Provider Press

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For the health of all.

Attributes of a health literate organization

Health literacy is often defined as an individual skill – **a person's ability** to read, understand and act on health information. However, it is increasingly evident that how health information is delivered plays a big part in how well someone understands. At Blue Cross, we have adopted a broader definition of health literacy, one that also includes **health care professionals' ability** to communicate clearly, educate about health and empower their patients.

The Institute of Medicine's (IOM's) Roundtable on Health Literacy recently pulled together industry leaders to discuss what it looks like to be a "health literate" organization. They compiled a list of 10 attributes that provide an aspirational vision. They show how health care organizations can move toward person-centered care, improved communication and better understanding between health care professionals and patients.

A health literate health care organization:

1. Has leadership that makes health literacy integral to its mission, structure and operations.
2. Integrates health literacy into planning, evaluation measures, patient safety and quality improvement.
3. Prepares the workforce to be health literate and monitors progress.
4. Includes populations served in the design, implementation and evaluation of health information and services.
5. Meets the needs of populations with a range of health literacy skills while avoiding stigmatization.
6. Uses health literacy strategies in interpersonal communications and confirms understanding at all points of contact.
7. Provides easy access to health information and services and navigation assistance.
8. Designs and distributes print, audiovisual and social media content that is easy to understand and act on.
9. Addresses health literacy in high-risk situations, including care transitions and communications about medicines.
10. Communicates clearly what health plans cover and what individuals will have to pay for services.

Participants in the IOM discussion believe that if health care organizations adopt most of the 10 attributes in even a small way, they will be more responsive to individuals' needs.

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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 September to November 2012 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
QP10-12	Non-participating out-of-state inpatient admissions review
QP11-12	Clarification to ancillary claims through BlueCard® program (Independent Clinical Labs, DME and Specialty Pharmacy)
QP12-12	The Winding Road to ICD-10 Codesets
QP13-12	MedicareBlue SM PPO (Regional PPO) Non-Renewal Notification
QP14-12	Benefit determination requests for Platinum Blue SM (Cost) members
QP15-12	Home care authorization changes for MSHO and MSC+ members
QP16-12	MNCare tax for home infusion providers
QP17-12	NBI MEDIC (Health Integrity, LLC) prescriber prescription verification requests
QP18-12	New Medicare product for 2013
QP19-12	Coding edit change for modifier 25
Bulletins	**Title**
P21-12	High-Technology Diagnostic Imaging (HTDI) program – important changes
P22-12	October ICD-9-CM and HCPCS code updates
P23-12	Concurrent review requirements for long-term acute care (LTAC) and acute rehabilitation (rehab) providers
P24-12	Timely filing limits on claims
P25-12	QS modifier payment change

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 September 2012 to November 2012. 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	The following topics had content changes: • Freestanding Ambulatory Surgical Center Billing • Observation • Present on Admission (POA) • Non Physician Health Care Providers
Provider Policy and Procedure Manual	Chapter 9 – Reimbursement/ Reconciliation	The following new topics were added: • Consumer Price Index Payment Increase • Replacement of Medical Services • Overpayments
Provider Policy and Procedure Manual	Chapter 10 – Appeals	• A new topic titled "Arbitration" was added to this chapter
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Coding section	Content change was made to Multiple Surgery Guidelines
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Modifiers section	Content changes were made to the Modifiers section
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Medical Services section	A new topic titled "Multiple E/M Same Day" was added to this section
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Surgical Services section	The following topics had content changes: • Bilateral Services • Fractures • Assistant Surgeons • Multiple Surgeries
Provider Policy and Procedure Manual	Chapter 4 – Integrated Health Management	Multiple changes were made to this chapter
Blue Plus Manual	Chapter 3 – Government Programs	Multiple changes to Care Coordination Delegation Guidelines

2013 Holiday schedule

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

Tuesday, January 1

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.

FYI

Healthy Start® Prenatal Support

Healthy Start is a personal, phone-based support and education program for pregnant women. The program helps pregnant women learn what they need to know to have the healthiest pregnancy and healthiest baby possible.

An experienced obstetric nurse provides education, support and encouragement throughout a woman's pregnancy and during the postpartum period. Pregnant women also receive a valuable prenatal resource guide and access to web-based and/or paper educational materials, as well as a VISA reward card for completing the program.

New in 2013! Healthy Start will be rolling out an online Childbirth Education class in conjunction with the program. Pregnant women who are enrolled in the Healthy Start telephonic program will be able to access this on-line program from the comfort of their own homes. The online class is very interactive and engaging for the participant and can be viewed whenever desired by the enrolled mom and/or support person.

Women who participate in the Healthy Start program have a 29 percent lower incidence of preterm birth and a 26 percent lower incidence of low birth weight babies, compared to national rates published by the National Center for Health Statistics.

The Healthy Start program was developed to complement the care you are providing. Healthy Start nurses should be considered an additional resource to help ensure the best outcomes for mom and baby. If you would like additional information or brochures to help promote the program, please contact us directly using the contact information below.

Healthy Start is available to all fully insured members, Prepaid Medical Assistance Program (PMAP)/MinnesotaCare members and most self-insured members.

If a Blue Cross member is expecting, please encourage her to take advantage of this highly rated program by calling the customer service number on the back of her member ID card or contact Healthy Start directly using the contact information below.

Phone: **(651) 662-1818** or toll free at **1-866-489-6948**

E-mail: healthy_start@bluecrossmn.com

Website: **myhealthystart.org**

Healthy Start conducts an annual member satisfaction survey.
Below are the results from the 2011 survey [1]:

- 99% of moms reported that enrolling in the program was easy
- 99% of moms reported that the conversations with their nurse helped them feel more supported during their pregnancy
- 99% of moms rated their overall level of satisfaction with the program from good to excellent
- 98% of moms rated the courtesy and sensitivity of their nurse from very good to excellent
- 95% of moms indicated that the book and information helped them to better prepare for what to expect in pregnancy and birth

[1] Survey conducted via SurveyMonkey for members who completed the Healthy Start program from January 1 to December 31, 2011.

Quality Improvement

Review UM criteria

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

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:

E-mail: pcc_complaint@bluecrossmn.com

Secure fax line: **651-662-4004**

Mail: Blue Plus
Attn: Quality Health Management Dept.
Route 472
P.O. Box 64179
St. Paul, MN 55164-0179

Quality Improvement

Clinical practice guidelines

At Blue Cross, we believe the use of clinical practice guidelines is a key component of health care improvement. Each year our Quality Council approves the adoption of select guidelines that are used to support various programs and initiatives. The guidelines do not substitute for sound clinical judgment; however, they are intended to assist clinicians in understanding key processes for improvement efforts.

Please note that some treatment and management options recommended in clinical practice guidelines may not be covered benefits under a member's health plan.

The clinical practice guidelines section can be reviewed on our provider website at **providers.bluecrossmn.com**, "Forms & publications," then "manuals," Provider Policy and Procedure Manual, Chapter 3 – Quality Improvement.

Recently updated ICSI guidelines:

- **Diagnosis and Management of Asthma**
- **Routine Prenatal Care**
- **Preventive Services for Adults**
- **Preventive Services for Children and Adolescents**
- **Colorectal Cancer Screening**
- **Diagnosis and Treatment of Hypertension**
- **Primary Care for Major Depression in Adults**
- **Low Back Pain**
- **Type II Diabetes Mellitus**

You may also contact the Quality and Health Management Department via e-mail at: QHM_Compliance@bluecrossmn.com for more information.

Utilization management statement

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

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

Medical necessity decisions

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

Coding Corner

Multiple anesthesia procedures

Only one anesthesia service should be coded per operative session. If multiple or bilateral surgical procedures are performed during the same operative session, only the single anesthesia code that has the highest base unit value should be reported. If multiple anesthesia services are submitted, only the highest base value service will be allowed. As a reminder, anesthesia time should be indicated on the 837P claim format in the unit(s) field of the 837P record. Anesthesia time begins when the anesthesiologist or CRNA begins to prepare the patient for the induction of anesthesia in the operating room, or an equivalent area, and ends when they are no longer in personal attendance. Anesthesia time is coded as minutes in the units of service field.

Medical records reminder

This is a reminder that all submitted medical records MUST include the signature of the practitioner rendering the service (electronic is acceptable) and date of the signature on the record. Blue Cross requires providers to maintain medical records in a manner that is current, detailed and organized and that ultimately supports all billed charges on a submitted claim. For additional information regarding medical record requirements, refer to Provider Bulletin P11-12 entitled "Blue Cross requirements regarding medical records." To view the Bulletin on our website, go to **providers.bluecrossmn.com** and enter P11-12 in the search field located on the top right.

Home health RAP service date

A RAP is a "Request for Anticipated Payment"-- an initial claim submitted by a home health provider to open a case. Blue Cross has received RAP claims from home health providers with a date later than the statement from and through dates. These claims are rejecting in pre-adjudication.

To prevent rejections, Blue Cross would like to remind providers that the date(s) of service must be within the statement from and through dates as supported by the Medicare Claim Processing Manual, which states under the Statement Covers Period (From-Through), "Typically, these fields show the beginning and ending dates of the period covered by a bill. Since the RAP is a request for payment for future services, however, the ending date may not be known. The RAP contains the same date in both the "from" and "through" date fields. On the first RAP in an admission, this date should be the date the first service was provided to the beneficiary. On RAPs for subsequent episodes of continuous care, this date should be the day immediately following the close of the preceding episode (day 61, 121, etc.)".

Coding Corner

Happy New Year

January 1, 2013, not only ushers in a new year but new, revised and discontinued HCPCS codes.

Normally we try to publish new HCPCS codes during the year as a courtesy; however, because the January update is the largest of the quarterly HCPCS code updates, we will not publish the codes via bulletin. HCPCS codes (CPT and Level II HCPCS) are a HIPAA medical code set and must be valid for the date of service submitted. So it is very important to get your new CPT and HCPCS manuals (if you do not have them already).

And as always, we will accept all new and revised HCPCS codes with a date of service of January 1, 2013, or after. Likewise, we will reject all discontinued codes with a date of service of January 1, 2013, or after.

Modifiers must be compatible

Modifiers are many times an important part of the claim submission. Appended to a procedure or service, it completes the picture of that visit or service. However, the modifier and procedure must be compatible. For example, it would not be appropriate to add modifiers -59 (distinct procedural service), -LT (left side) or –RT (right side) to an evaluation and management service.

An incompatible modifier may cause denial of the service or procedure to which it is appended.

Attributes of a health literate organization continued from page 1

This can lead to a substantial contribution to improved population health.

If you are interested in learning more about health literacy contact us at health_literacy@bluecrossmn.com.

To read the full paper, which includes examples of practical and concrete actions that health care organizations can do to close the gap between individual health literacy skills and the demands of complex health care information and systems, visit

http://iom.edu/~/media/Files/Perspectives-Files/2012/Discussion-Papers/BPH_Ten_HLit_Attributes.pdf

BlueCard

What is the BlueCard® Program?

BlueCard is a national program that enables members of one Blue plan to obtain health care service benefits while traveling or living in another Blue plan's service area. The program links participating health care providers with the independent Blue Cross and Blue Shield plans across the country, and in more than 200 countries and territories worldwide, through a single electronic network for claims processing and reimbursement. You may submit claims for patients from other Blue plans, domestic and international, to Blue Cross and Blue Shield of Minnesota (Blue Cross). Blue Cross is your sole contact for education, contracting, claims payment and problem resolution. Additional information about the BlueCard program is located in Chapter 7 (BlueCard) of the online Blue Cross Provider Policy and Procedure Manual. To access the manual go to **providers.bluecrossmn.com**.

Each Blue Cross and/or Blue Shield plan is an independent licensee of the Blue Cross and Blue Shield Association.

Below are answers to Frequently Asked Questions regarding the BlueCard program.

How do I handle Medicare Advantage claims?

For Medicare Advantage submit claims to Blue Cross. Do not bill Medicare directly for any services rendered to a Medicare Advantage member. Payment will be made directly by a Blue plan.

- Ask for the member ID card. Members will not have a standard Medicare card; instead, a Blue Cross and/or Blue Shield logo will be visible on the member ID card.
- Verify eligibility by contacting **1-800-676-BLUE** and providing the alpha prefix. Be sure to ask if Medicare Advantage benefits apply.

Please review the remittance notice concerning Medicare Advantage plan payment, member's payment responsibility and balance billing limitations.

What is an Administrative Services Only (ASO) account?

ASO accounts are self funded, where Blue Cross administers claims on behalf of the account, but does not fully underwrite the claims. Blue Cross receives and prices all local claims, handles all interactions with providers, with the exception of Utilization Management interactions, and makes payment to the local provider. As with any member benefit contract, be sure to verify member eligibility and benefits when rendering service.

How should clearinghouses be notified of changes in claims processing guidelines or policy?

It is the Provider's responsibility to ensure any changes to claims processing guidelines or policy is communicated to any billing service, clearinghouse or payer the provider has a vendor arrangement with. Failure to do so timely may result in delays or denials of payment due to incorrect claims submission.

Blue Plus Reminders

Human Papillomavirus (HPV) vaccination

Blue Plus wants to increase the appropriate vaccination of girls and young women against HPV to reduce the risk of cervical cancer. Blue Plus successfully completed the active phase of a collaborative project to increase vaccination among girls and young women with Prepaid Medical Assistance Program (PMAP) and MinnesotaCare coverage.

The Center for Disease Control and American Academy for Pediatrics recommend vaccinating 11- and 12-year-old girls and catching up with vaccination for females ages 13 to 26. Please:

- discuss the benefits of HPV vaccination with young women and parents or guardians of minor children,
- recommend vaccination and
- complete the 3-shot vaccination series for members who agree.

Use of statins for lipid management among members with coronary heart disease and/or diabetes

Blue Plus encourages continued clinical efforts to increase continuous use of statin drugs to reduce low density lipoprotein (LDL) cholesterol, particularly for members with coronary heart disease and/or diabetes. Blue Plus successfully completed the active phase of a project to increase use of statins among this population who have Prepaid Medical Assistance Program (PMAP) and MinnesotaCare coverage. Blue Plus recognizes the need for ongoing clinical efforts to encourage members to use a statin when appropriate.

Pharmacy Benefit for aspirin, calcium and vitamin D for seniors with Medicaid coverage

Blue Plus wants to increase the appropriate use of aspirin, calcium and vitamin D among seniors. A pharmacy benefit is provided for these supplements for seniors with SecureBlue℠ (MSHO) and Blue Advantage (MSC+) coverage. When physicians, nurses and pharmacists prescribe covered supplements, you increase the likelihood of patients using them by reducing the financial barrier.

Please write prescriptions for low-dose aspirin, calcium and vitamin D for seniors who can benefit from them. Contact provider services at **(651) 662-5200** or **1-800-262-0820** if you have questions about pharmacy benefits.

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 have a separate section titled "Coverage Guidelines for DHS Programs (MHCP Manual)."

The "Pre-Certification/Pre-Authorization" section identifies various services, procedures, prescription drugs, and medical devices that require pre-certification/pre-authorization. Please note, Commercial (including BlueLink TPA) and MN Government Programs have different pre-certification/ pre-authorization lists and requirements. These lists are not exclusive to medical policy services only; they encompass other services that are subject to pre-certification/pre-authorization requirements. For your convenience, links to the "Commercial Forms" and "BlueLink TPA Forms" have also been provided.

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: 10/08/12 Notification Posted: 08/23/12

Policies developed

None

Policies revised

Chelation Therapy

- The policy statements have been updated as follows:
- I. Chelation therapy may be considered medically necessary in the treatment of the following conditions:
  A. Control of ventricular arrhythmias or heart block, when associated with digitalis toxicity; OR
  B. Acute or long-term lead poisoning; OR
  C. Extreme conditions of metal toxicity (e.g., aluminum, mercury, arsenic, zinc, iron, copper,); OR
  D. Chronic iron overload due to blood transfusions (i.e., transfusional hemosiderosis); OR
  E. Copper storage disease (i.e., Wilson disease or hepatolentricular degeneration); OR
  F. Emergency treatment of hypercalcemia.
- II. Chelation therapy is considered investigative in the treatment of all other conditions including, but not limited to, the following:
  A. Arteriosclerosis;
  B. Coronary or peripheral vascular disease;
  C. Hypercholesterolemia;
  D. Multiple sclerosis;
  E. Arthritis;
  F. Diabetes;
  G. Scleroderma;
  H. Porphyria;
  I. Alzheimer's disease;
  J. All mental health disorders;
  K. All substance-related disorders;
  L. Mercury release from dental amalgams.
- Pre-Certification/Pre-Authorization: No.
  - However, services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial may result if criteria are not met.

Rituximab

- The policy statements have been updated as follows:
- I. Rituximab may be considered medically necessary for the following:
  A. Oncologic Indications
    1. Non-Hodgkin's lymphoma (NHL) (e.g. AIDS-related B-cell lymphoma, Burkitt's lymphoma, B-cell lymphoma; high-grade B-cell lymphoma, chronic lymphocytic leukemia/small lymphocytic lymphoma, diffuse large B-cell lymphoma, follicular lymphoma and nodal marginal zone lymphoma, gastric mucosa-associated lymphoid tissue (MALT) lymphoma, lymphoblastic lymphoma, mantle cell lymphoma, non-gastric MALT lymphoma, post-transplant lymphoproliferative disorders, primary cutaneous B-cell lymphoma, and splenic marginal zone lymphoma);

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2. Acute lymphocytic leukemia;
3. Chronic lymphocytic leukemia (CLL);
4. Central nervous system cancer – metastatic and primary lesions;
5. Hairy cell leukemia;
6. Hodgkin's lymphoma;
7. Waldenström macroglobulinemia.

B. Non-Cancer Indications

1. FDA Approved:
   a. In combination with methotrexate for the treatment of adults with moderately-to severely-active rheumatoid arthritis who have had an inadequate response to one or more tumor necrosis factor (TNF) antagonist therapies.
   b. In combination with glucocorticoids in the treatment of Wegener's granulomatosis (WG) or microscopic polyangiitis (MPA) in adults.
2. Non-FDA approved
   a. Idiopathic or immune thrombocytopenic purpura (ITP).
   b. Autoimmune hemolytic anemia (AIHA).

- II. The use of rituximab for treatment of all other conditions is considered investigative due to a lack of published clinical evidence establishing the role of rituximab in the treatment of these condition
- Pre-Certification/Pre-Authorization: No.

Amino Acid-Based Elemental Formula

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

A. The use of oral amino acid-based elemental formula may be considered medically necessary in patients five years of age and under when BOTH of the following criteria are met:

1. Patient has a definitive diagnosis, as supported by laboratory and/or diagnostic test results, of ONE of the following conditions:
   a. Cystic fibrosis;
   b. Amino acid, organic acid, and fatty acid metabolic and malabsorption disorders;
   c. IgE-mediated allergies to food proteins;
   d. Food protein-induced enterocolitis syndrome;
   e. Eosinophilic esophagitis;
   f. Eosinophilic gastroenteritis;
   g. Eosinophilc colitis;
   h. Short gut syndrome; AND
2. Condition was diagnosed by an allergist, gastroenterologist, or pediatrician.

B. The use of oral amino-acid based elemental formula may be considered medically necessary in children five years and under for up to 90 days when requested by a physician while actively seeking a confirmatory diagnosis and when ALL of the following documentation is submitted:

1. Presumptive diagnosis of one of the conditions defined in I.A.1; AND
2. Patient's symptoms; AND

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3. Minimum of three to four prior failed formula alternatives.

- II. Renewal Review

A. The use of oral amino-acid based formula may be considered medically necessary in children five years and under when the following documentation is submitted by a physician:
1. Improvement of the patient's symptoms while on the amino acid based formula; AND
2. Definitive diagnosis of one of the conditions defined in I A.1, accompanied with supporting lab and / or diagnostic test results.

- Pre-Certification/Pre-Authorization: Yes.

Panniculectomy/Excision of Redundant Skin or Tissue

- The policy title has been revised from "Excision of Redundant Skin or Tissue" to "Panniculectomy/Excision of Redundant Skin or Tissue".
- The policy statements have been updated as follows:
- I. Panniculectomy

A. Panniculectomy with or without abdominoplasty may be considered medically necessary when BOTH of the following criteria are met:
1. The pannus/panniculus extends at or below the level of the symphysis pubis; AND
2. The treating physician has documented that the pannus/ panniculus is associated with:
   a. chronic, recurrent infection that is refractory to medical management (e.g., antifungal, antibacterial, and moisture-absorbing agents; supportive garments; topically-applied skin barriers); OR
   b. recurrent non-healing ulcerations, accompanied by skin deterioration, that are nonresponsive to aggressive wound management.

B. Panniculectomy with or without abdominoplasty may be considered medically necessary as an adjunct to a medically necessary procedure when needed for exposure to improve surgical access or wound healing following surgery.

C. The following procedures are considered cosmetic as they are performed primarily to enhance or otherwise alter physical appearance without correcting or improving a physiological function:
1. Panniculectomy with or without abdominoplasty not meeting the criteria in IA or IB;
2. Abdominoplasty;
3. Nonfunctional procedures performed in association with a medically necessary panniculectomy (e.g., transposition of the umbilicus, undermining to the costal margin, lateral contouring imbrications, lipectomy);
4. Repair of diastasis recti.

- II. Excision of redundant skin or tissue of other anatomical areas

A. Excision of redundant skin or tissue of the upper extremities (e.g., brachioplasty), lower extremities, thighs or buttocks, may be considered medically necessary when at least one of the following are met:
1. Documentation by the treating physician that the redundant skin or tissue is associated with chronic, recurrent infection that is refractory to medical management (e.g., antifungal, antibacterial, and moisture-absorbing agents; supportive garments; topically-applied skin barriers); OR
2. The redundant skin or tissue results in a functional deficit due to a severe physical deformity or disfigurement AND the surgery is expected to restore or improve the functional deficit.

B. Excision of redundant skin or tissue of the upper extremities (e.g., brachioplasty), thighs or buttocks not meeting criterion IIA is considered cosmetic.

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C. Tissue excision procedures to change the appearance of the labia and/or the vagina are considered cosmetic including, but not limited to, labiaplasty (reduction of labia minora and/or labia majora).

- III. Documentation Requirements
  - Photographs must be submitted for indications that cannot be sufficiently described. Several different views of the affected area are helpful. Photographs should be limited to the affected area.
- Pre-Certification/Pre-Authorization: Yes.

Reduction Mammoplasty

- The policy statements have been updated as follows:
- I. Reduction mammoplasty may be considered medically necessary for patients 18 years of age and older who meet BOTH of the following criteria:

A. Documentation of at least a six (6) month history of two (2) or more of the following clinical symptoms related to the excess breast tissue:

1. Shoulder, neck, or back pain that is not responsive to at least six (6) weeks of conservative therapy (e.g., appropriate support bra, exercises, heat/cold treatment, and appropriate non-steroidal anti-inflammatory agents (NSAIDS)/ muscle relaxants);
2. Recurrent or chronic intertrigo between the pendulous breast and the chest wall;
3. Persistent shoulder grooving;
4. Neurologic symptoms associated with brachial plexus pressure (e.g., numbness or tingling of the shoulder, arm, or hand). AND

B. The combined weight estimated to be removed from both breasts must equal or exceed the value as calculated by the following method:

- STEP ONE:
  1. Determine Body Surface Area:
  2. BSA (m2) = √ ([height in inches x weight in pounds]/313)
- STEP TWO:
  - Tissue to be removed from breasts:
    1. If body surface area [BSA (m2)] is less than or equal to 1.70, a minimum average weight of 800 grams total should be removed from both breasts.
    2. If body surface area [BSA (m2)] is greater than 1.70, refer to the chart below for minimum average total weight to be removed from both breasts.

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AVERAGE WEIGHT OF TISSUE TO BE REMOVED	
Body Surface Area (BSA), m2	Grams estimated to be removed
1.70 or less	800 minimum
1.75	808
1.80	882
1.85	964
1.90	1054
1.95	1150
2.00	1256
2.05	1374
2.10	1486
2.15	1638
2.20	1790
2.25	1956
2.30	2136
2.35	2334
2.40	2550
2.45	2786
2.50	3044
≥ 2.55	3324

- II. Liposuction is considered investigative as a primary (i.e., stand alone) surgical procedure for breast reduction.
- Pre-Certification/Pre-Authorization: Yes.

Surgical Treatment of Gender Identity Disorder

- The policy title has been revised from "Medical and Surgical Treatment of Gender Identity Disorder" to "Surgical Treatment of Gender Identity Disorder".
- The policy statements have been updated as follows:
- I. Criteria for All Surgical Treatment
  - Surgical treatment of gender identity disorder may be considered medically necessary when ALL of the following criteria have been met. These criteria are based on the "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People, from the World Professional Association for Transgender Health," 7th version (2011).

    A. A comprehensive diagnostic evaluation has been completed by a psychiatrist, a clinical psychologist, or other licensed mental health professional who:

    1. Is experienced in the evaluation and treatment of transsexualism/gender identity disorder; and
    2. Has competence in the diagnosis of sexual and gender identity disorders, as well as in diagnosing possible co morbid disorders such as psychotic disorders, personality disorders, and substance related disorders; and
    3. Meets the Minnesota Department of Human Services qualifications for a mental health professional, as set forth in Minn.Stat.245.4871, subds.26 and 27 (2011) and Minn.Stat.245.462, subds. 17 and 18 (2011).

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  - Note: If the level of competence of the evaluating or treating mental health professional is uncertain, the health plan will seek a second opinion from a known expert in the diagnosis and treatment of GIDs. AND

B. Based on the comprehensive evaluation, the individual meets the diagnostic criteria for gender identity disorder per the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV-TR):

1. A strong and persistent cross-gender identification, not merely a desire for any perceived cultural advantages of being the other sex;
2. Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex;
3. The disturbance is not concurrent with a physical intersex condition;
4. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

- II. Breast surgery
  - Breast surgery may be considered medically necessary when criteria IA and IB and ALL of the following criteria are met:

A. The member is 18 years of age or older. In female to male (FtM) patients, chest surgery could be carried out earlier, preferably after ample time of living in the desired gender role and after one year of testosterone treatments (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones); AND

B. Substantial progress must be demonstrated in the treatment of any comorbid psychopathologies or substance use disorders, resulting in a positive prognosis based on psychological testing, clinical assessment, and clinical judgment prior to planning surgical treatment; AND

C. The member has demonstrated the capacity to make a fully informed decision and consented to treatment; AND

D. Male to female members have completed a minimum of 12 months of feminizing hormone therapy prior to breast augmentation surgery (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones); AND

E. Documentation Requirements

1. One letter of recommendation must be provided to a health plan representative from a qualified mental health professional. The letter must address ALL of the following:
   a. The member's general identifying characteristics; and
   b. Results of the member's psychosocial assessment, including any diagnoses; and
   c. The duration of the mental health professional's relationship with the member including the type of evaluation and therapy or counseling to date; and
   d. An explanation that the criteria for surgery have been met, and a brief description of the clinical rationale for supporting the member's request for surgery; and
   e. A statement about the fact that informed consent has been obtained from the patient; and
   f. A statement that the mental health professional is available for coordination of care and welcomes a phone call to establish this.
2. The health plan and the physician responsible for breast removal or augmentation must receive this letter and recommendations for surgery and the surgical treatment must be authorized by the health plan prior to its occurrence. If the providers are working within a multidisciplinary specialty team, the letters may be sent only to the health plan with documentation of the information in the member's chart.

- III. Genital Surgery
  - Genital surgery may be considered medically necessary when criteria IA and IB and ALL of the following criteria are

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met:

A. The member is 18 years of age or older; AND

B. The member has demonstrated the capacity to make a fully informed decision and consented to treatment; AND

C. The member has completed 12 continuous months of hormonal therapy as appropriate to the member's gender goals (unless the member has a medical contraindication or is otherwise unable or unwilling to take hormones); AND

D. The member has completed 12 continuous months of living full-time in the gender role that is congruent with their gender identity; AND

E. Substantial progress must be demonstrated in the treatment of any comorbid psychopathologies or substance use disorders, resulting in a positive prognosis based on psychological testing, clinical assessment, and clinical judgment prior to planning surgical treatment; AND

F. Documentation Requirements

1. Two letters of recommendation from licensed mental health professionals have been obtained; one must be from a licensed doctoral level clinical psychologist or a psychiatrist.
2. Both letters must include all of the information listed in IIE1 a-f.
3. These letters must be presented to the health plan and to the surgeon prior to genital surgery. If the providers are working within a multidisciplinary specialty team, the letters may be sent only to the health plan with documentation of the information in the patient's chart.

- IV. Other Surgical Procedures
  - Surgical procedures to alter the gender-specific appearance of a member who has undergone or is planning to undergo gender reassignment surgery, include but are not limited to:
    - Facial hair removal
    - Blepharoplasty
    - Face lift
    - Facial bone reconstruction
    - Rhinoplasty
    - Liposuction
    - Reduction thyroid chondroplasty
  - These procedures are subject to contract definitions for medical necessity or cosmetic surgery benefits, unless otherwise specified in the benefit chart.
- Pre-Certification/Pre-Authorization: Yes.
  - Treatments for the purpose of sex reassignment are subject to the member's contract benefits. Some contracts have no benefits. In others, benefits are listed in the benefit charts.
  - Preventive health screening guidelines developed for the general population are appropriate for transgender persons for organ systems that are unlikely to be affected by feminizing/masculinizing hormone therapy. Gender-specific preventive services are also necessary for transgender persons appropriate to their anatomy. Examples include the following:
    - Routine pap smears should be performed as recommended if cervical tissue is present in female-to-male transgender persons.
    - If mastectomy is not performed, mammograms should be performed as recommended.
    - Male-to-female transgender persons treated with estrogen should follow the same screening guidelines for breast

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cancer as those for all women.
- Screening for prostate cancer should be performed as recommended for those persons who have retained their prostate.

Dalfampridine (Ampyra™)

- The policy statements have been updated as follows:
- I. Initial Review
  A. The use of dalfampridine (Ampyra™) may be considered medically necessary when ALL of the following criteria have been met:
    1. A diagnosis of multiple sclerosis; AND
    2. Prescribed by a neurologist; AND
    3. No history of seizure disorder or epileptiform activity on EEG; AND
    4. Creatinine clearance of 51 mL/min or greater (i.e., patient does not have moderate or severe renal impairment); AND
    5. Completion of a timed 25 foot walking test, scored between 8-45 seconds; AND
  B. Initial approval will be for 12 weeks.
- II. Renewal Review at 12 Weeks
  A. The continued use of dalfampridine (Ampyra™) may be considered medically necessary when documentation supports at least a 20% improvement in the timed 25 foot walking test, from baseline.
  B. Approval will be for one year.
- III. Renewal Review after One Year
  A. The continued use of dalfampridine (Ampyra™) may be considered medically necessary when BOTH of the following criteria are met:
    1. Creatinine clearance of 51 mL/min or greater (i.e., patient does not have moderate or severe renal impairment; AND
    2. Documentation supporting the maintenance of at least a 20% improvement in the timed 25 foot walking test, from baseline.
  B. Approval will be for one year.
- IV. The use of dalfampridine (Ampyra™) is considered investigative for all other indications.
- Pre-Certification/Pre-Authorization: Yes.

Thermal Capsulorrhaphy

- The policy statement has been updated as follows:
- The use of thermal capsulorrhaphy as a treatment of joint instability, including, but not limited to the shoulder, knee, and elbow is considered investigative due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Not applicable.
  – Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

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Policies inactivated

- **Gynecomastia**
- **Targeted Amino Acid Therapy for Mental and Substance-Related Disorders**
- **Thought Field Therapy**
- **Penile Plethysmography**
- **Intravitreal Corticosteroid Implants**

Policies Effective: 11/12/12 Notification Posted: 09/27/12

Policies developed

Magnetic Esophageal Ring for Treatment of Gastroesophageal Reflux Disease

- The policy statement is as follows:
- Use of an implantable magnetic esophageal ring to treat gastroesophageal reflux disease (GERD) is considered investigative due to a lack of evidence demonstrating an impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Not applicable.

Policies revised

Vagus Nerve Stimulation

- The policy statements have been updated as follows:
- I. Vagus nerve stimulation may be considered medically necessary for the treatment of medically refractory or intractable epileptic seizures, defined as failure of at least two antiepileptic drugs.
- II. Vagus nerve stimulation is considered investigative for all other indications including, but not limited to, the following:
  A. Major depressive disorder;
  B. Essential tremor;
  C. Headache;
  D. Obesity;
  E. Fibromyalgia;
  F. Congestive heart failure.
- Pre-Certification/Pre-Authorization: No.

Deep Brain Stimulation

- The policy statements have been updated as follows:
- I. Deep brain stimulation (DBS) of the Thalamus
  A. Unilateral stimulation of the thalamus may be considered medically necessary for control of tremor due to essential tremor or Parkinson's disease when ALL of the following criteria are met:
    1. Tremor causes significant limitations in daily activities; AND
    2. Inadequate control of tremor by pharmacologic therapy.
  B. Bilateral stimulation of the thalamus is considered investigative for control of tremor due to essential tremor or Parkinson's disease, due to the lack of FDA approval for this indication.
- II. Deep brain stimulation (DBS) of the Subthalamic Nucleus (STN) or Globus Pallidus Interna (GPi)

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A. Unilateral or bilateral stimulation of the STN or GPi may be considered medically necessary in patients with Parkinson's disease when BOTH of the following criteria are met:
1. A good, early response to levadopa; AND
2. Inadequate control of motor complications by pharmacologic therapy.

- III. Deep brain stimulation (DBS) is considered investigative for all other indications including, but not limited to:

A. Multiple sclerosis;
B. Post-traumatic dyskinesia;
C. Progressive supranuclear palsy;
D. Cortical-basal ganglionic degeneration
E. Tardive dyskinesia;
F. Tourette syndrome;
G. Depression;
H. Cluster headaches;
I. Epilepsy.

- Pre-Certification/Pre-Authorization: No.

Hypnotherapy

- The policy statements have been updated as follows:
- I. Hypnotherapy may be considered medically necessary for the following indications when the primary treating clinician is a mental health professional* certified in clinical hypnotherapy:

A. To control chronic pain as part of a comprehensive pain management treatment plan; OR
B. As an adjunct treatment for anxiety, somatoform, and adjustment disorders; OR
C. As a stand-alone treatment for children, adolescents, and adults for pre-procedural anxiety.

– *Mental Health Professional is defined by Minn.Stat. §245.462, subd.18 and Minn.Stat. §245.4871, subd.27.

- II. The use of hypnotherapy for anesthesia is considered investigative. Individual consideration will be taken in cases presenting an unacceptable medical risk from the use of standard anesthesia.
- III. All other applications of hypnotherapy are considered investigative including, but not limited to the treatment of smoking, nicotine-related disorders, and obesity.
- Pre-Certification/Pre-Authorization: No.

Positron Emission Tomography (PET): Miscellaneous Applications

- The policy statements have been updated as follows:
- I. Positron emission tomography (FDG-PET) may be considered medically necessary for the following indications:

A. Localization of epileptic seizure focus in patients with complex partial epileptic seizures who are candidates for resections of a suspected epileptogenic focus and who:
1. Have not responded to standard medical treatment; AND
2. Have undergone conventional techniques for seizure localization which suggested, but did not conclusively determine, seizure focus.

B. Diagnosis of chronic osteomyelitis.

- II. Positron emission tomography (PET) is considered investigative for the diagnosis or evaluation of all other non-cardiac and non-oncologic conditions or disorders not identified in I.A or I.B, including but not limited to all behavioral health disorders.

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- Pre-Certification/Pre-Authorization: No.

Hyperhidrosis Treatments

- The policy statements have been updated as follows:
- I. Treatment for All Types of Hyperhidrosis
  - In addition to use of a treatment considered medically necessary for a specific focus of hyperhidrosis as described in section II, treatment of primary hyperhidrosis (axillary, palmar, plantar, or craniofacial) may be considered medically necessary in patients with one or more of the following indications:

    A. Medical complications secondary to hyperhidrosis including one or more of the following:
    1. Tingling and discoloration (acrocyanosis) of the hands;
    2. Recurrent skin maceration with bacterial or fungal infections;
    3. Recurrent secondary infections;
    4. Persistent eczematous dermatitis despite medical treatment with topical dermatological or systemic anticholinergic agents; OR

    B. Significant disruption of professional/personal life or significant functional impairment as a result of hyperhidrosis, as documented in the medical record.
- II. Treatments for Specific Foci of Hyperhidrosis

  A. Axillary
  1. The following treatments may be considered medically necessary:
     a. Aluminum chloride 20% solution;
     b. Botulinum toxin (intradermal injection) for severe primary axillary hyperhidrosis that is inadequately managed with topical agents in patients 18 years and older;
     c. Endoscopic transthoracic sympathectomy (ETS) or surgical excision of axillary sweat glands when BOTH of the following have failed:
        - Aluminum chloride 20% solution administered for a minimum of one month; AND
        - Botulinum toxin therapy.
  2. The following treatments are considered investigative:
     a. Axillary liposuction;
     b. Axillary coagulation of lymph glands;
     c. Microwave treatment.

  B. Palmar
  1. The following treatments may be considered medically necessary:
     a. Aluminum chloride 20% solution;
     b. Botulinumtoxin A (intradermal injection) for severe primary palmar hyperhidrosis that is inadequately managed with topical agents in patients 18 years and older;
     c. Endoscopic transthoracic sympathectomy (ETS) when BOTH of the following have failed:
        - Aluminum chloride 20% solution administered for a minimum of one month; AND
        - Botulinum toxin therapy.
  2. The following treatments are considered investigative:
     a. RimabotulinumtoxinB;
     b. Microwave treatment.

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C. Plantar
1. Aluminum chloride 20% solution may be considered medically necessary.
2. The following treatments are considered investigative:
   a. Botulinum toxin;
   b. Endoscopic transthoracic sympathectomy;
   c. Microwave treatment.

D. Craniofacial
1. The following treatments may be considered medically necessary:
   a. Aluminum chloride 20% solution;
   b. Endoscopic transthoracic sympathectomy (ETS) when aluminum chloride 20% solution administered for a minimum of one month has failed.
2. The following treatments are considered investigative:
   a. Botulinum toxin;
   b. Microwave treatment.

- Pre-Certification/Pre-Authorization: No.

Policies inactivated

None

Policies Effective: 12/10/12 Notification Posted: 10/25/12

Policies developed

Sacroiliac Joint Fusion

- The policy statements are as follows:
- I. Sacroiliac joint fusion may be considered medically necessary for ANY of the following indications:
  A. Adjunct to sacrectomy or partial sacrectomy for treatment of sacral tumors; OR
  B. Adjunct to the medical treatment of sacroiliac joint infection; OR
  C. Treatment of severe traumatic injuries associated with pelvic ring fracture.
- II. Sacroiliac joint fusion is considered investigative for all other indications including, but not limited to:
  A. Mechanical lower back pain; AND
  B. Sacral insufficiency fractures.
- Pre-Certification/Pre-Authorization: Yes.

Testing of Fetal Nucleic Acids in Maternal Blood for Detection of Fetal Aneuploidy

- The policy statements are as follows:
- I. Testing of cell-free fetal nucleic acids in maternal blood may be considered medically necessary in pregnant women when all of the following criteria are met:
  A. Singleton pregnancy; AND
  B. Member is at high risk of carrying a child with trisomy 13, 18, or 21 defined as one or more of the following:
     1. Age 35 and older; or
     2. Previous pregnancy complicated by fetal trisomy;
     3. Chromosomal translocation, inversion, or aneuploidy in themselves or their partner; or

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4. At least one major or two minor fetal structural anomalies (i.e. ultrasound markers) in the current pregnancy;
5. An increased risk for aneuploidy as determined by multiple marker screening (i.e. quad screen), first trimester screening or integrated/modified sequential screening. AND

C. Informed consent has been obtained prior to testing after the member has received detailed genetic counseling that includes the benefits and limitations of the test. Information provided to the patient should include:
1. The test does not detect all cases of fetal trisomy.
2. There are also occasional false-positive results and therefore women with positive results need to receive confirmatory testing through an amniocentesis or CVS.
3. Patients with positive results are at very high risk of fetal trisomy and for some women the extended period awaiting confirmatory invasive testing results is likely to be highly stressful.
4. For some patients a test result may not be informative.
5. For those women who are at increased risk of a child with a prenatally diagnosable disorder with Mendelian pattern of inheritance, microdeletion syndrome, and some other conditions, amniocentesis or CVS would still be indicated.

- II. Testing of cell-free fetal nucleic acids in maternal blood is considered investigative for all other indications including but not limited to testing in women with one or more of the following:
  A. At average risk of carrying a child with Down syndrome or other trisomy; or
  B. Under age 35; or
  C. With twin, triplet, or higher order pregnancy.
- Pre-Certification/Pre-Authorization: No.

Policies revised

Intravitreal Angiogenesis Inhibitors for Treatment of Retinal and Choroidal Vascular Conditions

- The policy title has been revised from "Ranibizumab (Lucentis™)" to "Intravitreal Angiogenesis Inhibitors for Treatment of Retinal and Choroidal Vascular Conditions".
- The policy statements have been updated as follows:
- I. Pegaptanib (Macugen)
  A. Intravitreal injections of pegaptanib may be considered medically necessary as a treatment of neovascular (wet) age-related macular degeneration.
  B. The use of pegaptanib for treatment of all other conditions is considered investigative.
- II. Aflibercept (Eylea)
  A. Intravitreal injections of aflibercept may be considered medically necessary for treatment of the following conditions:
  1. Neovascular (wet) age-related macular degeneration.
  2. Macular edema following central retinal vein occlusion.
  B. The use of aflibercept for treatment of all other non-neoplastic conditions is considered investigative.
- III. Ranibizumab (Lucentis)
  A. Intravitreal injections of ranibizumab may be considered medically necessary for treatment of the following conditions:
  1. Neovascular (wet) age-related macular degeneration;
  2. Macular edema following retinal vein occlusion;
  3. Diabetic macular edema;

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4. Proliferative diabetic retinopathy as an adjunctive treatment to vitrectomy or photocoagulation;
5. Choroidal neovascularization due to angioid streaks, central serous chorioretinopathy, choroidal rupture or trauma, idiopathic choroidal neovascularization, multifocal choroiditis, pathologic myopia, presumed ocular histoplasmosis syndrome or uveitis.

B. The use of ranibizumab for treatment of all other conditions is considered investigative.

- IV. Bevacizumab (Avastin)

A. Intravitreal injections of bevacizumab may be considered medically necessary for treatment of the following conditions:

1. Neovascular (wet) age-related macular degeneration;
2. Macular edema following retinal vein occlusion;
3. Diabetic macular edema;
4. Proliferative diabetic retinopathy as an adjunctive treatment to vitrectomy or photocoagulation;
5. Choroidal neovascularization due to angioid streaks, central serous chorioretinopathy, choroidal rupture or trauma, idiopathic choroidal neovascularization, multifocal choroiditis, pathologic myopia, presumed ocular histoplasmosis syndrome, or uveitis;
6. Stage 3+ retinopathy of prematurity;

B. The use of bevacizumab for treatment of all other non-neoplastic conditions is considered investigative.

- Pre-Certification/Pre-Authorization: No.

Nonpharmacologic Treatment of Rosacea

- The policy title has been revised from "Rosacea Treatment" to "Nonpharmacologic Treatment of Rosacea".
- The policy statements have been updated as follows:
- Nonpharmacologic treatment of rosacea, including but not limited to laser and light therapy, dermabrasion, chemical peels, surgical debulking and electrosurgery, is considered investigative due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- The following treatments are considered cosmetic when used to treat the cosmetic effects associated with rosacea such as erythema, telangiectasias, and facial scarring:
  - Laser treatment;
  - Phototherapy;
  - Dermabrasion;
  - Chemical peels;
  - Surgical debulking; and
  - Electrosurgery.
- Pre-Certification/Pre-Authorization: No.
  - However, services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial may result if criteria are not met.

Nonpharmacologic Treatment of Acne

- The policy title has been revised from "Acne Treatment" to "Nonpharmacologic Treatment of Acne".
- The policy statements have been updated as follows:
- The following may be considered medically necessary for treatment of active acne that is resistant to pharmacologic treatments:

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  - Cryotherapy;
  - Intralesional injections of corticosteroids; and
  - Chemical exfoliation, including epidermal chemical peels.
- The following treatments for active acne are considered INVESTIGATIVE due to the lack of clinical evidence demonstrating their impact on improved health outcomes:
  - Dermabrasion;
  - Photodynamic therapy;
  - Laser therapy, including pulsed dye laser therapy;
  - Light therapy, including red, blue or violet light therapy and intense pulsed light therapy; and
  - Thermal therapy devices.
- Treatment for acne scarring and other cosmetic effects of acne is considered cosmetic including, but not limited to, the following treatments:
  - Dermabrasion;
  - Laserabrasion;
  - Photodynamic therapy; and
  - Epidermal and dermal chemical peels.
- Pre-Certification/Pre-Authorization: No.
  - However, services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial may result if criteria are not met.

Policies inactivated

- **Nutritional Support**
- **Automated External Defibrillator for Home Use**
- **Treatment of Meniere's Disease**
- **Acoustic Cardiography**

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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12/12

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