Provider Press

March 2013 / Vol. 17, No. 1

For the health of all.

Pharmacy update

Pharmacy utilization management (UM) program descriptions are now available in one convenient location within the provider section of the Blue Cross and Blue Shield of Minnesota (Blue Cross) website. Programs include Quantity Limit, Step Therapy and Prior Authorization for various drugs and certain therapeutic categories. Each program description includes referenced content regarding FDA-approved indications and dosages for drugs of interest, clinical rationale for therapy, efficacy and safety, as well as UM program objectives and criteria sets. Medical policies and pharmacy UM programs are available online at **providers.bluecrossmn.com**:

- Under Tools & resources select Medical policy, then acknowledge the Acceptance statement
- Select View All Active Policies
- Select Pharmacy Utilization Management Active Programs

Health Literacy - Plain Language, Please.

Understanding health information can be demanding. Communicating about health-related topics can be equally challenging. Medical terms and acronyms can get in the way of clear, simple information. This adds to confusion and increases potential for errors and poor patient experience.

Almost 8 percent of adults reported that their providers sometimes or never explained things in a way they could understand, according to the Agency for Healthcare Research and Quality (2010). Using plain language is a way to help improve understanding, reduce treatment errors and improve patient experience. Plain language means language that the intended audience, including individuals with limited English proficiency, can readily understand and use (Affordable Care Act, 2009). In other words, use plain, everyday words that anyone could understand. Avoid jargon and medical terminology if possible and keep communication clear and simple.

You might assume that the lower the person's education, the more likely they would prefer plain language. A recent communication study shows, however, that people prefer plain language regardless of their level of education.

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Provider Press

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

Inside preview

FYI

Publications available online

The following is a list of Quick Points and Bulletins published from December 2012 to February 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
QP21-12	Provider cost data
QP22-12	Rehabilitative therapies coding reminder for Medicare Advantage plans
QP1-13	Availity 2012 enhancements for providers
QP2-13	Temporary edit removal – 99214-25 and 99215-25
QP3-13	Reminder of ancillary provider claim submission for Platinum Blue℠ (Cost) plan
QP4-13	Cost share adjustments for 2012 Medicaid claims
QP5-13	Colonoscopy claims incorrectly denied for Platinum Blue℠ (Cost) subscribers
Bulletins	**Title**
P26-12	January 2013 HCPCS code updates
P27-12	Substance abuse services revisions
P27R1-12	Revised: Substance abuse services revisions
P1-13	Update to Attachment B: Definition of Outpatient Health Services Categories
P2-13	Pre-certification and concurrent review for Medicare skilled nursing facility services for SecureBlueSM (HMO SNP) subscribers
P3-13	Changes to Blue Plus MHCP pre-certification and notification requirements

Provider Demographic Change Form

The Provider Demographic Change form needs to be completed when your address, phone number, hospital affiliation or office hours change. Go to **providers.bluecrossmn.com** and enter "provider demographic change form" in the search window to obtain the form. Completed forms can be:

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 December 2012 to February 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 1 – At Your Service Chapter 5 – Health Care Options Chapter 6 – Blue Plus Chapter 7 – BlueCard®	Replaced **providerhub.com** references with **availity.com**
Provider Policy and Procedure Manual	Chapter 8 – Claims Filing	The following topics had content changes: • Replaced **providerhub.com** references with **availity.com** • Timely Filing • Changed Non-Physician Health Care Practitioners to Non-Physician Health Care Professionals
Provider Policy and Procedure Manual	Chapter 9 – Reimbursement/ Reconciliation	Replaced **providerhub.com** references with **availity.com**
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, the following sub-sections: Coding, Anesthesia, Behavioral Health and Medical Services	Replaced **providerhub.com** references with **availity.com**
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Coding	Content changes to CPT/Level I, Level II HCPCS and Revenue Codes
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Behavioral Health	2013 Psychiatric coding changes
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Durable Medical Equipment	The following topics had content changes: • Prior Authorization Requirements • Claims Filing Requirements
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Home Health, Home Infusion and Hospice	Content change to Rules and Regulations
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Hospital/SNF Care	Content change to Medical Necessity Vendor

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FYI

Provider Manual Updates continued from page 3

Manual name	Chapter number and title	Change
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Laboratory	The following topics had content changes: • Venipunctures and Lab Handling • Genetic Testing Modifiers
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Maternity	The following topics had content changes: • Global Obstetrical Care • Submission Options and Coding Alternatives
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Surgical Services	Content changes to Acne and Rosacea Treatment
Blue Plus Manual	Chapter 1 – Introduction to Blue Plus	Replaced **providerhub.com** references with **availity.com**
Blue Plus Manual	Chapter 2 – Blue Plus Subscribers	Replaced **providerhub.com** references with **availity.com**
Blue Plus Manual	Chapter 4 – Referrals	Replaced **providerhub.com** references with **availity.com**

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 members 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

Health Literacy

Plain Language, Please. continued from page 1

Level of education	% who prefer plain language content
Less than bachelor's degree	76.5%
Bachelor's degree	79.4%
Master's degree	82.0%
Doctorate degree	86.0%

Respondents with master's degrees were actually 5.5% more likely to prefer plain language than those with less than a bachelor's degree (Trudeau, 2012). Everyone benefits from easy-to-understand content.

In the table below are some examples of plain language alternatives to medical terms patients may not understand.

Medical term	Translation into plain language
Anti-inflammatory	Lessens swelling and irritation
Cardiac problem	Heart problem
Contraception	Birth control
Hypertension	High blood pressure
Oral	By mouth

Clear communication is not only important for clinical interactions. Using plain language is important when explaining a bill, giving directions, or scheduling an appointment (Institute of Medicine, 2012).

To learn more about plain language, visit http://plainlanguage.nih.gov

Coding Corner

A few appeal basics

In addition to submitting documentation to support an appeal request, following are a few documentation basics that are considered during our review that could potentially deny your appeal if not met.

First, documentation must be signed and dated by the practitioner rendering the service. Author identification may be a (legible) handwritten signature, a unique electronic identifier, an electronic signature, or a stamped signature verified with initials. Initials alone are not an acceptable form of identification. Initials may be used in conjunction with a typed signature block that clearly identifies the author.

Second, all submitted medical records must not only be appropriately signed but must be complete and be the final document. Do not submit operative pre-dictated or preliminary dictation records.

And third, to find out more about the appeals process and requirements, please refer to Chapter 10-Appeals in the online Blue Cross Provider Policy and Procedure Manual.

Speaking of the Blue Cross Provider Policy and Procedure Manual

The manual was updated with coding changes that were effective January 1, 2013, so be sure to check out the updates to the various coding sections of Chapter 11. To access the manual, go to **providers.bluecrossmn.com** and select "Forms & publications" then "manuals."

Coding edit decisions

Several edits have been reviewed. The code edits and decisions are listed below.

Codes and Edits	Decision/Actions
K0552 denies when appended with the JB modifier	No change to current edit. Referring to Medicare policy, JB is not valid appended to K0552.
29825 denied incidental to 29826	Edit will be removed/corrected
76536 denied mutually exclusive to 76942	Edit will be removed/corrected
93321 billed twice on same day – with 26 on one entry and TC on the second entry, same provider	If the technical and professional components of a procedure are performed by the same practitioner/ entity the same day, the service should only be billed once as a global service with no modifier and one unit. MUEs will be changed to "1."

Coding Corner

Place of service 18

The Centers for Medicare & Medicaid Services (CMS) is establishing a new place of service (POS) code 18 – Place of Employment/Worksite effective April 1, 2013. The POS is described as: "a location, not described by any other POS code, owned or operated by a public or private entity where the patient is employed, and where a health professional provides ongoing or episodic occupational medical, therapeutic, or rehabilitative services to the individual."

Blue Cross will accept the new POS as of the effective date. Based on the description, we will be limiting the services rendered in this POS to physical and occupational services.

Medication/pharmacologic management reminder

There were extensive changes to the psychiatry section of the CPT manual for 2013. We would like to remind you that one of the new codes 90863 – Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (list separately in addition to the code for primary procedure), is not a covered service.

Per CPT, this service would only be reported if performed by a practitioner who is **not** eligible to report an evaluation and management (E/M) service for medication or pharmacologic management. Because practitioners who are eligible to render medication management can already submit an E/M 90863 should never be submitted.

Blue Cross is also extending this non-coverage decision to code M0064 - Brief office visit for the sole purpose of monitoring or changing drug prescriptions used in the treatment of mental psychoneurotic and personality disorders.

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: 1/14/13 Notification Posted: 11/29/12

Policies developed

Spinal Fusion: Cervical

- ***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. Cervical spinal fusion may be considered MEDICALLY NECESSARY for ANY of the following indications:

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

B. Osteomyelitis resulting in vertebral body destruction; OR

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

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

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

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

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

1. Persistent or progressive radicular pain or weakness secondary to nerve root compression despite eight (8) weeks of conservative therapy with at least two (2) of the following:
   a. Active pain management program or protocol; OR
   b. Medical management with oral steroids and epidural steroid injections; OR
   c. Physical therapy. AND
2. Diagnostic imaging (i.e., MRI or CT myelogram) demonstrates cervical nerve root compression. OR

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

1. Clinical signs and/or symptoms of myelopathy, as demonstrated by at least ONE of the following:
   a. Upper/lower extremity weakness, numbness, or pain; OR
   b. Bladder or bowel incontinence; OR
   c. Increased tone or spasticity; OR
   d. Gait abnormalities consistent with cervical myelopathy; OR
   e. Over active or overresponsive reflexes; OR
   f. Hoffman's sign; OR
   g. Positive Babinski sign; OR
   h. Hand incoordination or clumsiness. AND
2. Diagnostic imaging (i.e., MRI or CT myelogram) demonstrates spinal cord compression. OR

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

1. Symptoms of radiculopathy (as described in I.F) associated with the adjacent level of the cervical spine AND conservative nonsurgical treatment (as described in I.F) has failed; OR
2. Symptoms of myelopathy (as described in I.G) associated with the adjacent level of the cervical spine.

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

I. Other causes of nontraumatic instability or cervical spondylosis, when documentation demonstrates ALL of the following:
1. Moderate to severe neck pain despite eight (8) weeks of conservative therapy with at least two (2) of the following:
   a. Active pain management program or protocol; OR
   b. Medical management with oral steroids and epidural steroid injections; OR
   c. Physical therapy. AND
2. Clinically significant function limitation resulting in impaired, age-appropriate activities of daily living and diminished quality of life; AND
3. Diagnostic imaging by x-ray demonstrates ONE of the following:
   a. Instability by flexion and extension x-rays
      • Sagittal plane translation >3mm; OR
      • Sagittal plane translation > 20% of vertebral body width. OR
   b. Relative sagittal plane angulation > 11 degrees.
      • Pre-Certification/Pre-Authorization: Yes, for government programs products ONLY: Secure Blue, Blue Advantage (PMAP), Blue Plus (MNCare), Blue Advantage (MSC+).

Policies revised

Breast Implant Removal or Replacement

- The policy title has been revised from "Breast Implants" to "Breast Implant Removal or Replacement".
- The policy statements have been updated as follows:
- I. Breast implants may be considered MEDICALLY NECESSARY when performed for reconstructive purposes following:
  A. Mastectomy following a diagnosis of breast cancer; OR
  B. Prophylactic mastectomy.
- II. Breast implant removal and/or replacement may be considered MEDICALLY NECESSARY when:
  A. The original implants were placed for a medically necessary condition as described in section I; OR
  B. One or more of the following are present:
    1. Capsular contracture of Baker Class IV causing severe pain or hardening of the implant;
    2. Confirmed leakage of silicone implant with silicone migration resulting in pain, lumps, granulomas and increasing fibrosis;
    3. Recurrent infection secondary to the implant that does not resolve with medical treatment including antibiotics;
    4. Recurrent seroma or hematoma that does not resolve with repeated drainage; or
    5. Implant extrusion through the skin.
- III. Removal or replacement of breast implants is considered COSMETIC to address aesthetic appearance, malposition of the implant or anxiety related to the implant when the original implant was performed for cosmetic reasons.
- Pre-Certification/Pre-Authorization: No.

Growth Hormone Treatment

- The policy statements have been updated as follows:
- I. Recombinant human growth hormone (GH) may be considered MEDICALLY NECESSARY for ANY of the following indications:

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A. Children with a confirmed diagnosis of growth hormone deficiency determined by the following:
   1. Hypoglycemia in newborn accompanied by a diagnosis of hypopituitarism/panhypopituitarism; OR
   2. Failure to respond to at least TWO of the following standard GH stimulation tests, with failure defined as a peak GH level of less than 10 ng/ml after stimulation:
      a. Insulin; OR
      b. L-dopa; OR
      c. Arginine; OR
      d. Clonidine; OR
      e. Glucagon. AND
   3. Documentation of at least two of the following clinical features of GH deficiency:
      a. Growth velocity less than the 3rd percentile for bone age (greater than two standard deviations below the mean); OR
      b. Height less than the 3rd percentile for age (greater than two standard deviations below the mean); OR
      c. Delayed bone age.

B. Children with chronic renal insufficiency when ALL of the following conditions are met:
   1. Growth retardation with height less than the 3rd percentile for age (greater than two standard deviations below the mean); AND
   2. Growth velocity less than the third percentile for bone age (greater than two standard deviations below the mean); AND
   3. Bone age at least two standard deviations below the mean for age and gender; AND
   4. Pretreatment bone age less than 13 years for females and less than 15 years for males; AND
   5. No obvious clinical evidence of another unrelated etiology for growth retardation.

C. Patients with AIDS wasting.

D. Adults with proven GH deficiency when ALL of the following criteria are met:
   1. Pituitary disease documented by surgery or other insult (e.g., postpartum hemorrhage, cranial irradiation); AND
   2. Evidence of and treatment for other hormonal deficiencies (e.g., steroid replacement therapy, thyroid replacement therapy); AND
   3. Provocative testing indicates absolute deficiency of growth hormone (<3 ng/mL); AND
   4. Presence of clinical features associated with growth hormone deficiency (e.g., increased fat mass with abdominal preponderance, decreased lean body mass, decreased muscle mass and strength, decreased exercise capacity, impaired sense of well-being).

E. Patients with Turner's syndrome.

F. Patients with growth failure due to Prader-Willi syndrome.

G. Patients with short stature due to Noonan syndrome.

H. Promotion of wound healing in burn patients.

I. Prevention of growth delay in children with severe burns.

J. Patients with short bowel syndrome receiving specialized nutritional support in conjunction with optimal management of short bowel syndrome.

K. Children with short stature due to SHOX (short stature homeobox-containing gene) deficiency.

- II. Recombinant human growth hormone (GH) therapy is considered INVESTIGATIVE for the following indications, including, but are not limited to:

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A. Pediatric patients born small for gestational age (SGA) who fail to show catch-up growth by age 2 years.
B. Children with height standard deviation score of -2.25 or below who are not growth hormone deficient (i.e., idiopathic short stature).
C. Constitutional growth delay.
D. In conjunction with gonadotropin-releasing hormone (GnRH) analogs as a treatment of precocious puberty.
E. GH therapy in older adults without proven deficiency (i.e., anti-aging treatment).
F. Anabolic therapy except for AIDS provided to counteract acute or chronic catabolic illness (e.g., surgery outcomes, trauma, cancer, chronic hemodialysis, chronic infectious disease) producing catabolic (protein wasting) changes in both adult and pediatric patients.
G. Anabolic therapy to enhance body mass or strength for professional, recreational, or social reasons.
H. Glucocorticoid-induced growth failure.
I. Short stature due to Down's syndrome.
J. Treatment of altered body habitus (e.g., buffalo hump) associated with antiviral therapy in HIV- infected patients.
K. Treatment of obesity.
L. Treatment of cystic fibrosis.
M. Treatment of idiopathic dilated cardiomyopathy.
N. Treatment of juvenile idiopathic or juvenile chronic arthritis.
O. Treatment of fibromyalgia.

- III. Documentation Requirements for Renewal of Pre-Certification/Pre-Authorization
  A. Renewal for the following diagnoses must include documentation (i.e., growth charts) to support improvement in growth:
     1. Turner's syndrome;
     2. Renal failure;
     3. Growth hormone deficiency;
     4. Prader-Willi syndrome;
     5. Noonan syndrome;
     6. SHOX deficiency.
  B. Renewal for Adult Growth Hormone Deficiency or AIDS Wasting or Cachexia must include documentation supporting improvement in symptoms.
- Pre-Certification/Pre-Authorization: Yes.

Treatment of Urinary Dysfunction

- The policy statements have been updated as follows:
- I. Periurethral Bulking Agents
  A. Use of the following periurethral bulking agents may be considered MEDICALLY NECESSARY to treat stress urinary incontinence:
     1. Collagen implants (e.g., Contigen Bard collagen implants);
     2. Carbon-coated spheres (e.g., Durasphere);
     3. Calcium hydroxylapatite (e.g., Coaptite®);
     4. Polydimethylsiloxane (e.g., Macroplastique®).
  B. Use of these periurethral bulking agents as treatment for any other type of urinary incontinence is considered INVESTIGATIVE.

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C. Use of autologous cellular therapy (e.g., myoblasts, fibroblasts, muscle-derived stem cells, or adipose-derive stem cells), autologous fat, and autologous ear chondrocytes is considered INVESTIGATIVE.
D. Use of any other periurethral bulking agents for urinary incontinence is considered INVESTIGATIVE.

- II. Pelvic Floor Electrical Stimulation
  A. Use of pelvic floor electrical stimulation (i.e., pelvic TENS) may be considered MEDICALLY NECESSARY as treatment for stress and/or urge incontinence in patients who have undergone a documented trial of pelvic muscle exercises for a period of at least six (6) months with no significant improvement in incontinence.
- III. Personal Use Ultrasound Devices
  A. Use of a portable personal use ultrasound device to non-invasively measure bladder volume (e.g., BladderManager®) may be considered MEDICALLY NECESSARY only for spinal cord-injury patients with autonomic dysreflexia.
  B. All other uses are considered INVESTIGATIVE.
- IV. Botulinum Toxin Therapy
  A. Botulinum toxin may be considered MEDICALLY NECESSARY for incontinence related detrusor overreactivity and incontinence of neurogenic origin (e.g., spinal cord injury, multiple sclerosis) that is inadequately controlled with anticholinergic therapy.
- V. Magnetic Stimulation
  A. Use of magnetic stimulation of the pelvic floor muscles [Extracorporeal Magnetic Innervation (ExMI™), NeoControl® Pelvic Floor System] as treatment for urinary incontinence is considered INVESTIGATIVE due to lack of clinical evidence indicating its impact on improved health outcomes.
- VI. Percutaneous Tibial Nerve Stimulation (PTNS)
  A. Percutaneous tibial nerve stimulation may be considered MEDICALLY NECESSARY for treatment of urinary dysfunction (i.e., incontinence, urgency frequency, and non-obstructive urinary retention) in patients who meet all the following criteria:
    1. Absence of neurologic disease associated with detrusor hyperreflexia; AND
    2. Absence of outlet obstruction; AND
    3. Symptoms have resulted in significant disability (e.g., the frequency and/or severity of leakages are limiting the patient's ability to work or participate in activities outside the home); AND
    4. Conservative forms of treatment have been tried for at least one year and have failed.
  B. The use of percutaneous tibial nerve stimulation for any other indication is considered INVESTIGATIVE.
- VII. Transvaginal Radiofrequency Bladder Neck Suspension
  A. Use of transvaginal radiofrequency bladder neck suspension for treatment of stress urinary incontinence is considered INVESTIGATIVE due to a lack of published evidence supporting its impact on improved health outcomes.
- VIII. Transurethral Radiofrequency Micro-Remodeling
  A. Use of transurethral radiofrequency micro-remodeling (e.g., Renessa) for treatment of stress urinary incontinence is considered INVESTIGATIVE due to a lack of published evidence supporting its impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Yes, ONLY for Percutaneous Tibial Nerve Stimulation (PTNS).

Medical and Behavioral Health Policy Update

Policies Inactivated

Blepharoplasty and Brow Ptosis Repair
Buprenorphine
Extracranial Carotid Angioplasty / Stenting
Peripheral Arterial Tonometry (PAT)
Serum Holo-Transcobalamin as a Marker of Vitamin B12 Status

Policies Effective: 3/11/13 Notification Posted: 1/24/13

Policies developed

None

Policies revised

Anesthesia Services for Gastrointestinal Endoscopic Procedures

- The policy statements have been updated as follows:
- I. Intravenous sedation ("conscious sedation") ordered by the attending physician and administered by the surgeon or physician performing the gastrointestinal endoscopic procedure may be considered MEDICALLY NECESSARY.
- II. Other types of anesthesia services including general and monitored anesthesia care (MAC) may be considered MEDICALLY NECESSARY during gastrointestinal endoscopic procedures when there is documentation by the operating physician and/or the anesthesiologist that ANY of the following situations exist:

A. Prolonged or therapeutic endoscopic procedure requiring deep sedation; OR
B. A history of or anticipated intolerance to standard sedatives (e.g., patient is on chronic narcotics or benzodiazepines, or patient has a neuropsychiatric disorder, history of idiosyncratic reaction to sedatives, or a neurodevelopmental impairment); OR
C. Increased risk for complications due to severe comorbidity (American Society of Anesthesiologists [ASA] Physical Status 3 or greater); OR
D. Patients over 70 years of age; OR
E. Patients less than 18 years of age; OR
F. Pregnancy; OR
G. Patients with active medical problems related to drug or alcohol abuse; OR
H. Uncooperative or acutely agitated patients (e.g., delirium, organic brain disease, senile dementia); OR
I. Morbid obesity (body mass index [BMI] > 40); OR
J. Spasticity or movement disorder complicating the procedure; OR
K. Increased risk for airway obstruction due to anatomic variant including ANY of the following:
1. History of previous problems with anesthesia or sedation; OR
2. History of stridor or sleep apnea; OR
3. Dysmorphic facial features, such as Pierre-Robin syndrome or trisomy-21; OR
4. Presence of oral abnormalities including, but not limited to, a small oral opening (less than 3 cm in an adult), high arched palate, macroglossia , tonsillar hypertrophy, or a non-visible uvula (not visible when tongue is

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protruded with patient in sitting position, e.g., Mallampati class greater than II); OR

5. Neck abnormalities including, but not limited to, short neck, obesity involving the neck and facial structures, limited neck extension, decreased hyoid-mental distance (less than 3 cm in an adult), neck mass, cervical spine disease or trauma, tracheal deviation, or advanced rheumatoid arthritis; OR
6. Jaw abnormalities including, but not limited to, micrognathia, retrognathia, trismus, or significant malocclusion; OR

L. Increased risk of aspiration.

- III. The routine assistance of an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) for average riskadult patients undergoing standard upper and/or lower gastrointestinal endoscopic procedures is considered NOT MEDICALLY NECESSARY.
- Pre-Certification/Pre-Authorization: No.

Phototherapy for the Treatment of Psoriasis

- The policy title has been revised from "Treatment of Psoriasis (Phototherapy and Biologics)" to "Phototherapy for the Treatment of Psoriasis".
- The policy statements have been updated as follows:
- I. Ultraviolet B Phototherapy
  - The use of phototherapy with ultraviolet B may be considered MEDICALLY NECESSARY for the treatment of the psoriasis in the outpatient clinic setting OR in the home setting (when conducted under a physician's supervision).
- II. Psoralens with Ultraviolet A (PUVA) Phototherapy
  - The use of PUVA may be considered MEDICALLY NECESSARY for the treatment of psoriasis when used in the clinic or outpatient setting under physician supervision.
- III. Targeted Phototherapy

A. The use of targeted NB-UVB phototherapy (e.g., excimer laser or lamp devices) may be considered MEDICALLY NECESSARY for the treatment of localized psoriasis when the following criteria are met:

1. Psoriasis affects ≤ 10% of the patient's body surface area; OR
2. Psoriasis affects >10% of the patient's body surface area; AND
   a. Targeted phototherapy is being used to treat resistant localized lesions; AND
   b. A preceding two-month trial of conservative treatment with topical agents, with or without standard phototherapy (UVB or PUVA), has not provided adequate results.

B. The use of targeted phototherapy is considered INVESTIGATIVE for all other indications including but not limited to treatment of generalized psoriasis or psoriatic arthritis, Evidence does not permit conclusions due to the lack of clinical evidence demonstrating its impact on improved health outcomes

- Pre-Certification/Pre-Authorization: No.

Occlusion of Uterine Arteries

- The policy title has been revised from "Occlusion of Uterine Arteries as Treatment for Uterine Fibroids" to "Occlusion of Uterine Arteries".
- The policy statements have been updated as follows:
- I. Transcatheter Uterine Artery Embolization

A. Transcatheter uterine artery embolization may be considered MEDICALLY NECESSARY for treatment of EITHER of the following:

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1. Uterine fibroids; OR
2. Postpartum uterine hemorrhage.

B. ONE repeat transcatheter embolization of uterine arteries may be considered MEDICALLY NECESSARY to treat persistent symptoms of uterine fibroids after an initial UAE.

C. Transcatheter uterine artery embolization for the management of cervical ectopic pregnancy is considered INVESTIGATIVE due to the lack of evidence demonstrating an impact on improved health outcomes.

- II. Laparoscopic Occlusion of Uterine Arteries

A. Laparoscopic occlusion of the uterine arteries for treatment of uterine fibroids is considered INVESTIGATIVE due to a lack of clinical evidence demonstrating its impact on improved health outcomes.

- Pre-Certification/Pre-Authorization: No.

Thrombopoietin Mimetic Agents for Treatment of Thrombocytopenia

- The policy title has been revised from "Thrombopoietin Mimetic Agents for Immune Thrombocytopenic Purpura" to "Thrombopoietin Mimetic Agents for Treatment of Thrombocytopenia".
- The policy statements have been updated as follows:
- I. Thrombopoietin mimetic agents (e.g., romiplostim and eltrombopag) may be considered MEDICALLY NECESSARY for treatment of thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenic purpura (ITP) who meet ALL of the following criteria:

A. Disease duration greater than six (6) months; AND

B. Insufficient response to corticosteroids, immunoglobulins, or splenectomy. An insufficient response is defined as a platelet count of less than 30,000 per microliter OR a platelet count less than 50,000 per microliter and at increased risk of bleeds due to concomitant disease states or occupation.

- II. Eltrombopag may be considered MEDICALLY NECESSARY for treatment of thrombocytopenia in patients with chronic hepatitis C virus (HCV) infection for patients whose level of thrombocytopenia prevents the start or maintenance of interferon-based therapy.
- III.Romiplostim is considered INVESTIGATIVE to increase platelet counts and facilitate treatment for hepatitis C virus infection in patients with thrombocytopenia associated with HCV-related cirrhosis due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- IV. All other uses of thrombopoietin mimetic agents (e.g., romiplostim and eltrombopag) are considered INVESTIGATIVE including, but not limited to, the following due to the lack of clinical evidence demonstrating their impact on improved health outcomes:

A. Initial therapy for chronic ITP;

B. Acute ITP;

C. Normalization of platelet counts in patients with chronic ITP in the absence of increased risk for bleeding;

D. Thrombocytopenia due to myelodysplastic syndrome;

E. Thrombocytopenia due to chronic liver disease;

F. Chemotherapy-induced thrombocytopenia.

- Pre-Certification/Pre-Authorization: Yes.

Infliximab

- The policy statements have been updated as follows:
- I. Use of infliximab may be considered MEDICALLY NECESSARY for the following FDA-approved indications:

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A. Rheumatoid Arthritis
- Used in combination with methotrexate, for reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in patients with moderately to severely active rheumatoid arthritis.

B. Crohn's disease
1. For reducing signs and symptoms and inducing and maintaining clinical remission in adult and pediatric patients who are six years of age or older with moderately to severely active Crohn's disease who have had an inadequate response to conventional therapy.
2. For reducing the number of draining enterocutaneous and rectovaginal fistulas and maintaining fistula closure in adult patients with fistulizing Crohn's disease.

C. Ankylosing Spondylitis
- For reducing signs and symptoms in patients with active ankylosing spondylitis.

D. Psoriatic Arthritis
- For reducing signs and symptoms of active arthritis, inhibiting the progression of structural damage, and improving physical function in patients with psoriatic arthritis.

E. Plaque Psoriasis
1. Patient has moderate to severe psoriasis with EITHER of the following:
   a. Greater than 5% of body surface area with plaque psoriasis; OR
   b. Less than or equal to 5% body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily functioning (e.g., palms, soles of the feet, head/neck, or genitalia). AND
2. Dermatologist or physician with expertise in treating moderate to severe psoriasis prescribes the therapy; AND
3. Patient must have:
   a. Documented failure of treatment with phototherapy (UVB or PUVA) OR topical and systemic therapy (methotrexate, cyclosporine, or acitretin); OR
   b. A medical contraindication to these treatments.

F. Ulcerative Colitis
1. For reducing signs and symptoms, inducing and maintaining clinical remission and mucosal healing, and eliminating corticosteroid use in adult patients with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy.
2. For reducing signs and symptoms and inducing and maintaining clinical remission in pediatric patients who are six year of age or older with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy.

- II. Other uses of infliximab are considered INVESTIGATIVE, including but not limited to the following due to the lack of clinical evidence demonstrating their impact on improved health outcomes.
  - Age-related macular degeneration
  - Alcoholic hepatitis
  - Arthritis (other than rheumatoid arthritis and psoriatic arthritis)
  - Behcet syndrome
  - Behcet syndrome uveitis
  - Cancer cachexia
  - Depression
  - Diabetic macular edema

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  - Endometriosis
  - Erythrodermic or exfoliative psoriasis
  - Giant cell arteritis
  - Graft-versus-host disease
  - Hidradenitis suppurativa
  - Intra-articular injections
  - Juvenile idiopathic arthritis
  - Juvenile idiopathic arthritis-associated uveitis
  - Kawasaki syndrome
  - Polyarteritis nodosa
  - Polymyalgia rheumatica
  - Renal cell carcinoma
  - Sacroiliitis
  - Sarcoidosis
  - Sclerosing cholangitis
  - Sjogren syndrome
  - Systemic lupus erythematosis
  - Systemic necrotizing vasculitides
  - Systemic sclerosis
  - Takayasu's arteritis
  - Wegener's Granulomatosis
- III. Testing of Serum Antibodies to Infliximab
  - Testing of antibodies to infliximab in a patient receiving treatment with infliximab, either alone or as a combination test that includes the measurement of serum infliximab levels, is considered INVESTIGATIVE due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: No.

Autism Spectrum Disorders: Assessment

- The policy statements have been updated as follows:
- I. Initial Assessment

A. To ensure appropriate multidisciplinary care and use of benefits, there will be a comprehensive, multidisciplinary, diagnostic assessment completed within the past 12 months on file for each member before health services for Autism Spectrum Disorders are initiated. The diagnostic assessment must indicate that the individual has the intellectual and functional capacity to benefit from the type and intensity of the services proposed and include ALL of the following:

1. Diagnostic assessment by a licensed Mental Health Professional*; AND
2. Current diagnoses on all five (5) axes of the DSM-IV multiaxial system; AND
3. A complete medical evaluation by a licensed physician; AND
4. Testing, supervised and interpreted by an independent, licensed psychiatrist or Ph.D psychologist, including standardized:
   a. Intellectual testing; and
   b. Adaptive testing; and

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c. Communication testing; and
d. Autism measures (e.g., ADOS, CARS, ADI-R); AND

5. A comprehensive hearing test by an audiologist; AND
6. The member's developmental history, focusing on developmental milestones and delay; AND
7. Family history; examples of important information include whether there are other family members with an ASD, mental retardation, fragile X syndrome, or tuberous sclerosis; AND
8. The member's medical history such as signs of deterioration, seizure activity, brain injury, head circumference; AND
9. Lead screening for those members with mental retardation; AND
10. Review of educational (school) system records; AND
11. Other evaluations and testing as indicated or as necessary to confirm the diagnosis.

– *The Mental Health Professional must meet the Minnesota Department of Human Services qualifications, as set forth in Minn.Stat.245.4871, subd. 27 and Minn.Stat.245.462, subd. 18.

II. Assessment of Treatment Progress

A. For a member participating in intensive behavioral intervention for the treatment of an Autism Spectrum Disorder, a summary document outlining the member's progress, based on the measures of progress established in the member's plan of care and standardized testing results, must be submitted to the Plan at least every 6 months. This summary document, which may be used to determine the medical necessity of ongoing treatment, must include ALL of the following:

1. Current diagnoses on all five (5) axes of the DSM-IV multiaxial system;
2. Testing, supervised and interpreted by an independent licensed Mental Health Professional* who is qualified to administer appropriate assessment instruments, must be administered, at the time intervals described below. Testing must include standardized:
   a. Intellectual testing, every 12 months; AND
   b. Adaptive testing, every 6 months; AND
   c. Communication testing, every 6 months; AND
   d. Autism measures (e.g., ADOS, CARS, ADI-R), every 6 months.

   – *The Mental Health Professional must meet the Minnesota Department of Human Services qualifications, as set forth in Minn.Stat.245.4871, subd. 27 and Minn.Stat.245.462, subd. 18.

- Pre-Certification/Pre-Authorization: No. However, any psychological and/or neuropsychological testing that is completed as part of the assessment will need pre-certification/pre-authorization as outlined in policy X-45 (Psychological and Neuropsychological Testing).
  – NOTE: Refer to the behavioral health policy on Psychological and Neuropsychological Testing, #X-45, for pre-certification/pre-authorization information specific to that type of testing.
  – Coverage is subject to the member's contract benefits.

Policies inactivated

Dermatoscopy

Transanal Endoscopic Microsurgery

Altered Auditory Feedback for Treatment of Stuttering

Autism Spectrum Disorders: Early Intensive Behavioral Intervention (EIBI)

– Please note, The Mihalik Group's Medical Necessity Manual for Behavioral Health will continue to be utilized for review of EIBI services.

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Selective Internal Radiation Therapy
Pneumograms
Laboratory Tests for Heart Transplant Rejection
Pulmonary Rehabilitation
Intravitreal Implant: Ganciclovir

There was no Medical and Behavioral Health Policy Activity for December 2012.

Policies reviewed with no changes in November 2012 and January 2013:

Actigraphy
Allogeneic Hematopoietic Stem-Cell Transplantation for Genetic Diseases and Acquired Anemias
Ambulatory Event Monitors and Mobile Outpatient Cardiac Telemetry
Anterior Eye Segment Optical Imaging
Autologous Chondrocyte Implantation and Other Cell-Based Treatments of Focal Articular Cartilage Lesions
Axial (percutaneous) Lumbar Interbody Fusion
Bioimpedance Spectroscopy Devices for the Detection and Management of Lymphadema
Bone Morphogenetic Protein (BMP)
Cooling/Heating Devices Used in the Outpatient Setting
CT Colonography (Virtual Colonoscopy)
Electromagnetic Navigation Bronchoscopy
Extracorporeal Shock Wave Treatment for Plantar Fasciitis and Other Conditions
Functional Neuromuscular Electrical Stimulation Devices
Genetic Testing for Familial Alzheimer's Disease
Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia
Hematopoietic Stem-Cell Transplantation for Hodgkin Lymphoma
Hematopoietic Stem-Cell Transplantation for Myelodysplastic Syndrome and Myeloproliferative Neoplasms
Implantation of Intrastromal Corneal Ring Segments
Microarray-based Gene Expression Testing for Cancers of Unknown Primary
Neurofeedback/Electroencephalogram (EEG)
Orthognathic Surgery
Osteochondral Allografts and Autografts in the Treatment of Focal Articular Cartilage Lesions
Pegloticase (KRYSTEXXA)
Percutaneous Electrical Nerve Stimulation (PENS) or Percutaneous Neuromodulation Therapy (PNT)
Percutaneous Vertebroplasty, Kyphoplasty, and Sacroplasty
Psychological and Neuropsychological Testing
Scanning Laser Technologies for Glaucoma Testing and Monitoring
Skilled Nursing Facility (SNF) Care
Spinal Cord Stimulation
Subtalar Arthroereisis
Suprachoroidal Delivery of Pharmacologic Agents
Treatment for Temporomandibular Disorder (TMD)

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Tumor Markers, Urinary
T-Wave Alternans
Ultrasound-Guided High Intensity Focused Ultrasound Ablation for treatment of Prostate Cancer and Other Tumors
Uterine Activity Monitoring (Home, Ambulatory)
Ventricular Assist Devices and Total Artificial Hearts

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

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

Advisors/Faith Bauer, CPC, CPC-H, CPC-P; Jeannie Harp, CPC-A; Janine Utecht, CPC, CPC-H, CPC-P, CPMA; and Jessica Truax, M.S., CCC-SLP

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

03/13

For the health of all.

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