Provider Press

June 2013 / Vol. 17, No. 2

For the health of all.

Spirometry testing – important for the diagnosis and management of COPD

The Minnesota COPD Coalition reports that "Among Minnesota adults with COPD, over a quarter have never received a spirometry test, the standard for COPD diagnosis." Blue Plus is participating in a collaborative with HealthPartners and Medica to increase the rate of spirometry testing in our MSHO/MSC+ populations. Spirometry testing is important for patients who are newly diagnosed or have recently active symptoms of COPD. Providers may receive a letter from the plan that identifies a patient whose administrative data indicates a recent (within previous 2 years) diagnosis of COPD and does not have a claim for spirometry testing. Please consider spirometry testing where appropriate and fax back the response included in the mailing. Thank you for your participation in this performance improvement project. Please direct any questions concerning this project to Sheila Dalen, RN at **(651) 662-1170** or Sheila_M_Dalen@bluecrossmn.com.

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: precertification and preauthorization
- 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 March 2013 to May 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
QP6-13	Autism Spectrum Disorders: EIBI policy inactivation effective March 11, 2013
QP7-13	EquiClaim to perform DRG and hospital chart audits on facility claims
QP8-13	Healthcare Effectiveness Data Information Set (HEDIS) medical record reviews are in process
QP9-13	Dental electronic format for claim submission
QP10-13	Payment transformation
QP11-13	Dialectical Behavior Therapy for Borderline Personality Disorder
QP12-13	Reminder of the award for Jurisdiction 6 Part A/Part B Medicare Administrative Contractor to National Government Services
Bulletins	**Title**
P4-13	National Drug Code submission on Minnesota Health Care Programs (MHCP) claims
P4R1-13	Revised: Changes to the National Drug Code submission on Minnesota Health Care Programs (MHCP) claims
P5-13	Hysterectomy Acknowledgement Statement for Minnesota Health Care Programs (MHCP) subscribers
P6-13	Payment provisions based on practitioner licens
P7-13	Revised: Substance abuse services revisions
P8-13	Observation room policy revision
P9-13	April 2013 HCPCS code updates
P10-13	Anesthesia Services for Gastrointestinal Endoscopic Procedures
P11-13	Requesting that providers validate their information on Medicare and Blue Cross websites
P12-13	Cervical spinal fusion pre-certification/pre-authorization review requirement
P13-13	Sequestration and impacts to processing of claims for services under Medicare programs
P14-13	Medical necessity review criteria vendor change for behavioral health

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:

E-mailed 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 March 2013 to May 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 8, Claims Filing	• Content change made to Surgical Technicians and MBBS Practitioners • Added a new topic entitled "Master Level Practitioners" • Content change to reporting MNCare and Sales tax
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Introduction	Added a new section entitled "Introduction"
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Coding	Content changes to Preventive services required under the PPACA
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Behavioral Health	Content change to Autism Spectrum Disorder: Assessment/EIBI
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Public Programs	Content changes to Formulary Exception Process
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Optometric/Optical Services	Content change to eyewear billing and reimbursement

Coding Corner

Claims edit reminder

Blue Cross' coding edits are updated at minimum annually to incorporate new codes, code definition changes and edit rule changes. While all of the code additions and revisions effective January 2013 are being accepted, edits involving the code changes for 2013 are currently under development and review. Once the edits are loaded, all claims submitted after the implementation date of this update, regardless of service date, will be processed according to the updated version.

FYI

Blue Plus pre- and post-chiropractic review

To assist with timely pre- and post-chiropractic review for Prepaid Medical Assistance Program (PMAP), MinnesotaCare, Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) subscribers, please note the following information:

Chiropractic services require a prior authorization after 12 visits in a calendar year per the subscriber's contract. Please note chiropractic claims and prior authorizations must be submitted separately.

Prior authorization is required for all chiropractic visits beyond the initial 12 and for each episode of care. For example, the subscriber's condition required 12 visits for a specific diagnosis and then 3 months later, requires additional chiropractic services for either the same or different diagnosis. This new episode of care would require a prior authorization, as the subscriber has already received the 12 visits for the year without review.

All prior authorization reviews are completed within 10 business days of receipt of request. Notification of prior authorization is by phone or fax to the provider and letter to member and provider.

All retrospective reviews (claims) beyond 12 visits will require the provider to submit clinical information. Clinical information would include:

- Initial assessment
- Progress/treatment notes
- Plan of care with specific and measurable treatment goals

Generally, claim reviews are completed within 30 days of receipt of claim. Notification is sent to the provider and the subscriber as an Explanation of Health Care Benefits (EOB).

2013 Holiday schedule

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

Monday, May 27

Thursday, July 4

Friday, July 5

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

Quality Improvement

2013 performance improvement project: Chlamydia screening in women

This performance improvement project (PIP) is a Collaborative effort among four Minnesota health plans: Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica and UCare with project support provided by Stratis Health.

The goal of this PIP is to increase the rate of Chlamydia screening in women among the Prepaid Medical Assistance (PMAP) and MinnesotaCare (MNCare) subscribers who meet study population criteria.

Provider/clinic interventions

The Collaborative will work with clinics in a variety of ways to impact the Chlamydia screening rates for Minnesota Health Care Program (MHCP) subscribers:

1. **Provider trainings.** The Collaborative will offer periodic online provider trainings on the topic of Chlamydia, including the medical issues related to the disease such as symptoms, prevalence, treatment options, and short and long-term effects.
2. **Provider toolkit.** The Collaborative will offer a toolkit to clinics and providers across the state to improve their clinic processes and awareness of the issue.

The **provider toolkit** was developed to help clinics and providers across the state make simple changes to improve their clinic processes and raise awareness of this public health issue. The toolkit includes:

- Current information on the status of the disease
- Sample office protocols
- Resources for your clinic, patients and parents
- Profiles of four Minnesota clinics with successful Chlamydia screening efforts

The toolkit is available at:
stratishealth.org/pip/documents/Chlamydia_Toolkit.pdf

Blue Cross and Blue Shield of Minnesota, HealthPartners, Medica and UCare developed this toolkit as a collaborative effort with support from Stratis Health.

Please direct any questions concerning this project to Margaret Crawford at **(651) 662-7098** or Margaret_M_Crawford@bluecrossmn.com.

Coding Corner

Units reminder

Each service must be submitted with a unit of measurement. Multiple units (more than "1") of service per code, per date of service are applicable only if the HCPCS code definition supports submission of more than one unit. This is usually indicated by words such as each, per, or a specific dose for drug codes.

The number of units for codes that qualify for submission of multiple units may be subject to limits. Blue Cross edits procedure code units on professional claims (837P/1500 HICF). This edit will occur in the pre-adjudication phase of processing. If the claim submission does not pass (or fails for greater than one unit per day) it will stop and be rejected back to the provider.

This rejection occurs before the submission is accepted as a claim, therefore a claim number is not assigned and the provider must correct the data and resubmit all charges. There will not be any duplicate editing or adjustments because a "claim" was not created in the payer adjudication system.

26 and TC modifiers versus global

If performing both the technical (TC) and professional component (26) of a procedure, the service should be submitted globally (no modifier). This policy is supported by Minnesota Statutes, § 62J.536 and instructions are found in the Minnesota Uniform Companion Guide, Table A.5.1 Minnesota Coding Specifications, Chapter 13, Radiology Services and Other Diagnostic Procedures, Technical and professional coding.

And the codes keep a-coming

All of the HCPCS changes for July 1, 2013, are not posted to the CMS website at the same time. First out is a file of "other" codes available on the HCPCS Quarterly Update site (cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html). Also, the CPT category III codes that become effective July 1, 2013, have been posted on the AMA's category III webpage at

ama-assn.org/resources/doc/cpt/cptcat3codes.pdf.

The new codes start with 0319T on page 4 of that PDF.

Blue Cross will issue a Provider Bulletin closer to the July effective date with the new, discontinued or revised codes.

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: 4/15/13 Notification Posted: 2/27/13

Policies developed

Genetic Testing for FMR1 Mutations (Including Fragile X Syndrome)

- The policy statements are as follows:
- I. Genetic testing for FMR1 mutations may be considered MEDICALLY NECESSARY for the following patient populations:
  - A. Individuals of either sex with mental retardation, developmental delay, or autism spectrum disorder; or
  - B. Individuals seeking reproductive counseling who have a family history of fragile X syndrome or a family history of undiagnosed mental retardation; or
  - C. Prenatal testing of fetuses of known carrier mothers; or
  - D. Affected individuals or their relatives who have had a positive cytogenetic fragile X test results who are seeking further counseling related to the risk of carrier status among themselves or their relatives.
- II. Population-based screening for FMR1 mutations in individuals not meeting one or more of the criteria above is INVESTIGATIVE due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: No

Abatacept (Orencia®)

- The policy statements are as follows:
- I. Abatacept may be considered MEDICALLY NECESSARY for treatment of:
  - A. Moderate to severe rheumatoid arthritis (RA) in adults (age 18 and older) who have had an inadequate response to one or more DMARD **or** one or more TNF antagonist.
  - B. Moderate to severe active polyarticular juvenile idiopathic arthritis (JIA) in patients aged 6 years and older.
- II. Abatacept is considered INVESTIGATIVE for all other indications, including but not limited to:
  - A. RA in patients under age 18
  - B. Concomitant administration of abatacept with a TNF antagonist
  - C. JIA in patients under age 6
  - D. Systemic lupus erythematosus
  - E. Multiple sclerosis
  - F. Psoriasis vulgaris
  - G. Psoriatic arthritis
  - H. Graft versus host disease
  - I. Ankylosing spondylitis
  - J. Giant cell arteritis
  - K. Takayasu's arteritis
  - L. Scleroderma
  - M. Type I diabetes
  - N. Uveitis.
- Pre-Certification/Pre-Authorization: No.

Proteomics-Based Testing Panels for the Evaluation of Ovarian (Adnexal) Masses

- The policy statements are as follows:

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- Proteomics-based testing panels including OVA1™ and ROMA™ are considered INVESTIGATIVE for all indications including but not limited to:
  A. Preoperative evaluation of adnexal masses to triage for malignancy
  B. Screening for ovarian cancer
  C. Selecting patients for surgery for an adnexal mass
  D. Evaluation of patients with clinical or radiologic evidence of malignancy
  E. Evaluation of patients with nonspecific signs or symptoms suggesting possible malignancy
  F. Postoperative testing and monitoring to assess surgical outcome and/or to detect recurrent malignant disease following treatment.
- Pre-Certification/Pre-Authorization: Not applicable.

Policies developed

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

- The policy statements have been updated as follows:
- I. MRI-guided high-intensity focused ultrasound ablation is considered INVESTIGATIVE for ALL indications due to a lack of clinical evidence demonstrating its impact on improved health outcomes. Investigative indications include, but are not limited to:
  A. Uterine fibroids;
  B. Palliation of bone pain in cancer that has metastasized to the bone;
  C. Brain tumors;
  D. Breast tumors;
  E. Prostate tumors.
- Pre-Certification/Pre-Authorization: Not applicable.

Hematopoietic Stem-Cell Transplantation for Multiple Myeloma

- The policy statements have been updated as follows:
- I. Autologous Hematopoietic Stem-Cell Transplantation
  – Autologous hematopoietic stem-cell transplantation (i.e., single, tandem, or second [salvage]) may be considered MEDICALLY NECESSARY to treat multiple myeloma.
- II. Tandem Autologous-Nonmyeloablative Allogeneic Hematopoietic Stem-Cell Transplantation
  – Tandem transplantation with an initial round of autologous hematopoietic stem-cell transplantation followed by allogeneic hematopoietic stem-cell transplantation using a reduced-intensity conditioning (RIC) regimen may be considered MEDICALLY NECESSARY to treat newly diagnosed multiple myeloma patients.
- III. Allogeneic Hematopoietic Stem-Cell Transplantation
  – Allogeneic hematopoietic stem-cell transplantation, myeloablative or nonmyeloablative, as upfront therapy of newly diagnosed multiple myeloma or as salvage therapy, is considered INVESTIGATIVE.
- Pre-Certification/Pre-Authorization: Yes.

Implantable Cardioverter-Defibrillator

- The following policy statement has been added in regard to Subcutaneous Cardioverter-Defibrillators:
- The use of a subcutaneous implantable cardioverter-defibrillator is considered INVESTIGATIVE for ALL indications in

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adult and pediatric patients, due to a lack of evidence demonstrating an impact on improved health outcomes.
- No changes have been made to the remaining policy statements.
- Pre-Certification/Pre-Authorization: No.

Allergy Testing and Treatment
- The following policy statement has been removed in regard to repeat testing:
- Repeat testing following initial testing is considered NOT MEDICALLY NECESSARY and is ineligible for reimbursement unless there is a documented change in symptoms or environment, which clearly justifies the need for re-testing.
- No changes have been made to the remaining policy statements.
- Pre-Certification/Pre-Authorization: No.

Policies inactivated:

Adoptive Immunotherapy
Catheter Ablation for Treatment of Atrial Fibrillation
Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure
Constraint-Induced Movement Therapy for Motor Disorders in Children
Dynamic Spinal Visualization
Meniscal Allografts and Collagen Meniscus Implants
Suit Therapy for Motor Disorders
Surgical Decompression for Treatment of Diabetic Neuropathy
Transanal Radiofrequency Treatment of Fecal Incontinence
Zoster Vaccine Live (Zostavax®)
- The Zoster Vaccine will now be addressed by the Preventive Health Benefit, where applicable.

Policies Effective: 5/13/13 Notification Posted: 3/28/13

Policies developed

Spinal Fusion: Thoracic
- ***This policy applies to Government Programs products only: Secure Blue, Blue Advantage (PMAP), Blue Plus (MNCare), Blue Advantage (MSC+)***
- The policy statements are as follows:
- I. Thoracic spinal fusion may be considered MEDICALLY NECESSARY for ANY of the following indications:
  A. Acute traumatic spinal injury resulting in thoracic spinal instability; OR
  B. Osteomyelitis resulting in vertebral body destruction; OR
  C. Primary or metastatic bone tumor resulting in fracture instability or spinal cord compression; OR
  D. Thoracic nerve root compression verified by diagnostic imaging (i.e., MRI or CT myelogram) and resulting in severe pain (e.g., pain necessitating hospital admission for pain control) OR profound weakness of the extremities; OR
  E. 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;

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OR

F. Severe kyphosis when EITHER of the following criteria are met:
   1. Thoracic spondylosis with kyphosis, resulting in spinal cord compression; OR
   2. Kyphotic curve > 75 degrees that has either progressed over time OR is refractory to bracing; OR

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, within the last six (6) months:
      a. Active pain management program or protocol; 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), performed within the last year, demonstrates thoracic nerve root compression
      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 and/or lower extremity weakness, numbness, or pain; OR
      b. Bladder or bowel incontinence; OR
      c. Increased tone or spasticity; OR
      d. Gait abnormalities consistent with thoracic myelopathy OR
      e. Over active or overresponsive reflexes; OR
      f. Hoffman's sign; OR
      g. Positive Babinski sign; OR
      h. Hand incoordination or clumsiness
      AND
   2. Diagnostic imaging (i.e., MRI or CT myelogram), performed within the last year, demonstrates spinal cord compression.

- Pre-Certification/Pre-Authorization: Yes, for Government Programs products ONLY: Secure Blue, Blue Advantage (PMAP), Blue Plus (MNCare), Blue Advantage (MSC+).

Air Ambulance

- The policy statements are as follows:
- I. Trauma

A. Air ambulance transportation services may be considered (or determined to be) MEDICALLY NECESSARY in trauma response when all of the following criteria are met:
   1. The individual's medical condition requires immediate and rapid ambulance transport that could not have been provided by land ambulance OR the point of pickup is not accessible by land vehicle;
      AND
   2. The individual's medical condition is such that the time needed to transport the individual by ground poses a threat to the individual's survival or seriously endangers the individual's health. Examples of cases for which air ambulance may be medically necessary include, but are not limited to the following:
      a. Evidence of significant multi-system trauma, or trauma requiring immediate intervention at a center with

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the appropriate ACS trauma center verification,
b. Intracranial bleeding requiring neurosurgical intervention;
c. Major burns requiring immediate treatment in a burn center;
d. Limb threatening trauma;
e. Conditions requiring immediate treatment in a hyperbaric oxygen unit;
f. Shock, sepsis, or organ failure with immediate life-threatening implications requiring tertiary care;
g. Individuals with near-drowning injuries.
AND

3. The individual is transported to the nearest hospital with the appropriate ACS trauma center verification based upon the patient's injuries and condition.

B. Transport to the next nearest facility may be considered (or determined to be) MEDICALLY NECESSARY when:
1. Criteria A1 and A2 are met;
AND
2. The first hospital does not have the required services facilities to treat the individual.

C. Transport of a trauma victim by air from a community hospital to a tertiary center (e.g. an ACS verified level I-II trauma center) may be considered (or determined to be) MEDICALLY NECESSARY when initial evaluation at the community hospital reveals injuries (e.g. intra-abdominal hemorrhage on abdominal computed tomography) or potential injuries (e.g., aortic trauma suggested by widened mediastinum on chest x-ray; spinal column injury with potential for spinal cord involvement) requiring further evaluation and management beyond the capabilities of the referring hospital.

D. All other uses of air ambulance services in the transport of trauma victims DO NOT MEET THE DEFINITION OF MEDICALLY NECESSARY including but not limited to the following:
1. Transfers from one hospital to another if above criteria not met;
2. Transfers from a hospital capable of treating an individual to another hospital primarily for the convenience of the individual or the individual's family or physician;
3. Transportation to a hospital other than the nearest one with appropriate facilities unless criteria in I-4 above are met;
4. When land transportation is available and the time required to transport the individual by land does not endanger the individual's life or health;
5. Transportation to a facility that is not an acute care hospital;
6. Individual is legally pronounced dead prior to the ambulance service being called; or
7. The services are provided for transfer of a deceased individual to a funeral home, morgue, or hospital, when the individual was pronounced dead at the scene;
8. Search and rescue operations.

- II. Non-Trauma Interfacility Air Transport

A. Air ambulance services may be considered (or determined to be) MEDICALLY NECESSARY when **all** of the following criteria are met:
1. Great distances, limited timeframes, or other obstacles are involved in transporting the individual by ground;
AND
2. The individual's medical condition requires uninterrupted care and attendance by qualified medical staff during transport;

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AND

3. The individual's medical condition requires specialty care not available at the referring hospital. Examples include but are not limited to:
   a. Acute coronary syndrome with need for urgent intervention such as cardiac catheterization;
   b. Cardiogenic shock, cardiac tamponade or mechanical cardiac disease such as acute cardiac rupture or decompensating valvular heart disease;
   c. Critically ill medical or surgical patients requiring emergent care not available at the referring hospital;
   d. Obstetric emergency (e.g., third-trimester hemorrhage, fetal hydrops, severe pre-eclampsia or eclampsia) for which ground transport is not feasible and risk of intratransport delivery is low;
   e. Neonate with very low birthweight or medical condition requiring a specialized neonatal team during transport and ground transport is not feasible within a reasonable time frame;
   f. Organ or organ transplant recipient requires air transport to the appropriate approved transplant facility.

   AND
4. The individual is transported to the nearest appropriate facility for treatment (in accordance with their benefit plan);

   AND
5. The origin (point of pick-up) is an acute care facility (e.g., hospital, rehabilitation hospital) [and is not otherwise precluded from eligibility in the member contract];

   AND
6. The destination has the appropriate facilities to treat the individual's condition (The destination is not precluded from eligibility in the member contract).

B. All other uses of air ambulance services in inter-facility transport DO NOT MEET THE DEFINITION OF MEDICAL NECESSITY including but not limited to the following:
   1. Transfers from one hospital to another if above criteria not met;
   2. Transfers from a hospital with the facilities to treat an individual to another hospital primarily for the convenience of the individual or the individual's family or physician;
   3. Transportation to a facility that is not an acute care hospital with appropriate facilities to treat the condition for which the transfer was made.

- Pre-Certification/Pre-Authorization: No.

Policies revised

Balloon Catheter Therapy for Chronic Rhinosinusitis

- The policy statements have been updated as follows:
- I. Catheter based inflatable balloon therapy may be considered MEDICALLY NECESSARY when ALL of the following are met:

  A. Patient has disease of the frontal sinuses without presence of tumors or diffuse polyposis;

  AND

  B. Rhinosinusitis has persisted for a minimum of 12 weeks with the presence of nasal blockage/obstruction/congestion or nasal discharge confirmed by radiographic evidence or nasal endoscopy;

  AND

  C. Presence of at least one of the following:

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1. Facial pain or pressure, or
2. Reduction or loss of the sense of smell;

AND

D. Documented failure of medical therapy (e.g., courses of different antibiotics, steroid spray, antihistamine spray and/or decongestant) greater than twelve weeks in duration.

- II. Catheter-based inflatable balloon therapy is considered INVESTIGATIVE for all other indications including but not limited to the ethmoid, sphenoid, and maxillary sinuses due to the lack of clinical evidence demonstrating its impact on improved health.
- Pre-Certification/Pre-Authorization: No.

Intra-Articular Hyaluronan Injections for Osteoarthritis

- The policy statements have been updated as follows:
- I. Intra-articular hyaluronan injections may be considered MEDICALLY NECESSARY for the treatment of painful osteoarthritis of the knee in patients who have insufficient pain relief from conservative nonpharmacologic therapy and simple analgesics.
- II. Repeated courses of intra-articular hyaluronan injections may be considered MEDICALLY NECESSARY when both of the following criteria have been met:
  A. Significant pain relief achieved with the prior course of injections; and
  B. At least 6 months have passed since the prior course.
- III Injection of corticosteroids concomitantly with hyaluronan is considered INVESTIGATIVE.
- IV. The use of intra-articular hyaluronan injections for the following indications is considered INVESTIGATIVE:
  A. Injection into joints other than the knee including but not limited to the foot, ankle, hip, shoulder, elbow and hand.
  B. Injection for chondromalacia patella (patellofemoral syndrome) or osteochondritis dissecans.
- Pre-Certification/Pre-Authorization: No.

Rhinoplasty

- The policy statements have been updated as follows:
- I. Rhinoplasty may be considered MEDICALLY NECESSARY when:
  A. A structural abnormality displaces the nasal structure, resulting in fixed, medically significant airway obstruction that medical therapy has failed to correct;
  OR
  B. Performed on an eligible dependent child who has a congenital disease or anomaly that has caused a functional defect (e.g. cleft palate) as determined by the attending physician;
  OR
  C. Incidental to or following another surgery that was needed because of injury, sickness or disease of that part of the body.
- II. Submitted documentation must include:
  A. The extent of the obstruction or deformity;
  B. A description of how the deformity relates to the nasal symptoms the patient is experiencing and planned surgical approach;

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AND

C. Results of history and physical, clinical studies or tests, including radiographic studies, as appropriate to the condition.

D. Photographs may be submitted but are not required.

- III. Rhinoplasty is considered COSMETIC for all other indications.
- Pre-Certification/Pre-Authorization: Yes.

Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood

- The policy statements have been updated as follows:
- I. Autologous Hematopoietic Stem-Cell Transplantation

A. Autologous hematopoietic stem-cell transplantation may be considered MEDICALLY NECESSARY for:

1. Initial treatment of high-risk neuroblastoma;
2. Recurrent or refractory neuroblastoma;
3. Initial treatment of high-risk Ewing's sarcoma; and
4. Recurrent or refractory Ewing's sarcoma.

B. Tandem autologous-autologous hematopoietic stem-cell transplantation may be considered MEDICALLY NECESSARY for treatment of high-risk neuroblastoma.

C. Autologous hematopoietic stem-cell transplantation (single or tandem) is considered INVESTIGATIVE for treatment of all other solid tumors of childhood, including but not limited to:

1. Initial treatment of low- or intermediate-risk neuroblastoma,
2. Initial treatment of low- or intermediate-risk Ewing's sarcoma,
3. Rhabdomyosarcoma;
4. Wilms tumor;
5. Osteosarcoma;
6. Retinoblastoma.

- II. Allogeneic Hematopoietic Stem-Cell Transplantation

A. Allogeneic (myeloablative or nonmyeloablative) hematopoietic stem-cell transplantation for treatment of pediatric solid tumors is considered INVESTIGATIVE due to a lack of evidence demonstrating an impact on improved health outcomes.

B. Salvage allogeneic hematopoietic stem-cell transplantation for neuroblastoma or other pediatric solid tumors that relapse after autologous transplantation or fail to respond is considered INVESTIGATIVE due to a lack of evidence demonstrating an impact on improved health outcomes.

- Pre-Certification/Pre-Authorization: Yes.

Percutaneous Facet Joint Denervation

- The policy statements have been updated as follows:
- I. Non-Pulsed Radiofrequency Facet Joint Denervation

A. Initial Procedure:

Non-pulsed radiofrequency denervation of cervical facet joints (C2-3 and below) and lumbar facet joints may be considered MEDICALLY NECESSARY when ALL the following criteria are met:

1. No prior spinal fusion surgery in the vertebral level being treated; AND

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2. Non-radicular low back (lumbosacral) or neck (cervical) pain, suggestive of facet joint origin as evidenced by absence of nerve root compression as documented in the medical record on history and physical, and radiographic evaluations performed within the last 12 months; AND
3. Pain has failed to respond to three (3) months of conservative management with oral pain medications (e.g., non-steroidal anti-inflammatory medications, analgesics, muscle relaxants, or pharmacological therapy) AND **at least** one of the following therapies, within the last six (6) months (as documented in the medical record):
   a. Course of physical therapy, with weekly visits for a period of four (4) weeks; OR
   b. Trial of manipulative therapy for a period of four (4) weeks
   AND
4. No therapeutic intra-articular injections (i.e., steroids, saline, or other substances) for a period of at least 4 weeks prior to use of a diagnostic medial branch block; AND
5. Diagnostic block with local anesthetic of the facet nerve (medial branch block) or injection under fluoroscopic guidance into the facet joint has resulted in at least 50% reduction in pain for the duration of the specific local anesthetic used (e.g., bupivacaine or lidocaine)

B. Repeat Procedure

1. Repeat non-pulsed radiofrequency denervation may be considered MEDICALLY NECESSARY when performed at intervals greater than six (6) months (per side, per anatomical level of the spine) AND when greater than 50% relief has been obtained from the previous procedure.

C. Non-pulsed radiofrequency denervation is considered INVESTIGATIVE for the treatment of chronic spinal/back pain for all uses that do not meet the criteria listed above, including but not limited to treatment of thoracic facet or sacroiliac (SI) joint pain.

- II. Pulsed Radiofrequency Denervation
  Pulsed radiofrequency denervation is considered INVESTIGATIVE for the treatment of chronic spinal/back pain due to a lack of evidence supporting its impact on improved health outcomes.
- III. Other Percutaneous Techniques for Facet Joint Denervation
  All other techniques for percutaneous facet joint denervation for treatment of chronic spinal/back pain are considered INVESTIGATIVE due to a lack of evidence supporting an impact on improved health outcomes. These other techniques include, but are not limited to:
  A. Laser;
  B. Cryodenervation.
- Pre-Certification/Pre-Authorization: Yes.

Immune Globulin Therapy

- The policy statements have been updated as follows:
- I. INTRAVENOUS IMMUNE GLOBULIN
  The use of intravenous immune globulin may be considered MEDICALLY NECESSARY in the treatment of the following conditions:
  A. Primary Immunodeficiencies
  1. X-linked agammaglobulinemia (X-LA or Bruton's disease);
  2. Common variable immune deficiency when the following criteria are met;

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a. Significant and clearly documented recurrent infections (e.g., recurrent pneumonias, frequent episodes of bacterial sinusitis, and not just isolated chronic sinusitis); **AND**
b. Onset of symptoms after two (2) years of age; AND
c. Abnormally low serum levels of IgM and/or IgA (2 standard deviations below the age-adjusted mean) IN ADDITION TO abnormally low serum levels of IgG, as demonstrated by EITHER of the following:
   - Total serum IgG level < 200mg/dL; OR
   - Total serum IgG level ≥ 200 or < 400mg/dL OR at least 2 standard deviations below the normal age-adjusted mean AND
     – A demonstrated impaired response to immunization with protein AND/OR polysaccharide antigens:
       - For protein antigens: Serum antibody titers to tetanus and/or diphtheria should be obtained before immunization with tetanus and/or diphtheria vaccine and then three to four weeks after immunization. An abnormal response is defined as less than a four-fold rise in antibody titer
       - For polysaccharide antigens: Serum antibody titers to pneumococcus should be obtained before immunizations and then three to six weeks after immunization with a polyvalent pneumococcal polysaccharide vaccine (such as Pneumovax). An abnormal response is defined as less than a four-fold rise in titer;

       AND
     – Exclusion of other possible causes of hypogammaglobulinemia;
       AND
d. Documentation must include the patient's serum immunoglobulin levels AND the age-adjusted reference ranges for the laboratory performing the tests.

3. IgG subclass deficiencies
   a. Significant and clearly documented recurrent infections (e.g., recurrent pneumonias, frequent episodes of bacterial sinusitis, and not just isolated chronic sinusitis); AND
   b. Abnormally low levels of one or more IgG subclasses (2 standard deviations below the age-adjusted mean) in patients with normal levels of total IgG and IgM; AND
   c. A demonstrated impaired response to immunization with protein AND/OR polysaccharide antigens:
      - For protein antigens: Serum antibody titers to tetanus and/or diphtheria should be obtained before immunization with tetanus and/or diphtheria vaccine and then three to four weeks after immunization. An abnormal response is defined as less than a four-fold rise in antibody titer
      - For polysaccharide antigens: Serum antibody titers to pneumococcus should be obtained before immunization and then three to six weeks after immunization with a polyvalent pneumococcal polysaccharide vaccine (such as Pneumovax). An abnormal response is defined as less than a four-fold rise in titer;
        AND
   d. Documentation must include the patient's serum immunoglobulin levels AND the age-adjusted reference ranges for the laboratory performing the tests.
4. X-linked immunodeficiency with hyper IgM;
5. Immunodeficiency with thrombocytopenia and eczema (Wiscott-Aldrich syndrome);
6. Hyperimmunoglobulin E syndrome;
7. Severe combined immune deficiency;

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8. Cellular immunodeficiency with immunoglobulins (Nezelof syndrome);
9. Thymic hypoplasia (DiGeorge's syndrome);
10. Pediatric human immunodeficiency virus (HIV) infection;
11. Kawasaki disease (mucocutaneous lymph nodes syndrome);
12. Acquired hypogammaglobulinemia caused from either of the following two malignancies:
    a. Chronic lymphocytic leukemia
    b. Multiple myeloma.

B. Hematologic Disorders
1. Idiopathic thrombocytopenic purpura;
2. Neonatal alloimmune thrombocytopenia - as antenatal treatment in women who have previously had an infant with alloimmune thrombocytopenia or as neonatal treatment for the infant;
3. Warm antibody autoimmune hemolytic anemia, refractory to cortocosteroids and splenectomy,

C. Musculoskeletal System and Connective Tissue Disorders
1. Dermatomyositis that has not responded to treatment with prednisone and immunosuppressant therapy (e.g., azathioprine, methotrexate);
2. Polymyositis that has not responded to treatment with prednisone and immunosuppressant therapy (e.g., azathioprine, methotrexate).

D. Nervous System Disorders
1. Acute inflammatory demyelinating polyneuropathy (Guillain-Barré syndrome);
2. Chronic inflammatory demyelinating polyneuropathy (CIDP);
3. Myasthenia gravis
    a. Myasthenic crisis (i.e., an acute episode of respiratory muscle weakness);
    b. Myasthenia gravis in patients with chronic debilitating disease (e.g., restricted daily activities and symptomatic at rest or worse) despite treatment with cholinesterase inhibitors, or complications from or failure of steroids and /or azathioprine;
4. Multifocal motor neuropathy in patients with conduction block and anti-GM1 antibodies.

E. Organ and Stem-Cell Transplantation
1. Prior to solid organ transplantation, for treatment of patients at high risk of antibody-mediated rejection, including highly sensitized patients and those receiving an ABO incompatible organ;
2. Following organ transplantation, for treatment of antibody-mediated rejection;
3. Following hematopoietic stem-cell transplantation, for treatment of related immunodeficiencies.

F. Dermatologic Disorders
1. Autoimmune Mucocutaneous Blistering Diseases
   Treatment of the following conditions in patients with severe, progressive disease despite treatment with conventional medical therapy (e.g., corticosteroids, azathioprine, cyclophosphamide):
    a. Pemphigus vulgaris;
    b. Pemphigus foliaceus;
    c. Bullous pemphigoid;
    d. Mucous membrane pemphigoid;
    e. Bullous systemic lupus erythematosus (SLE)
    f. Epidermolysis bullosa acquisita

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2. Toxic epidermal necrolysis (TEN)

- II. SUBCUTANEOUS IMMUNE GLOBULIN

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

  A. Congenital agammaglobulinemia;
  B. Severe combined immunodeficiency;
  C. Wiskott-Aldrich syndrome;
  D. X-linked agammaglobulinemia (XLA);
  E. Common variable immune deficiency (CVID) when the following criteria are met:
  1. Significant and clearly documented recurrent infections (e.g., recurrent pneumonias, frequent episodes of bacterial sinusitis, and not just isolated chronic sinusitis); and
  2. Onset of symptoms after two (2) years of age; and
  3. Abnormally low serum levels of IgM and/or IgA (2 standard deviations below the age-adjusted mean) IN ADDITION TO abnormally low serum levels of IgG, as demonstrated by EITHER of the following:
     a. Total serum IgG level < 200mg/dL; OR
     b. Total serum IgG level ≥ 200 or < 400mg/dL OR at least 2 standard deviations below the normal age-adjusted mean AND
        - A demonstrated impaired response to immunization with protein AND/OR polysaccharide antigens:
          – For protein antigens: Serum antibody titers to tetanus and/or diphtheria should be obtained before immunization with tetanus and/or diphtheria vaccine and then three to four weeks after immunization. An abnormal response is defined as less than a four-fold rise in antibody titer
          – For polysaccharide antigens: Serum antibody titers to pneumococcus should be obtained before immunizations and then three to six weeks after immunization with a polyvalent pneumococcal polysaccharide vaccine (such as Pneumovax). An abnormal response is defined as less than a four-fold rise in titer
        - Exclusion of other possible causes of hypogammaglobulinemia
          AND
  4. Documentation must include the patient's serum immunoglobulin levels AND the ade-adjusted reference ranges for the laboratory performing the tests.

- III. DOCUMENTATION FOR RENEWAL REVIEW

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

- IV. INVESTIGATIVE INDICATIONS

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

  A. Chronic fatigue syndrome;
  B. Multiple sclerosis (relapsing-remitting and chronic, progressive);
  C. Recurrent fetal loss;
  D. Chronic sinus infections *(unless the sinus infection is a symptom of one of the primary immunodeficiencies listed above. Chronic sinus infection is common in most primary immunodeficiencies listed, especially antibody

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deficiency with normal or near-normal immunoglobulins);
E. Inclusion body myositis;
F. Asthma;
G. POEMS syndrome (polyneuropathy, organeomegaly, endocrinopathy, monoclonal gammopathy, and skin changes);
H. Autistic spectrum disorders;
I. PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections);
J. Fisher syndrome.

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

Policies inactivated

Dialectical Behavior Therapy

Policies Effective: 6/10/13 Notification Posted: 4/25/13

Policies developed

None

Policies revised

Quantitative Sensory Testing

- The policy statements have been updated as follows:
- The use of the quantitative sensory testing is considered INVESTIGATIVE including but not limited to current perception threshold testing, pressure-specified sensory device testing, vibration perception threshold testing, and thermal threshold testing due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Not applicable.

W**ireless Capsule Endoscopy**

- The policy statements have been updated as follows:
- I. Wireless capsule endoscopy may be considered MEDICALLY NECESSARY for the following indications:
  A. Obscure bleeding of the small intestine when evaluation by upper and lower endoscopies has been inconclusive
  B. Initial diagnosis in patients with suspected Crohn's disease when conventional diagnostic tests (e.g., small bowel follow-through, lower endoscopy) have been inconclusive
  C. Surveillance of the small bowel in patients with hereditary GI polyposis syndromes, including familial adenomatous polyposis and Peutz-Jeghers syndrome
- II. The use of wireless capsule endoscopy is considered INVESTIGATIVE for all other indications, including, but not limited to:
  A. Initial diagnosis or follow-up of all other intestinal conditions (e.g., irritable bowel syndrome, celiac sprue, small bowel neoplasm, or intestinal polyposis syndrome);
  B. Evaluation of the extent of involvement of known Crohn's disease;
  C. Evaluation of diseases involving the esophagus (e.g., chronic gastroesophageal reflux disease, Barrett's esophagus);
  D. Evaluation of the colon including, but not limited to, detection of colonic polyps or colon cancer.

- III. Use of the patency capsule prior to wireless capsule endoscopy is considered INVESTIGATIVE due to a lack of clinical evidence demonstrating its impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: No.

Proton Beam Radiation Therapy (formerly titled Charged-Particle (Proton or Atomic Nuclei) Radiation Therapy)

- The policy statements have been updated as follows:
- I. Proton beam radiation therapy may be considered MEDICALLY NECESSARY in the following clinical situations:
  - A. Primary therapy for melanoma of the uveal tract (iris, choroid, or ciliary body), with no evidence of metastasis or extrascleral extension, and with tumors up to 24 mm in largest diameter and 14 mm in height; OR
  - B. Postoperative therapy (with or without conventional high-energy x-rays) in patients who have undergone biopsy or partial resection of chordoma or low-grade (I or II) chondrosarcoma of the basisphenoid region (skull-base chordoma or chondrosarcoma) or cervical spine and have residual localized tumor without evidence of metastasis; OR
  - C. Treatment of central nervous system (CNS) tumors in pediatric patients (< 18 years of age). OR
  - D. Treatment of localized prostate cancer (i.e., organ-confined [T1 and T2] with no radiographic evidence of metastasis).
- II. All other applications of proton beam radiation therapy are considered INVESTIGATIVE due to a lack of clinical evidence demonstrating an impact on improved health outcomes. Other applications include, but are not limited to:
  - A. Non-small-cell lung cancer (NSCLC) at any stage or for recurrence;
  - B. Non-central nervous system tumors in pediatric patients (< 18 years of age);
  - C. Tumors of the head and neck (other than skull-based chordomas or chondrosarcomas).
- Pre-Certification/Pre-Authorization: Yes.

Saliva Hormone Tests (formerly titled Saliva Hormone Tests for Menopause)

- The policy statements have been updated as follows:
- The use of saliva hormone tests such as estrogen, progesterone, testosterone, melatonin, cortisol, or dehydroepiandrosterone (DHEA) is considered INVESTIGATIVE for all indications including but not limited to screening, diagnosis and monitoring of menopause, conditions related to aging, or behavioral health (e.g. depression, bipolar disorder, eating disorders). There is a lack of clinical evidence indicating its validity as an appropriate form of testing.
- Pre-Certification/Pre-Authorization: Not applicable.

Multigene Expression Assays for Predicting Recurrence in Colon Cancer (formerly titled *Multigene Expression Assay for Predicting Recurrence in Colon Cancer*)

- The policy statements have been updated as follows:
- Multigene expression assays for determining the prognosis of colon cancer following surgery are considered INVESTIGATIVE due to the lack of evidence that use of the assays improves health outcomes.
- Pre-Certification/Pre-Authorization: Not applicable.

Policies inactivated

Retinal Telescreening Systems for Diabetic Retinopathy

Temporary Prostatic Stent

Policies reviewed with no changes in February, March and April 2013:

Anesthesia-Assisted Opioid Withdrawal
Artificial Intervertebral Disc: Lumbar Spine
Automated Point-of-Care Nerve Conduction Tests
Biomarker Genes for the Detection of Lymph Node Metastases in Breast Cancer
Botulinum Toxin
BRAF Mutation Analysis
Coverage of Routine Care Related to Cancer Clinical Trials
Cryoablation of Solid Tumors
Detection of Circulating Tumor Cells in the Management of Patients with Cancer
Digital Breast Tomosynthesis
Electrical/Electromagnetic Stimulation for Treatment of Arthritis
Electrocardiographic (ECG) Body Surface Mapping
Endoluminal Ablation for Treatment of Varicose Veins/Venous Insufficiency
Endovascular Procedures (Angioplasty and/or Stenting) for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)
Extended Hours Home Care Skilled (Private Duty) Nursing
Eye Movement Desensitization and Reprocessing for Posttraumatic Stress Disorder (PTSD)
Full Body CT Scanning
Genetic Testing and Counseling
Genetic Testing for Helicobacter Pylori Treatment
Genetic Testing for Tamoxifen Treatment
Genetic Testing for Warfarin Dose
Hair Analysis
Hematopoietic Stem-Cell Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma
Hippotherapy
Humanitarian Use Devices
In Vitro Chemoresistance and Chemosensitivity Assays
Intradiscal Electrothermal Annuloplasty (IDET), Percutaneous Radiofrequency Annuloplasty (PIRFT), and Intradiscal Biacuplasty
Intravenous Anesthetics for the Treatment of Chronic Pain
Islet Transplantation
Ketamine for Treatment of All Mental Health and Substance-Related Disorders
Knee Arthroplasty (Knee Replacement)
Laparoscopic and Percutaneous Techniques for the Myolysis of Uterine Fibroids
Low-Density Lipid (LDL) Apheresis
Low-Level Laser Therapy (Cold Laser) and Deep Tissue Laser Therapy
Lysis of Epidural Adhesions
Methadone Maintenance Treatment for Chronic Opioid Dependence
Microwave Ablation of Solid Tumors
Occipital Nerve Stimulation
Oral Fentanyl for Cancer-Related Pain

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Oscillator Devices for the Treatment of Cystic Fibrosis and Other Respiratory Disorders
Pathfinder Molecular Testing
Percutaneous and Endoscopic Techniques for Disc Decompression
Peripheral Nerve Stimulation of the Trunk or Limbs for Treatment of Pain
Pfeiffer Treatment Center / Health Research Institute Metallothionein Protein Assessment and Treatment
Photodynamic Therapy for Skin Conditions
Phototherapy for Seasonal Affective Disorder
Pneumatic Compression Devices in the Home Setting
Positron Emission Mammography
Pressure-Reducing Support Surfaces
Prolotherapy
Psychoanalysis
Replacement of Amalgams
Rhinomanometry and Acoustic/Optical Rhinometry
Scintimammography/Breast-Specific Gamma Imaging/Molecular Breast Imaging
Skin Contact Monochromatic Infrared Energy Therapy
Squeeze Machine for Autistic Spectrum Disorders
Surface Electromyography (SEMG)
Surgical Interruption of Pelvic Nerve Pathways for Primary and Secondary Dysmenorrhea
Tobacco Cessation Treatments
Transcranial Magnetic Stimulation
Treatment of Hereditary Angioedema
Treatment of Pulmonary Arterial Hypertension with Prostacyclin Analogues, Endothelin Receptor Antagonists, or Phosphodiesterase Inhibitors
Treatment of Tinnitus

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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