoplasty (LAUP)

C. Radiofrequency volumetric reduction of the palatal tissues

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

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

F. Tongue base suspension

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

Organ Transplantation

- NOTE: Previous separate medical policies on specific types of organ transplantation have now been combined into one policy.
- The policy statements have been updated as follows:
- I. The following organ transplant procedures may be considered MEDICALLY NECESSARY when the following criteria are met:
  - A. Kidney transplantation (with either a living or cadaver donor) for carefully selected patients with end-stage renal disease who meet patient selection criteria established by the Organ Procurement and Transplantation Network (OPTN) and the United Network of Organ Sharing (UNOS).
  - B. Heart transplantation for carefully selected adult or pediatric patients with end-stage heart failure who meet patient selection criteria established by the Organ Procurement and Transplantation Network (OPTN) and the United Network of Organ Sharing (UNOS)
  - C. Heart/Lung transplantation for carefully selected patients with end-stage cardiac and pulmonary disease who meet patient selection criteria established by the Organ Procurement and Transplantation Network (OPTN) and the United Network of Organ Sharing (UNOS)
  - D. Lung and Lobar Lung transplantation for carefully selected patients with irreversible, progressively disabling, end-stage pulmonary disease who meet patient selection criteria established by the Organ Procurement and Transplantation Network (OPTN) and the United Network of Organ Sharing (UNOS)
  - E. Small Bowel transplantation for patients who meet the following criteria:
    1. Intestinal failure, characterized by loss of absorption and the inability to maintain protein-energy, fluid, electrolyte, or micronutrient balance; AND
    2. Established long-term dependency on total parenteral nutrition (TPN) and patient is developing or has developed severe complications due to TPN*

       * Severe complications due to TPN include, but are not limited to: multiple and prolonged hospitalizations to treat TPN-related complications (especially repeated episodes of catheter-related sepsis) or the development of progressive liver failure. In the setting of progressive liver failure, small bowel transplant may be considered a technique to avoid end-stage liver failure related to chronic TPN, thus avoiding the necessity of a multivisceral transplant. In those receiving TPN, liver disease with jaundice (total bilirubin above 3 mg/dl) is often associated with development of irreversible progressive liver disease. The inability to maintain venous access and great vein damage are additional reasons to consider small bowel transplant in those who are dependent on TPN.
  - F. Small Bowel/Liver and Multivisceral transplantation for patients who meet the following criteria:
    1. Intestinal failure characterized by loss of absorption and the inability to maintain protein-energy, fluid, electrolyte, or micronutrient balance; AND
    2. Established long-term dependency on total parenteral nutrition (TPN) and evidence of impending end-stage liver failure
  - G. Allogeneic Pancreas
    1. Combined pancreas-kidney transplantation in diabetic patients with end-stage renal disease;
    2. Pancreas transplantation after a prior kidney transplantation in patients with insulin-dependent diabetes;
    3. Pancreas transplantation alone in patients with severely disabling and potentially life-threatening

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complications due to hypoglycemia unawareness or labile diabetes that persists despite optimal medical management;

4. Pancreas retransplantation after a failed primary pancreas transplantation

H. Liver

1. Transplantation with either a cadaver or living donor, in carefully selected patients with end-stage liver failure due to irreversible damage to the liver. Conditions causing end-stage liver disease include, but are not limited to, the following:
   a. Hepatocellular disease
      - Alcoholic cirrhosis;
      - Viral hepatitis (A, B, C)
      - Autoimmune hepatitis;
      - Alpha-1 antitrypsin deficiency;
      - Hemochromatosis;
      - Non-alcoholic steatohepatitis (NASH);
      - Protoporphyria;
      - Wilson's disease;

   b. Cholestatic liver disease
      - Primary biliary cirrhosis;
      - Primary sclerosing cholangitis with development of secondary biliary cirrhosis;
      - Biliary atresia

   c. Vascular disease
      - Budd-Chiari syndrome

   d. Primary hepatocellular carcinoma;
   e. Inborn errors of metabolism;
   f. Trauma and toxic reactions;
   g. Polycystic disease of the liver;
   h. Familial amyloid polyneuropathy;
   i. Unresectable hilar cholangiocarcinoma
2. Liver retransplantation in patients with the following indications:
   a. Primary graft non-function;
   b. Hepatic artery thrombosis;
   c. Chronic rejection;
   d. Ischemic-type biliary lesions;
   e. Recurrent non-neoplastic disease causing late graft failure

- II. All other indications for organ transplantation are considered INVESTIGATIVE, due to a lack of evidence demonstrating an impact on improved health outcomes. Those indications include, but are not limited to:
  A. Liver transplantation
     1. Intrahepatic cholangiocarcinoma;
     2. Hepatocellular carcinoma extending beyond the liver;
     3. Neuroendocrine tumors metastatic to the liver.
- Pre-Certification/Pre-Authorization: Yes, EXCEPT for kidney transplantation.

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

- The policy statements have been updated as follows:
- I. Genetic testing of BRCA1 and BRCA2 may be considered MEDICALLY NECESSARY under any of the following circumstances:

A. Personal history of breast cancer

Individual has a personal history of breast cancer including invasive cancer or ductal carcinoma in situ with ANY of the following:

1. Diagnosed at age 45 or younger with or without family history of breast or other cancers.
2. Diagnosed at age 50 or younger with limited family history (e.g., fewer than two first-or second-degree female relatives or female relatives surviving beyond 45 years in either lineage, may have an underestimated probability of a familial mutation).
3. Diagnosed at age 60 or younger with breast cancer that is triple negative (estrogen receptor, progesterone receptor and HER2 negative).
4. Diagnosed at any age with one or more of the following:
   a. Male gender
   b. Primary tumors in both breasts or clearly defined multiple tumors in one breast when first breast cancer diagnosis occurred at or younger than age 50
   c. One or more close blood relatives with breast cancer at or before age 50
   d. One or more close blood relatives with ovarian, fallopian tube, or primary peritoneal cancer at any age
   e. Two or more close blood relatives from the same side of the family with breast cancer at any age
   f. Two or more close blood relatives from the same side of the family with pancreatic cancer at any age
   g. Two or more close blood relatives from the same side of the family with prostate cancer (Gleason score of 7 or greater) at any age
   h. Close male blood relative with breast cancer
   i. Of an ethnicity associated with higher BRCA1 and/or BRCA2 mutation frequency (e.g., Ashkenazi Jewish, Icelandic, Swedish, Dutch, or Hungarian descent)

B. Individual has a personal history of one or more of the following cancers:

1. Ovarian cancer
2. Fallopian tube cancer
3. Primary peritoneal cancer
4. Pancreatic cancer at any age with two or more close blood relatives from the same side of the family with breast, ovarian, fallopian tube, primary peritoneal, pancreatic or prostate cancer (Gleason score of 7 or greater) at any age
5. Prostate cancer (Gleason grade of 7 or greater) at any age with two or more close blood relatives from the same side of the family with breast, ovarian, fallopian tube, primary peritoneal, pancreatic or prostate cancer (Gleason score of 7 or greater) at any age

C. Individual 18 years of age or older with no personal history of cancers listed above AND meets one or more of the following after pre-test genetic counseling with pedigree analysis has determined the risk of developing cancer, the potential utility of testing, and surveillance or risk reduction options based on the family history. Significant limitations of interpreting test results for an unaffected individual should be discussed.

1. Is a member of a family with a known deleterious BRCA1 and/or BRCA2 mutation in a close blood relative.

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Individuals who meet this criterion are candidates for BRCA single-site analysis.

OR

2. An appropriate affected family member is unavailable for testing;

AND

3. A first-or second-degree blood relative meets any of the above criteria;

OR

4. A third-degree blood relative with breast cancer and/or ovarian cancer;

AND

a. Two or more close blood relatives from the same side of the family with breast cancer (at least one with breast cancer diagnosed at age 50 or younger), and/or

b. Two or more close blood relatives from the same side of the family with ovarian cancer.

- II. Testing for rearrangements of the BRCA1 and BRCA2 genes [BRACAnalysis® Rearrangement Test (BART)] may be considered MEDICALLY NECESSARY for individuals who:
  A. Meet one or more of the criteria for BRCA1 and/or BRCA2 testing,
  AND
  B. Have tested negative for mutations in BRCA1 and/or BRCA2 sequencing.
- III. BRCA1 and/or BRCA2 testing is considered INVESTIGATIVE for all other indications, including but not limited to testing in individuals younger than age 18 without a personal history of cancers addressed in this policy. There is a lack of clinical evidence demonstrating its impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Yes.

Myoelectric Prostheses for the Upper Limb

- The policy statements have been updated as follows:
- I. Myoelectric upper limb prosthetic components may be considered MEDICALLY NECESSARY when all of the following conditions are met:
  A. The patient has an amputation or missing limb at the wrist or above (e.g., forearm, elbow, shoulder);
  AND
  B. Standard body-powered prosthetic devices cannot be used or are insufficient to meet the functional needs of the individual (e.g., gripping, releasing, holding, and coordinating movement of the prosthesis);
  AND
  C. The remaining musculature of the arm(s) contains the minimum microvolt threshold to allow operation of a myoelectric prosthetic device;
  AND
  D. The patient has demonstrated sufficient neurological and cognitive function to operate the prosthesis effectively;
  AND
  E. The patient is free of comorbidities that could interfere with function of the prosthesis (e.g., neuromuscular disease);
  AND
  F. Functional evaluation indicates that with training, use of a myoelectric prosthesis is likely to meet the functional needs (e.g., gripping, releasing, holding, and coordinating movement of the prosthesis) of the individual. This evaluation should consider the patient's needs for control, durability (maintenance), function (speed, work

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capability), and usability.

- II. A prosthesis with individually powered digits, including but not limited to a partial hand prosthesis, is considered INVESTIGATIVE due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Yes.

Microprocessor – Controlled Prostheses for the Lower Limb

- The policy statements have been updated as follows:
- I. The use of a microprocessor-controlled knee may be considered MEDICALLY NECESSARY for transfemoral amputees or knee disarticulation amputees who meet all the following criteria:

A. Demonstrated need for long distance ambulation at variable rates (use of the limb in the home or for basic community ambulation is not sufficient to justify provision of the computerized limb over standard limb applications) OR demonstrated patient need for regular ambulation on uneven terrain or for regular use on stairs (use of the limb for limited stair climbing in the home or employment environment is not sufficient evidence for prescription of this device over standard prosthetic application);

AND

B. Individual has a functional ambulation level of K3 or K4.

- Level K3 - Has ability or potential for ambulation at variable cadence typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion;

OR

- Level K4 - Has ability or potential for prosthetic ambulation that exceeds basic ambulation skills such as those exhibiting high impact, stress, or energy levels typical of the prosthetic demands of an active adult or athlete;

AND

C. Meets height and weight requirements of the device specified by the manufacturer;

AND

D. Physical ability, including adequate cardiovascular and pulmonary reserve, for ambulation at variable walking speeds; and

E. Cognitive ability to understand gait sequencing, use and care requirements for the technology;

AND

F. Adequate strength and balance to stride and activate the knee unit and use the swing and stance features of the unit, with no significant deformity of the remaining limb that would impair the ability to stride;

AND

G. Free of any condition, such as ataxia, that limits ambulation;

AND

H. Absence of significant hip flexion contracture (i.e., over 20 degrees);

AND

I. Use of limb will not include long distance or competitive running;

AND

J. Limb will not be used in environments that limit functional life of the device such as those with excessive moisture, dust, or inability to charge the prostheses; or use in extremely rural conditions where maintenance is limited.

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- II. The use of a powered knee is considered INVESTIGATIVE due to a lack of evidence demonstrating improved health outcomes.
- III. The use of a microprocessor-controlled or powered foot is considered INVESTIGATIVE due to lack of evidence demonstrating improved health outcomes.
- Pre-Certification/Pre-Authorization: Yes.

Spinal Fusion: Lumbar

- The policy statements have been updated as follows:
- I. Lumbar spinal fusion may be considered MEDICALLY NECESSARY for any of the following indications when confirmed by imaging studies (e.g., x-ray, CT, MRI):
  - A. Epidural compression or vertebral destruction from a tumor;
  - B. Neural compression after spinal fracture;
  - C. Instability after debridement for infection;
  - D. Spinal infections (e.g., osteomyelitis, spinal tuberculosis);
  - E. Severe or rapidly progressive symptoms of motor loss, neurogenic claudication or cauda equina syndrome;
  - F. Idiopathic scoliosis when EITHER of the following criteria are met:
    1. Scoliotic curve with a Cobb angle > 45 degrees in children who are skeletally immature; OR
    2. Scoliotic curve with a Cobb angle > 50 degrees resulting in functional impairment in skeletally mature individuals;
  - G. Pseudoarthrosis
- II. Lumbar spinal fusion, alone or in conjunction with a primary decompression surgery, may be considered MEDICALLY NECESSARY for treatment of degenerative conditions with spinal instability when ALL the following criteria are met:
  - A. ONE of the following conditions are present:
    1. Post-laminectomy instability; OR
    2. Degenerative scoliosis or kyphosis; OR
    3. Spondylolisthesis, OR
    4. Spinal stenosis with spondylolisthesis;

  AND
  - B. Documented unremitting pain and disability refractory to intensive conservative therapy for three (3) months. Intensive conservative therapy must have occurred within the previous six (6) months AND must include ALL of the following:
    1. An active, organized, and progressive strength and flexibility program; AND
    2. A minimum of two sessions per week over the 3-month period; AND
    3. An educational component that deals with patient expectations and perceptions, as well as the anatomic sources of back pain; AND
    4. Documentation for intensive conservative therapy must include Oswestry Disability Index (ODI) scores demonstrating ONE of the following:
       a. Less than 30% improvement in the ODI score between the first and last physical therapy session; OR
       b. Continued ODI score of greater than or equal to 40% at the conclusion of physical therapy

  AND

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

AND

D. Documentation, from the patient's primary care physician or a Mental Health Professional* of an absence of untreated, underlying, contributory mental health conditions or psychosocial issues including, but not limited to, depression or drug or alcohol abuse.

*The Mental Health Professional must meet the Minnesota Department of Human Services qualifications, as set forth in MINN.STAT.245.462, subd. 18 (2012) and MINN. STAT.245.4871, subd. 27 (2012).

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

A. ONE of the following conditions are present:

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

AND

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

1. An active, organized, and progressive strength and flexibility program; AND
2. A minimum of two sessions per week over the 3-month period; AND
3. An educational component that deals with patient expectations and perceptions , as well as the anatomic sources of back pain; AND
4. Documentation for intensive conservative therapy must include Oswestry Disability Index (ODI) scores demonstrating ONE of the following:
   a. Less than 30% improvement in the ODI score between the first and last physical therapy session; OR
   b. Continued ODI score of greater than or equal to 40% at the conclusion of physical therapy

AND

C. Diagnostic imaging (e.g., CT, MRI) demonstrates spinal cord compression; AND

D. Documentation from the patient's primary care physician or a Mental Health Professional* of an absence of untreated, underlying, contributory mental health conditions or psychosocial issues including, but not limited to, depression or drug or alcohol abuse.

*The Mental Health Professional must meet the Minnesota Department of Human Services qualifications, as set forth in MINN.STAT.245.462, subd. 18 (2012) and MINN. STAT.245.4871, subd. 27 (2012).

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

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

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1. Anti-inflammatory medication and analgesics, unless contraindicated; AND
2. Therapeutic injections; AND
3. An active, organized, and progressive strength and flexibility program; AND
4. A minimum of two sessions per week over the 3-month period; AND
5. An educational component that deals with patient expectations and perceptions , as well as the anatomic sources of back pain; AND
6. Documentation for intensive conservative therapy must include Oswestry Disability Index (ODI) scores demonstrating ONE of the following:
   a. Less than 30% improvement in the ODI score between the first and last physical therapy session; OR
   b. Continued ODI score of greater than or equal to 40% at the conclusion of physical therapy

   AND

B. Documentation from the patient's primary care physician or a Mental Health Professional* of an absence of untreated, underlying, contributory mental health conditions or psychosocial issues including, but not limited to, depression or drug or alcohol abuse.

*The Mental Health Professional must meet the Minnesota Department of Human Services qualifications, as set forth in MINN.STAT.245.462, subd. 18 (2012) and MINN. STAT.245.4871, subd. 27 (2012).

AND

C. Diagnostic imaging (e.g. MRI, CT) demonstrates degenerative disc disease limited to 1 – 2 disc levels.

- Pre-Certification/Pre-Authorization: Yes.

Respiratory Syncytial Virus (RSV) Prophylaxis

- The following sections of the policy have been updated:
- I. INITIAL RSV SEASON

  The use of immune prophylaxis (e.g., palivizumab [Synagis]) for RSV for the initial RSV season, may be considered MEDICALLY NECESSARY when used in the following patient populations with the described number of doses:

  A. Maximum of Five (5) Doses

  4. Infants born before 32 weeks' gestation (i.e., 31 weeks, 6 days or less)
     a. All infants born ≤ 28 weeks of gestation and less than one year of age at onset of RSV season;
     b. Infants born on or after May 1st at 29 to 32 weeks of gestation and less than 6 months old at onset of RSV season;
     c. Maximum of 5 monthly doses.

  B. Maximum of Three (3) Doses

  1. Infants born on or after August 1st at 32 to less than 35 weeks' gestation (i.e., 32 weeks, 0 days through 34 weeks, 6 days) who do not meet the above criteria:
     a. Infants less than 3 months old at onset of RSV season or who are born during the RSV season and who have at least one of the following high-risk factors:
        - Sibling (not a twin or a multiple) younger than 5 years of age; or
        - Infant attends child care
     b. Infants may receive prophylaxis through 3 months of age (i.e., through the 3rd month until the infant reaches 4 months of age);
     c. Maximum of 3 monthly doses.

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- III. ADMINISTRATION OF RSV PROPHYLAXIS
  - A. Once a child qualifies for prophylaxis, administration should continue the entire season through the maximum monthly doses allowed as described above.
  - B. The first dose of immune prophylaxis for RSV will be approved for coverage of administration on or after November 1st.
  - C. Administration of more than the number of doses described above in one RSV season (defined as November 1st through March 31st) is considered NOT MEDICALLY NECESSARY without documented widespread local community RSV activity, indicating early onset of season or extending past April.
- No significant changes were made to the remaining sections of the policy.
- Pre-Certification/Pre-Authorization: Yes

There was no Medical and Behavioral Health Policy Activity for July 2013.

Policies reviewed with no changes in May 2013 and June 2013:

Artificial Intervertebral Disc - Cervical Spine
Audio-Visual Entrainment
Belimumab
Bone Growth Stimulators
Cardiovascular Disease Risk Assessment and Management: Laboratory Evaluation of Lipid Subclasses
Cellular Immunotherapy for Prostate Cancer
Compassionate Use
Cranial Electrotherapy Stimulation
Cytochrome P450 Genotyping
Dynesys® Spinal System and Lumbar Dynamic Stabilization
Endoscopic Radiofrequency Ablation or Cryoablation for Barrett's Esophagus
Epidermal Growth Factor Receptor (EGFR) Analysis for Non-Small Cell Lung Cancer
Fecal Calprotectin Testing
Gene-based Tests for Screening, Detection, and/or Management of Prostate Cancer
Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma
Hematopoietic Stem-Cell Transplantation in the Treatment of Germ-Cell Tumors
Homocysteine Testing in Risk Assessment and Management of Cardiovascular Disease
Image-Guided Minimally Invasive Lumbar Decompression for Spinal Stenosis
Liposuction
Lung Cancer Screening Using Computed Tomography (CT)
Mastopexy
Measurement of Lipoprotein-Associated Phospholipase A2 (Lp-PLA2) in the Assessment of Cardiovascular Risk
Positron Emission Tomography (PET): Cardiac Applications
Prometa
Sleep Disorder Testing in Adults
Spider Veins/Dermal Telangiectasias
Stem-Cell Therapy for Peripheral Arterial Disease

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Subcutaneous Hormone Pellets
Surgical Treatment of Femoroacetabular Impingement
Systems Pathology Testing for Predicting Risk of Recurrence in Prostate Cancer
Tesamorelin (Egrifta®)
Testing for Common Genetic Variants to Predict Risk of Non-Familial Breast Cancer
Traction Decompression of the Spine (VAX-D, LORDEX, DRX9000)
Treatment of Obstructive Sleep Apnea and Snoring
Transilluminated Powered Phlebectomy

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

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

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For the health of all.

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