Provider Press

September 2012 / Vol. 16, No. 3

For the health of all.

Help Decrease the 'no show' rate for LEP Blue Plus members

In an effort to administer Minnesota Health Care Program dollars wisely, Blue Plus conducts quarterly audits on various provider types and vendors.

Through a routine audit of our contracted Interpreter agencies, we found a number of clinic appointments with a high number of 'no shows' for limited English proficiency (LEP) Blue Plus members.

While automated telephone appointment reminders are helpful for most people, a different approach may have a higher impact for LEP patients.

Here are a few suggestions and resources to help decrease the number of 'no shows' for LEP patients.

1) **Use an interpreter when scheduling an appointment.** This will ensure that both the clinic and LEP patient understand the date and time of the appointment.

2) **Ask the LEP patient how they plan to get to their appointment.** If they are unable to identify a mode of transportation to their appointment, please alert them to BlueRide -- the Blue Plus transportation team at **651-662-8648** or toll free **1-866-340-8648**. Follow this link for more information: http://www.bluecrossmn.com/bc/wcs/groups/bcbsmn/@mbc_bluecrossmn/documents/public/mbc1_blueride.pdf

3) **If possible, use an interpreter to make the appointment reminder calls.** This will again ensure that the LEP patient understands the date and time of the appointment. It would also give them the opportunity to reschedule or cancel the appointment with a 'live' person if it no longer works for the patient.

We appreciate the considerations made for LEP patients and their varying needs. If you have any questions or would like to discuss further ideas related to decreasing the number of LEP patient 'no shows,' please contact Adrienne Olson at **651-662-7261** or Adrienne_Olson @bluecrossmn.com.

Provider Press

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

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FYI

Publications available online

The following is a list of Quick Points and Bulletins published from June 2012 to August 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
QP7-12	Home Health Services
QP8-12	Claims migration begins third quarter 2012
QP9-12	Payment date error on facility paper checks and 835 remits
Bulletins	**Title**
P13-12	Change in Minnesota law may affect providers performing health services for county prisoners
P14-12	July 2012 HCPCS code updates
P15-12	Women's preventive services
P16-12	Update to Attachment B: Definition of Outpatient Health Services Categories
P17-12	Knee arthroplasty pre-certification/pre-authorization review requirements
P18-12	Claims processing change when additional information is required
P19-12	Revised: Collection and handling of specimens for Prepaid Medical Assistance Program (PMAP) members and MinnesotaCare members only

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, S116
P.O. Box 64560
St. Paul, MN 55164-0560

FYI

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

FYI

Provider Manual Updates

The following is a list of Blue Cross and Blue Shield of Minnesota provider manuals that have been updated from June 2012 to August 2012. As a reminder, provider manuals are available online at **providers.bluecrossmn.com**. To view the manuals, select "forms and publications" then "manuals." Updates to the manuals are documented in the "Summary of changes" section of the online manuals.

Manual name	Chapter number and title	Change
Provider Policy and Procedure Manual	Chapter 4 – Care Management	Content change to Medical Policy and Behavioral Health Policy Manual
Provider Policy and Procedure Manual	Chapter 10 – Appeals	New topic added: Utilization Review Decision Appeal
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Coding	• Content change to CPT/Level I Coding Immunizations and Injections • Content change to Preventive Care Services • New topic added: General Guides
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Behavioral Health	• Content change to Coding Restrictions • New topic added: MHCP screening requirements • Content change: Intensive Residential Treatment Services (IRTS) changed to (Medicaid Government Programs Only)
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Durable Medical Equipment (DME)	Content change to DME Rental Guidelines
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Home Health, Home Infusion, Hospice	Content changes to: • Home Infusion section • Home Health section
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Hospital Care	New topic added: Leave of Absence (LOA) or furlough days
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Maternity	Content change to Delivery section
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Medical Services	Content changes to: • Evaluation and Management • Office and Other Outpatient and Initial Inpatient Consultations • Chemotherapy Administration • Immunizations • Infusion Therapy • Coding • Weight Management Care • Assessment Management Program for Fully Insured Members

Health Literacy

Improve Patient Understanding: Use the Teach-Back Method

Health literacy represents a patient's ability to understand and use health information. Low health literacy is directly related to extra hospital stays, longer hospital stays, increased emergency department visits, medication errors, missed appointments and a generally higher level of illness (Weiss, 2007). These consequences of low health literacy and misunderstood health care information contribute significantly to the increased cost of care.

In addition, there is a high prevalence of inadequate health literacy. In fact, only 12 percent of adult English-speaking Americans are proficient at understanding and acting on health information (National Assessment of Adult Literacy, 2003).

The Challenge

The current health system doesn't acknowledge the problem. It continues to rely heavily on the written word for patient education/information, allow navigation confusion and produce complex forms to complete. Patients most likely remember and understand less than half of what clinicians explain to them.

- 40 to 80 percent of medical information is forgotten immediately (Kessels, 2003)
- Almost half of information is remembered incorrectly (Anderson et al, 1979)
- The more information given, the more information forgotten (McGuire, 1996)

One Solution: The Teach-Back Method

Teach-back method is a way that clinicians can work with their patients to ensure that any information that has been presented to the patient and/or family members has been understood. The teach-back is a method that is successful regardless of patients' health literacy abilities, and has been shown to improve outcomes (Weiss, 2007).The National Quality Forum asks health care providers to *"ask each patient or legal surrogate to recount what he or she has been told"* as a safe practice and the Agency for Healthcare Research & Quality considers teach-back *"one of the 11 most highly rated patient safety practices (with respect to informed consent)"*. In addition, The Minnesota Hospital Association, the Institute for Clinical Systems Improvement and Stratis Health consider teach-back to be an important part of their Minnesota campaign to Reduce Avoidable Readmissions Effectively (RARE).

What is Teach-Back?

- Asking patients to explain in their own words what they need to know or do
- A chance to check understanding and re-teach information if needed
- It is **not** a test of the patient, but of how well the clinician explained a concept

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Health Literacy

Improve Patient Understanding: Use the Teach-Back Method

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Sample Teach-Back Questions

- I want to be sure I explained everything clearly, so can you please explain it back to me so I can be sure I did?
- Can you tell me what you will do when you get home?
- I know your spouse wasn't able to come with you to this appointment. What will you tell him or her about what we discussed?

Opportunities to Use Teach-Back

The teach-back method can work in any setting and in all situations where you want clarification for what was taught or said. Here are just a few examples to help get you started.

- Discharge instructions
- New medications
- New self-care technique
- Informed consent
- Procedure preparations
- Health education
- Asthma action plans
- Care planning/goal setting

Think about how and where you can use teach-back in your setting.

Resources on the Teach-Back

The Minnesota Health Literacy Partnership has created a program guide providing more information about the teach-back method and resources to help you create your own program for adopting the teach-back method in your setting. To view more helpful information on the teach-back method, click on the link below:
http://healthliteracymn.org/resources/presentations-and-training

Quality Improvement

Annual provider communications mailing

Be sure to watch for our annual practitioner communications mailing that includes information about Blue Cross and Blue Shield of Minnesota and Blue Plus' Quality Improvement Program, clinical practice guidelines, access and availability guidelines, case management, disease management, and utilization management, plus much more!

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.

Please note:

If you send your PCC QOC complaint reporting form to any source other than listed below, it may not be processed in a timely manner.

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

Your Role in Improving Transitions of Care: Communication Between the Emergency Department and Primary Care

Nineteen percent of practitioners stated "rarely" and 25 percent stated "never" when asked how often they received verbal or written communications from the Emergency Department (ED), according to the Annual Provider Satisfaction Survey conducted by Blue Cross and Blue Shield of Minnesota (Blue Cross). These are alarming results given that useful and timely communication between ED and primary care is essential for successful transitions of care and health care handoffs.

According to The Joint Commission, communication problems were the third most commonly cited root cause of sentinel events in 2010 and 2011 (http://www.jointcommission.org/assets/1/18/Root_Causes_by_Event_Type_2004-1Q2012.pdf). A meta-analysis of information transfer at hospital discharge found that direct communication between hospital-based and primary care physicians (PCP) was uncommon, occurring at only 3 percent to 20 percent of discharges (http://jama.jamanetwork.com/article.aspx?articleid=205790).

Blue Cross' Annual Provider Satisfaction Survey Results

Blue Cross believes communication between the ED and primary care can improve patient satisfaction, quality of care and reduce avoidable readmissions. Each year, Blue Cross conducts a provider satisfaction survey, which also looks at communication between the ED and primary care. Last year, 1,023 practitioners responded to the satisfaction survey. When asked how useful the information in the verbal or written communications is, 94 percent of respondents stated "usually useful" or "sometimes useful." Yet, when asked how often verbal or written communications (such as discharge summaries, progress notes, consult letters, etc.) are received from the ED, only 56 percent of respondents stated "usually" or "sometimes."

As our partners in enhancing the quality of care and patient experience for our members, we rely on you to help improve useful and timely communication between ED and primary care. Given our survey results, it is clear we have work to do. We appreciate all your efforts in addressing this issue.

Rare Campaign: Actions You Can Take

Several Minnesota health care groups have joined together in support of the Reducing Avoidable Readmissions Effectively (RARE) Campaign (www.RAREreadmissions.org). The RARE campaign provides several resources for improving communication in transitions of care.

To read their latest article and to get additional information to prevent avoidable hospital readmissions, go to http://www.rarereadmissions.org/resources/RARE_Report_2012_07.html#parknicollet.

Coding Corner

Coding edit decisions

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

Codes and Edits	Decision/Actions
There is no edit for 11043 with 27062	Edit will be added to deny 11043 incidental to 27062
29806 denies incidental to 29807	Edit will be reversed – 29807 will deny incidental to 29806
29877 denies incidental to 29874	No change to current edit
29914 and 29915 not allowed with AS modifier	No change to current edit
64612 is allowed with the -50 modifier	Edit will be added to deny 64612 with the -50 modifier as ineligible
There are no edits for 77055 with 77056 or G0204 with G0206	Edits will be added denying 77055 mutually exclusive to 77056 and G0206 mutually exclusive to G0204
97802-97804 denied incidental to E/Ms	No change to current edits; denial will be upheld regardless of diagnosis
E/Ms deny post-op to 61782	No change; 61782 has a 90-day global period
G0123 denies mutually exclusive to 88155	Edit will be removed denying G0123 or G0124 to 88155

October trick and treat

October 1st reflects a dual medical coding update. Both ICD-9-CM and HCPCS coding updates are effective the same date. The treat this year is that there is only one added ICD-9-CM procedure effective October 1. The trick is that we do not know what HCPCS changes will be coming our way. Added, revised or discontinued HCPCS codes had not been released at the time of this article. However, we will recognize and accept any changes that will be published by Centers for Medicare & Medicaid Services (CMS) or the American Medical Association (AMA) for October 1.

A provider bulletin will be issued before the effective date with details, along with the new, revised and deleted codes, if any.

To replace or not to replace, that is the question

And the answer is easy. Are you making a coding change or changing or adding a medical code, such as a CPT®, HCPCS, ADA, revenue, diagnosis code or modifier? If the answer is yes, a replacement claim must be submitted. If no, send an appeal.

Replacement claims submitted without a code change or addition will be rejected. If you wish a claim denial to be reconsidered when there are no changes, an appeal must be submitted.

Refer to Chapter 10 in the online Blue Cross Provider Policy and Procedure Manual for additional information.

Coding Corner

Sign here please

The documentation for a service or visit is part of the patient's permanent legal record. Signatures are an important element of documentation. As such, appealed or reviewed claims submitted with unsigned documentation, such as medical records, will be denied.

Refer to our online Blue Cross Provider Policy and Procedure Manual, Chapter 10, Appeals, for additional appeal and supporting documentation information.

Scope reminder

Our coding software makes the following assumptions when determining payment for multiple scope procedures billed on the same date of service.

- A diagnostic scope is always incidental to a surgical scope.
- A diagnostic scope with biopsy is always incidental to a surgical scope.

On appeal we only allow one scope regardless of how the lesions are being removed or how many are being removed.

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.

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**.

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

Should a provider include medical records with the original claim?

If medical records or other relevant information are needed to finalize the claim payment, Blue Cross will notify you. Providers are not encouraged to submit unsolicited medical records or other clinical information unless requested.

- If you receive requests for medical records from other Blue plans prior to rendering services, as part of the prior authorization process, please submit them directly to the member's plan that requested them.

- Follow the submission instructions given on the request, using the specified physical or e-mail address or fax number. The address or fax number for medical records may be different than the address you use to submit claims.

- In the case of a denial where medical records were requested for pre-authorization or pre-certification, additional information may be required that was not included in the original submission due to an additional service that was not pre-certified or subject to retrospective review.

- There is a difference between reviewing a claim for medical necessity after the service has already been rendered versus reviewing a pre-authorization for a service for medical appropriateness from a member Blue plan perspective; these reviews are not the same:

  - Medical Necessity -- validates the service is medically necessary according to their member's Blue plan medical policy.

  - Medically Appropriate -- validates that service rendered matches the pre-authorization and the dollar amounts are in line.

- If you are the rendering or performing provider for a service, we recommend that you include the name and address

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BlueCard

What is the BlueCard® Program? continued from page 10

of the referring or ordering provider on your original claim submission. Including this information will help ensure that, should records be needed, they will be requested from the correct provider and assist with timelier claim payment.

Who determines the use of revenue/ procedure codes?

All Blue Cross and/or Blue Shield plans must accept and use valid standard medical codes. It is Blue Cross' responsibility for all claims coding based on the contractual agreement with the provider. When a claim contains non-standard codes, it maybe be rejected back to the provider, and the provider may be asked to resubmit with the standard code.

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.

*****Important Notification - Changes to Medical Policy Implementation*****

Beginning on June 27, 2012, Medical Policies, once approved, will be implemented in 45 days rather than 90 days. There will be a two-month transition period in July and August, as policies that are still on the 90-day timeline (March, April and May 2012 policies) are implemented and the full transition to 45-day policy implementation begins. August 2012 will implement policies on both the old 90-day and the new 45-day timeline. Those policies are: May and June 2012 approved policies.

Medical and Behavioral Health Policy Update

Medical and Behavioral Health Policy Activity

Policies Effective: 08/27/12 Notification Posted: 05/25/12

Policies developed

Subcutaneous Hormone Pellets

- I. Subcutaneous Administration of Testosterone
  - Use of the subcutaneous testosterone pellet Testopel™ may be considered medically necessary as replacement therapy in males for conditions associated with a deficiency or absence of endogenous testosterone when the following criteria are met:
    - Diagnosis of ONE of the following:
      - Primary hypogonadism (congenital or acquired); OR
      - Secondary hypogonadism (congenital or acquired); OR
      - Delayed puberty; AND
    - Oral, topical, and/or intramuscular testosterone replacement therapy have been tried and found to be ineffective or not tolerated.
  - Use of the subcutaneous testosterone pellet Testopel™ is considered investigative for all other indications, including but not limited to, symptoms associated with female menopause, due to lack of FDA approval of any other indications.
  - The subcutaneous administration of formulations of testosterone other than Testopel™ is considered investigative due to lack of FDA approval of any other products.
- II. Subcutaneous Administration of Estrogen or Estrogen Combined with Testosterone
  - Subcutaneous hormone pellets containing estrogen alone OR estrogen combined with testosterone (including bioidentical hormone formulations) are considered investigative for all indications including, but not limited to, symptoms associated with female menopause because there are no FDA-approved formulations of these products.
- 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 revised

Sleep Disorder Testing in Adults

- The policy statements have been updated as follows:
- I. Polysomnography – Initial Study
  - Supervised polysomnography performed in a sleep laboratory may be considered medically necessary as a diagnostic test in patients with any of the following:
    1. Observed apneas during sleep; OR
    2. At least two of the following:
       - Excessive daytime sleepiness evidenced by an Epworth Sleepiness Scale greater than 10, inappropriate daytime napping (e.g., during driving, conversion, or eating), or sleepiness that interferes with daily activities and is not explained by other conditions;
       - Habitual snoring, or gasping/choking episodes associated with awakenings;
       - Documented hypertension;
       - A body mass index greater than 35 kg/m2;
       - Craniofacial or upper airway soft tissue abnormalities; OR
    3. Moderate or severe congestive heart failure, stroke/transient ischemic attack, coronary artery disease, or significant tachycardia or bradycardic arrhythmias in patients who have nocturnal symptoms suggestive of a sleep-related

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breathing disorder or otherwise are suspected of having sleep apnea.

- II. Polysomnography – Repeat Study
  - Repeat supervised polysomnography performed in a sleep laboratory may be considered medically necessary under any of the following circumstances:
    1. To initiate and titrate continuous positive airway pressure (CPAP) in adult patients with clinically significant OSA defined as those patients who have:
       - An AHI of 15 or greater; OR
       - An AHI between 5 and 14 with any of the following associated symptoms:
         - Excessive daytime sleepiness
         - Documented hypertension
         - Ischemic heart disease
         - History of stroke
    2. To assess efficacy of treatment (e.g., CPAP, oral appliances, surgery); OR
    3. To re-evaluate the diagnosis of obstructive sleep apnea and need for continued CPAP. Examples include significant change in weight or change in symptoms suggesting that CPAP should be re-titrated or possibly discontinued.
- III. Unattended Home Sleep Study: Initial Study
  - Unattended (unsupervised) home sleep studies, with a Type II or III device (minimum of 4 recording channels including oxygen saturation, respiratory movement, ECG or heart rate and airflow) may be considered medically necessary under the following circumstances:
    1. Patient meets ALL of the following:
       - Habitual snoring; AND
       - Observed apneas; AND
       - Excessive daytime sleepiness (Epworth sleepiness scales score greater than10); AND
       - Body mass index (BMI) of 35 kg/m2 or less. A BMI greater than 35 requires a supervised polysomnography; AND
    2. Patient has no evidence by history or physical examination of a health condition that might alter ventilation or require alternative treatment, including any of the following:
       - Central sleep apnea
       - Congestive heart failure
       - Chronic pulmonary disease
       - Pulmonary hypertension
       - Obesity hypoventilation syndrome
       - Narcolepsy
       - Periodic limb movements in sleep
       - Restless leg syndrome
  - Unattended (unsupervised) sleep studies with a Type IV device or any device that does not record RDI/AHI and also simultaneously record oxygen saturation, heart rate and respiratory analysis are considered investigative.
  - The use of overnight pulse oximetry to screen patients for sleep apnea is considered investigative.
- IV. Unattended Home Sleep Study – Repeat Study
  - Repeat unattended (unsupervised) home sleep studies with a minimum of four recording channels (including oxygen saturation, respiratory movement, airflow, and ECG/heart rate) may be considered medically necessary in adult patients under the following circumstances:

Medical and Behavioral Health Policy Update

1. To assess efficacy of surgery or oral appliances/devices; OR
2. To re-evaluate the diagnosis of OSA and need for continued CPAP. Examples include significant change in weight or change in symptoms suggesting that CPAP should be re-titrated or possibly discontinued.

- V. Multiple Sleep Latency or Maintenance of Wakefulness Testing
  - Multiple sleep latency testing (MSLT) or maintenance of wakefulness testing (MWT) is considered not medically necessary in the diagnosis of obstructive sleep apnea syndrome (OSA) except to exclude or confirm narcolepsy in the diagnostic work-up of OSA syndrome.
- 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.

Treatment of Obstructive Sleep Apnea and Snoring

- The policy title has been revised from "Treatment of Obstructive Sleep Apnea / Upper Airway Resistance Syndrome and Snoring" to "Treatment of Obstructive Sleep Apnea and Snoring".
- The policy statements have been updated as follows:
- Medical Management
  - Oral Appliances
    - Oral appliances (e.g., mandibular advancing/positioning devices or tongue-retaining devices) may be considered medically necessary in patients when all of the following conditions are met:
      - Confirmed OSA, with an AHI of 15 – 30, or an AHI of at least 5 in a patient with excessive daytime sleepiness or documented hypertension; AND
      - There is absence of temporomandibular dysfunction or periodontal disease; AND
      - The device is prescribed by a treating physician; AND
      - The device is custom-fitted by qualified dental personnel.
    - Oral appliances may be considered medically necessary in patients with confirmed OSA and an AHI greater than 30 when:
      - A trial of CPAP has failed or is contraindicated; AND
      - Temporomandibular dysfunction or periodontal disease is absent; AND
      - The criteria above for prescribing and fitting of the device are met.
  - Continuous Positive Airway Pressure (CPAP)
    - Continuous positive airway pressure (CPAP) may be considered medically necessary in patients with confirmed OSA with:
      - An AHI of 15 or greater; OR
      - An AHI between 5 and 14 with any of the following associated symptoms:
        - Excessive daytime sleepiness
        - Impaired cognition
        - Mood disorders
        - Insomnia
        - Documented hypertension
        - Ischemic heart disease
        - History of stroke

Medical and Behavioral Health Policy Update

- Bi-level Positive Airway Pressure (BiPAP)
  - BiPAP may be considered medically necessary in patients who:
    - Meet the criteria for CPAP; AND
    - Have failed a prior trial of CPAP; OR
    - For whom BiPAP is found to be more effective that CPAP in the sleep laboratory.
- Auto-Adjusting PAP (APAP)
  - APAP may be considered medically necessary in patients who:
    - Meet the criteria for CPAP above; AND
    - Have failed a prior trial of CPAP or for whom CPAP is contraindicated; AND
    - Patient has no evidence by history or physical examination of the following conditions:
      - Central sleep apnea
      - Congestive heart failure
      - Chronic pulmonary disease such as chronic obstructive pulmonary disease
      - Pulmonary hypertension
      - Obesity hypoventilation syndrome or other condition which may cause nocturnal arterial oxyhemoglobin desaturation
  - APAP may be considered medically necessary during a 2-week trial to initiate and titrate CPAP in adult patients who meet the criteria above for CPAP treatment.
- Expiratory Positive Airway Pressure (EPAP)
  - An EPAP device (ie, Provent®) is considered investigative due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- Atrial Pacing
  - Atrial pacing is considered investigative in the treatment of obstructive sleep apnea due to the lack of clinical evidence demonstrating its impact on improved health outcomes.

- Surgical Management
  - Uvulopalatopharyngoplasty (UPPP)
    - UPPP may be considered medically necessary in adults when all the following criteria are met:
      - Presence of significant, unexplained cor pulmonale or cardiac arrhythmia resulting from documented OSA; OR an AHI of 15 events per hour or greater; or an AHI between 5 and 14 with documented hypertension, ischemic heart disease, or history of stroke; AND
      - BMI less than 40; AND
      - Patient has not responded to or does not tolerate CPAP, BiPAP, or APAP following a minimum of 4 hours per night for three (3) months of PAP usage.
  - Maxillofacial Procedures
    - Maxillofacial surgical procedures, such as inferior sagittal mandibular osteotomy and genioglossal advancement with or without hyoid myotomy and suspension or mandibular-maxillary advancement (MMA) may be considered medically necessary in adults when the following criteria are met:
      - Presence of significant, unexplained cor pulmonale or cardiac arrhythmia resulting from documented OSA; OR an AHI of 15 events per hour or greater; or an AHI between 5 and 14 with documented hypertension, ischemic heart disease, or history of stroke; AND
      - Objective evidence of hypopharyngeal obstruction documented by either fiberoptic examination or

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cephalometric radiographs; AND
  - Patient has not responded to or does not tolerate CPAP, BiPAP, or APAP following a minimum of 4 hours per night for three (3) months of PAP usage.
- Other Surgical Procedures
  - All other surgical procedures are considered investigative for the sole or adjunctive treatment of obstructive sleep apnea/upper airway resistance syndrome, including, but not limited to:
    - Uvulectomy
    - Laser-assisted palatoplasty (LAUP)
    - Radiofrequency volumetric reduction of the palatal tissues
    - Radiofrequency volumetric tissue reduction of the tongue, with or without radiofrequency reduction of the palatal tissues
    - Palatal stiffening procedures, including but not limited to, cautery-assisted palatal stiffening operation, and the implantation of palatal implants
    - Tongue base suspension
- Treatment of Snoring
  - Treatment of snoring is considered not medically necessary because simple snoring in the absence of documented obstructive sleep apnea is not considered a medical condition. Therefore, all procedures for the sole or adjunctive treatment of snoring are considered not medically necessary, including but not limited to:
    - Uvulectomy
    - Laser-assisted palatoplasty (LAUP)
    - Radiofrequency volumetric reduction of the palatal tissues
    - Radiofrequency volumetric tissue reduction of the tongue, with or without radiofrequency reduction of the palatal tissues
    - Palatal stiffening procedures, including but not limited to, cautery-assisted palatal stiffening operation, and the implantation of palatal implants
    - Tongue base suspension
  - Pre-Certification/Pre-Authorization: Yes, for surgical procedures ONLY.

Bariatric Surgery

- The policy statements have been updated as follows:
- I. Patient Selection Criteria
  - The surgical treatment of morbid obesity may be considered medically necessary for patients 18 years of age or older who meet ALL the following criteria:
    - The patient must have a Body Mass Index (BMI) of ≥ 40. Patients with a BMI of 35-40 will be considered when there is documentation of a co-morbid condition, such as hypertension refractory to standard drug regimens, cardiovascular disease, degenerative joint disease, documented obstructive sleep apnea, severe persistent asthma, or diabetes (See attached Body Mass Index [BMI] table at the end of this policy. This table was adapted from the NIH "Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults"). AND
    - The condition of morbid obesity must be of at least two years duration. Because attempts to lose weight over this two-year time period may cause the patient's BMI to fluctuate around the required levels, the two-year time period will not necessarily start over, or be prolonged, but will be reviewed on a case-by-case basis. AND

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- Over the last year prior to surgery, the patient has actively participated in a structured, nonsurgical weight loss program (i.e,, a program that provides diet, exercise, and behavior modification strategies through individual or group counseling) , for a total of six months with failure to achieve weight loss goals or maintain weight loss. Participation in one of these programs must be at least 3 consecutive months in duration. Participation must be monitored by the primary care physician providing medical oversight for the patient and must be documented in the medical record. AND
- The patient must be evaluated preoperatively by an eligible licensed Mental Health Professional* to ensure the absence of significant psychopathology that would hinder the ability of an individual to understand the procedure and comply with medical/surgical recommendations. AND
  - * The "Mental Health Professional" must meet the Minnesota Department of Human Services qualifications, as set forth in Minn.Stat.245.4871, subd. 27 (2011).
- The physician requesting authorization for the surgery must confirm that the patient's treatment plan includes a surgical preparatory program addressing all the following components in order to improve outcomes related to the surgery and to establish the member's ability to comply with post-operative medical care and dietary restrictions:
  - Pre-operative and post-operative dietary plan; AND
  - Behavior modification strategies; AND
  - Counseling and instruction on exercise and increased physical activity; AND
  - Ongoing support for lifestyle changes necessary to make and maintain appropriate choices that will reduce health risk factors and improve overall health.

- II. Surgical Procedures
  - The following surgical procedures may be considered medically necessary in the treatment of morbid obesity when the previous patient selection criteria have been met:
    - Open gastric bypass using a Roux-en-Y anastomosis with an alimentary or Roux limb of ≤ 150 cm;
    - Laparoscopic gastric bypass using a Roux-en-Y anastomosis;
    - Open vertical banded gastroplasty;
    - Adjustable gastric banding, consisting of an adjustable external band placed around the stomach (i.e., Lap-Band® and REALIZE Band);
    - Open or laparoscopic biliopancreatic bypass (i.e., Scopinaro procedure) with duodenal switch in patients with a BMI ≥ 50);
    - Open or laparoscopic sleeve gastrectomy.
  - Any other surgical or minimally invasive procedures are considered investigative as a treatment of morbid obesity, including but not limited to:
    - Laparoscopic vertical banded gastroplasty;
    - Gastric bypass using a Billroth II type of anastomosis, known as the mini-gastric bypass;
    - Biliopancreatic bypass (i.e., the Scopinaro procedure) without duodenal switch;
    - Long-limb gastric bypass procedure (i.e., > 150 cm);
    - Endoluminal (also called endosurgical, endoscopic, sclerosing endotherapy or natural orifice transluminal endoscopic) procedure as a primary bariatric procedure or as a revision procedure (e.g., to treat weight gain after bariatric surgery or to remedy large gastric stoma or large gastric pouches), by any method (e.g., insertion of the StomaphyX™ device);
    - Bariatric surgery (any procedure) solely as a cure for type 2 diabetes mellitus.

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- Re-operation Criteria:
  - Subsequent surgery for morbid obesity is subject to the previous criteria and the patient's contract benefits.
- Pre-Certification/Pre-Authorization: Yes, for all bariatric surgery and revisions/reoperations. Submitted documentation should address the patient selection criteria described above.

Artificial Intervertebral Discs: Cervical Spine

- All of the policy statements have been updated as follows:
- Artificial intervertebral cervical discs may be considered medically necessary when ALL of the following criteria are met:
  - The device is approved by the U.S. Food and Drug Administration (FDA); AND
  - Replacement is performed at one level from C3 to C7; AND
  - Patient is skeletally mature; AND
  - Patient has failed at least six weeks of non-surgical therapy; AND
  - Patient has intractable radiculopathy and/or myelopathy due to herniated disc or osteophyte formation with symptomatic nerve root and/or spinal cord compression documented by ALL the following:
    - Neck and/or arm pain; AND
    - Functional and/or neurological deficit; AND
    - Radiographic imaging (e.g., computed tomography (CT), magnetic resonance imaging (MRI), x-rays).
- The use of artificial intervertebral cervical discs is considered investigative for treatment of disorders of the cervical spine, including degenerative disc disease, for all other indications. There is a lack of clinical evidence demonstrating their impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: No.

Lung Cancer Screening Using Computed Tomography (CT)

- The policy title has been revised from "Lung Cancer Screening Using Computed Tomography (CT) or Chest Radiographs" to "Lung Cancer Screening Using Computed Tomography (CT)".
- All of the policy statements have been updated as follows:
- The use of low-dose computed tomography (CT), no more frequently than annually for three (3) consecutive years, may be considered medically necessary as a screening technique for lung cancer in individuals who meet ALL of the following criteria:
  - No signs or symptoms suggestive of underlying lung cancer; AND
  - Aged 55 - 74 years of age; AND
  - History of cigarette smoking of at least 30 pack-years; AND
  - If a former smoker, the individual has quit within the previous 15 years.
- The use of low-dose CT is considered investigative as a screening technique for lung cancer in all other situations, due to a lack of evidence demonstrating an impact on improved health outcomes.
- 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.
  - Effective November 1, 2011, ordering providers are required to use a decision support system as part of their process for ordering elective, outpatient HTDI procedures. This can be performed either by Electronic Medical Record (EMR) integrated RadPort software or the web-based version. Those providers using other previously approved decision support systems may continue doing so. This applies to most local products and local providers.
  - All providers must continue to follow Medical and Behavioral Health Policies for selected HTDI procedures both before and after November 1, 2011.

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Bone Growth Stimulators

- The policy statements have been updated as follows:
- All other applications of invasive or noninvasive electrical bone growth stimulators are considered investigative including, but not limited to:
  - Noninvasive or invasive electrical bone growth stimulators for treatment of a fresh fracture (less than seven days old);
  - Noninvasive or invasive electrical bone growth stimulators for delayed union fracture, with delayed union defined as a decelerating fracture healing process, as identified by serial x-rays;
  - Noninvasive or invasive electrical bone growth stimulators as adjunct to cervical fusion surgery and for failed cervical spinal fusion;
  - Noninvasive or invasive electrical bone growth stimulators for any non-lumbar fusion/arthrodesis (e.g., as an adjunct to cervical or thoracic fusion; for failed cervical or thoracic spinal surgery; as an adjunct to ankle arthrodesis; for failed ankle arthrodesis);
  - Noninvasive electrical bone growth stimulators for immediate post-surgical treatment after appendicular skeletal surgery (e.g., femoral osteotomy).
- Pre-Certification/Pre-Authorization: Yes. Documentation from the ordering physician supporting the use and medical necessity of the bone growth stimulator must be included in the prior authorization.

Policies inactivated

Vacuum Therapy for Female Sexual Dysfunction
Palliative Care
Measurement of Exhaled Nitric Oxide and Exhaled Breath Condensate in the Diagnosis and Management of Asthma and Other Respiratory DisordersGrenz Ray Therapy for Skin Conditions
Phosphodiesterase-5 Inhibitors

Policies Effective: 08/13/12 Notification Posted: 06/28/12

Policies developed

None

Policies revised

Belimumab

- The policy statements have been updated as follows:
- Use of belimumab may be considered medically necessary in adults (18 years of age or older) with active systemic lupus erythematosus (SLE) who meet ALL of the following criteria:
  - Clinical diagnosis of systemic lupus erythematosus (SLE), according to the American College of Rheumatology (ACR) classification criteria (See Appendix); AND
  - Positive test for serum autoantibodies, using the anti-nuclear antibody (ANA) test OR the anti-double-stranded DNA test, at two (2) independent time points. A serum autoantibody test is considered positive when:
    - Anti-nuclear antibody (ANA) titer ≥ 1:80;
    - Anti-double-stranded DNA ≥ 30 IU/mL; AND

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  - Patient is receiving a stable standard of care treatment regimen for SLE for at least 30 days. Standard of care treatment regimens comprise any of the following drug classes, alone or in combination:
    - Corticosteroids;
    - Antimalarials (e.g., hydroxychloroquine);
    - Non-biologic immunosuppressives (e.g., azathioprine, methotrexate); AND
  - Absence of ALL of the following:
    - Severe active lupus nephritis, defined as either:
      - Proteinuria > 6 g/24 hour, or
      - Serum creatinine > 2.5 mg/dL
    - Severe active central nervous system (CNS) lupus, including seizures, psychosis, organic brain syndrome, cerebrovascular accident, cerebritis or CNS vasculitis requiring therapeutic intervention within 60 days before initiation of belimumab;
    - Current treatment with other biologics or intravenous cyclophosphamide.
- Use of belimumab is considered investigative for all other indications, due to a lack of evidence demonstrating improved health outcomes for any condition other than SLE.
- Pre-Certification/Pre-Authorization: Yes. Because the reference range for a positive anti-nuclear antibody (ANA) test OR a positive anti-double-stranded DNA test may vary among clinical laboratories, the patient's results and the reference range for the laboratory performing the test must be included in the documentation.
  - Initial approval will be for one year.
  - Renewal of pre-certification/pre-authorization should include documentation supporting sustained treatment-related response, such as substantial improvement in disease condition or a reduction in disease progression. Patients should also be monitored for new or worsening depression, suicidal thoughts, or other mood changes.

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

- The policy title has been revised from "Genetic Testing for Hereditary Breast and/or Ovarian Cancer (BRCA1, BRCA2, and CHEK2 Genes)" to "Genetic Testing for Hereditary Breast and/or Ovarian Cancer Syndrome (BRCA1 and BRCA2 Genes)".
- The policy statements have been updated as follows:
- Genetic testing of BRCA1and BRCA2 may be considered medically necessary under any of the following circumstances:
  - I. Breast cancer
    - Individual has a personal history of breast cancer including invasive cancer or ductal carcinoma in situ with ANY of the following:
      A. Diagnosed at age 45 or younger with or without family history of breast or other cancers.
      B. Diagnosed at age 46-50, AND
        1. One or more close blood relatives with breast cancer diagnosed at age 50 or younger, OR
        2. One or more close blood relatives with epithelial ovarian, fallopian tube, or primary peritoneal cancer at any age, OR
        3. Limited family history (e.g., fewer than two first-or second-degree female relatives or female relatives surviving beyond 45 years in either lineage, may have an underestimated probability of a familial mutation).
      C. Diagnosed before age 60 that is triple negative (estrogen receptor, progesterone receptor and HER2 negative)
      D. Diagnosed at any age with one or more of the following:
        1. Male gender;

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2. Primary tumors in both breasts or clearly defined multiple tumors in one breast when first breast cancer diagnosis occurred at or younger than age 50;
3. Two or more close blood relatives with breast and/or ovarian, fallopian tube, primary peritoneal or pancreatic cancer diagnosed at any age;
4. Personal history of ovarian, fallopian tube, or primary peritoneal cancer diagnosed at any age;
5. First or second degree male relative with history of breast cancer;
6. Close blood relatives with known deleterious BRCA1 or BRCA2 mutation. Individuals who meet this criterion are candidates for BRCA single-site analysis;
7. Of an ethnicity associated with higher mutation frequency (e.g., Ashkenazi Jewish).

– II. Individual has a personal history of one or more of the following cancers:
  A. Epithelial ovarian cancer;
  B. Fallopian tube cancer;
  C. Primary peritoneal cancer;
  D. Pancreatic cancer at any age with two or more first or second degree relatives with breast and/or ovarian, fallopian tube, primary peritoneal, and/or pancreatic cancer diagnosed at any age.

– III. Individual is 18 years of age or older with family history that meets one or more of the following:
  A. Has a first-or second-degree relative meeting any of the above criteria;
  B. Is a member of a family with a known deleterious BRCA1 and/or BRCA2 mutation in a close blood relative. Individuals who meet this criterion are candidates for BRCA single-site analysis;
  C. Third-degree relative with breast cancer and/or ovarian cancer with:
    1. Two or more close blood relatives with breast cancer (at least one with breast cancer diagnosed at age 50 or younger), and/or
    2. Two or more close blood relative relatives with breast cancer.
  • NOTE: Testing of an individual with family history but no personal history of cancers addressed in this policy, should be considered only after pre-test genetic counseling with pedigree analysis to determine the risk of developing cancer, the potential utility of testing, and surveillance or risk reduction options based on the family history.

– IV. Testing for rearrangements of the BRCA1 and BRCA2 genes [BRAC®Analysis Rearrangement Test (BART)] may be considered medically necessary for individuals who:
  A. Meet one or more of the criteria for BRCA1 and/or BRCA2 testing, AND
  B. Have tested negative for mutations in BRCA1 and/or BRCA2 sequencing.

• BRCA1 and/or BRCA2 testing is considered investigative for all other indications, including testing in individuals younger than age 18 without a personal history of cancers addressed in this policy. There is a lack of clinical evidence demonstrating its impact on improved health outcomes.
• Pre-Certification/Pre-Authorization: Yes.

Endoscopic Radiofrequency Ablation or Cryoablation for Barrett's Esophagus

• The policy statements have been updated as follows:
• Radiofrequency ablation may be considered medically necessary for treatment of Barrett's esophagus with biopsy confirmed dysplasia.
  – Documentation must include a copy of the pathology report establishing the diagnosis of Barrett's esophagus with dypslasia.

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- Radiofrequency ablation for treatment of Barrett's esophagus in the absence of dysplasia is considered investigative due to a lack of evidence demonstrating its impact on improved health outcomes.
- Cryoablation for treatment of Barrett's esophagus, with or without dysplasia is considered investigative due to a lack of evidence demonstrating its impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Yes.

Liposuction

- The policy statements have been updated as follows:
- Liposuction is considered cosmetic as it is performed primarily to enhance or otherwise alter physical appearance without correcting or improving a physiological function.
- Pre-Certification/Pre-Authorization: Not applicable. However, these services are subject to retrospective review and denial of coverage as cosmetic services are not eligible for reimbursement.

Positron Emission Tomography (PET): Cardiac Applications

- The policy statements have been updated as follows:
- Positron emission tomography (PET) may be considered medically necessary to assess myocardial perfusion and diagnose coronary artery disease in patients with either of the following indications:
  - Indeterminate SPECT; OR
  - The patient's body type or physique is expected to lead to an indeterminate SPECT (e.g., BMI ≥ 35 kg/m2, chest wall deformity, breast implant).
- Positron emission tomography (PET) may be considered medically necessary to assess myocardial viability in patients with severe left ventricular dysfunction, as a technique to determine candidacy for cardiac surgery.
- Positron emission tomography (PET) may be considered medically necessary to assess suspected cardiac sarcoidosis in patients unable to undergo magnetic resonance imaging (MRI) (e.g., patients with pacemakers, automatic implanted cardioverter-defibrillators, or other metal implants).
- Positron emission tomography (PET) is considered investigative for all other cardiac applications, due to a lack of evidence demonstrating an impact on improved health outcomes.
- 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.
  - Effective November 1, 2011, ordering providers are required to use a decision support system as part of their process for ordering elective, outpatient HTDI procedures. This can be performed either by Electronic Medical Record (EMR) integrated RadPort software or the web-based version. Those providers using other previously approved decision support systems may continue doing so. This applies to most local products and local providers.
  - All providers must continue to follow Medical and Behavioral Health Policies for selected HTDI procedures both before and after November 1, 2011.

Hyperhidrosis Treatments

- Only the Pre-Certification/Pre-Authorization statement has been updated for this policy. This Pre-Certification/Pre-Authorization statement has been updated as follows:
- Pre-Certification/Pre-Authorization: No.

Policies inactivated

Fetal Tissue Transplantation

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Allograft for Breast Reconstructive Surgery
Signal-Averaged Electrocardiography
Biventricular Pacemakers for the Treatment of Heart Failure
Diastasis Recti Abdominus Repair
Re-Birthing Therapy
Auditory Integration Therapy
Prophylactic Mastectomy
Cochlear Implantation
Orthoptics or Vision Therapy
Sacral Nerve Stimulation for Pelvic Floor Dysfunction
Otoplasty
Monoclonal Antibody Therapy for Allergic Asthma
Bone-Conduction and Bone-Anchored Hearing Aids
MRI of the Breast
Refractive Eye Surgery
Hospital Beds
Radiofrequency Ablation of Solid Tumors, Excluding Liver Tumors
Gastric Electrical Stimulation
Scar Excision / Revision
Wearable Cardioverter-Defibrillator as a Bridge to ICD Placement

Policies Effective: 08/27/12 Notification Posted: 07/05/12

Policies developed

Knee Arthroplasty (Knee Replacement)

- Total knee arthroplasty (also known as total knee replacement) may be considered medically necessary for the treatment of advanced knee joint disease caused by one of the following:
  1. Radiographic or arthroscopic evidence of complete (bone-on-bone) cartilage destruction (i.e., modified Outerbridge grade IV) AND both of the following:
     - Moderate to severe persistent knee pain; AND
     - Clinically significant functional limitation resulting in impaired, age-appropriate activities of daily living and diminished quality of life. OR
  2. Radiographic or arthroscopic evidence of cartilage damage (i.e., modified Outerbridge grade III: Large fissuring to the level of subchondral bone) when ALL of the following criteria are met:
     - Moderate to severe persistent knee pain despite use of BOTH of the following:
       – Intra-articular corticosteroids or at least one course of intra-articular hyaluronate injections (i.e., 1-5 injections lasting 4-6 months, depending on the product); AND
       – Physical therapy: 6 week course; AND
     - Clinically significant functional limitation resulting in impaired, age-appropriate activities of daily living and diminished quality of life.

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- Unicompartmental knee arthroplasty (also known as partial knee replacement) may be considered medically necessary for the treatment of advanced knee joint disease limited to the medial or lateral compartment when ALL of the following criteria are met:
  - Radiographic or arthroscopic evidence of cartilage damage (i.e., modified Outerbridge grade III: Large fissuring to the level of subchondral bone) AND both of the following:
    - Moderate to severe persistent knee pain despite use of BOTH of the following:
      - Intra-articular corticosteroids or at least one course of intra-articular hyaluronate injections (i.e., 1-5 injections lasting 4-6 months, depending on the product); AND
      - Physical therapy: 6 week course; AND
    - Clinically significant functional limitation resulting in impaired, age-appropriate activities of daily living and diminished quality of life.
- Unicompartmental knee arthroplasty (also known as partial knee replacement) may be considered medically necessary for the treatment of advanced knee joint disease limited to the patellofemoral compartment when ALL of the following criteria are met:
  - Radiographic or arthroscopic evidence of cartilage damage (i.e., modified Outerbridge grade III: Large fissuring to the level of subchondral bone) AND both of the following:
    - Moderate to severe persistent knee pain despite use of BOTH of the following:
      - Intra-articular corticosteroids or at least one course of intra-articular hyaluronate injections (i.e., 1-5 injections lasting 4-6 months, depending on the product); AND
      - Physical therapy: 6 week course; AND
    - Clinically significant functional limitation resulting in impaired, age-appropriate activities of daily living and diminished quality of life. AND
  - Involved knee demonstrates adequate alignment and ligamentous stability.
- Revision of knee arthroplasty may be considered medically necessary for any of the following indications:
  - Instability of the prosthetic components or aseptic loosening; OR
  - Periprosthetic fractures; OR
  - Fracture or dislocation of the patella; OR
  - Infection of the implant.
- The following knee procedures are considered investigative due to a lack of evidence demonstrating an impact on improved health outcomes:
  - Bicompartmental knee arthroplasty and bi-unicompartmental knee arthroplasty;
  - Unicondylar interpositional spacer.
- Pre-Certification/Pre-Authorization: Yes, ONLY when BOTH of the following criteria are met:
  - The provider performing the knee arthroplasty is located in Minnesota or a bordering county; AND
  - The member is less than 60 years of age OR 80 years of age or older.
- This policy does not apply to the following lines of business:
  - Federal Employee Plan (FEP); OR
  - Government Programs products; OR
  - Medicare Primary products.

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Policies reviewed with no changes in May, June, and July 2012

Audiovisual Entrainment
Cardiovascular Disease Risk Assessment and Management: Laboratory Evaluation of Lipid Subclasses
Cellular Immunotherapy for Prostate Cancer
Compassionate Use
Constraint-Induced Movement Therapy for Motor Disorders in Children
Corneal Topography / Computerized Corneal Topography
Cranial Electrotherapy Stimulation
Cytochrome P450 Genotyping
Dynamic Spinal Visualization
Dynesys® Spinal System and Lumbar Dynamic Stabilization
Epidermal Growth Factor Receptor (EGFR) Analysis for Non-Small Cell Lung Cancer
Fecal Calprotectin Testing
Fetal Surgery for Prenatally Diagnosed Malformations
Gene - Based Tests for Screening, Detection, and / or Management of Prostate Cancer
Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma
Hematopoietic Stem-Cell Transplantation in the Treatment of Germ-Cell Tumors
Homocysteine Testing in Risk Assessment and Management of Cardiovascular Disease
Image-Guided Minimally Invasive Lumbar Decompression for Spinal Stenosis
Mastopexy
Measurement of Lipoprotein-Associated Phospholipase A2 (Lp-PLA2) in the Assessment of Cardiovascular Risk
Measurement of Long Chain Omega-3 Fatty Acids as a Cardiac Risk Factor
Micropropessor-Controlled Prostheses for the Lower Limb
Myoelectric Prosthesis for the Upper Limb
Nociceptive Trigeminal Inhibition – Tension Suppression System (NTI-tss) For Treatment Of Headache
Organ Transplantation: Allogeneic Pancreas
Organ Transplantation: Heart
Organ Transplantation: Heart/Lung
Organ Transplantation: Kidney
Organ Transplantation: Liver
Organ Transplantation: Lung and Lobar Lung
Organ Transplantation: Small Bowel
Organ Transplantation: Small Bowel/Liver Multivisceral
Orthopedic Applications of Stem Cell Therapy
Prometa
Respiratory Syncytial Virus Prophylaxis
Spider Veins / Dermal Telangiectasias
Spinal Fusion: Lumbar
Stem-Cell Therapy for Peripheral Arterial Disease
Suit Therapy for Motor Disorders
Surgical Treatment of Femoroacetabular Impingement

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Systems Pathology Testing for Predicting Risk of Recurrence in Prostate Cancer
Tesamorelin (Egrifta)
Testing for Common Genetic Variants to Predict Risk of Non-Familial Breast Cancer
Traction Decompression of the Spine (VAX-D, LORDEX, DRX9000)
Transilluminated Powered Phlebectomy
Unicondylar Interpositional Spacer (Unispacer)

ICD-10 Webinar

ICD-10 education

SAVE THE DATE

"The Winding Road to ICD-10 Codesets"
Minnesota ICD-10 Collaborative is pleased to present a 90-minute free webinar on the business challenges of ICD-10
When: Tuesday, October 9th, from 9:30 - 11:00am cst
A Provider Quick Points will be published with details on how to register for the free webinar prior to October 9, 2012.

The mission of the ICD-10 Collaborative is to bring together a consortium of providers and payers to identify and evaluate opportunities to minimize the disruption in health care billing, reporting, and related processes for a variety of stake-holders in the healthcare industry in connection with the ICD-10 conversion.

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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