Provider Press

June 2012 / Vol. 16, No. 2

For the health of all.

Blue Cross awarded NCQA's highest accreditation status

Blue Cross and Blue Shield of Minnesota (Blue Cross) has earned an accreditation status of "Excellent" from the National Committee for Quality Assurance (NCQA). The "excellent" designation is awarded only to health plans that exceed NCQA's rigorous requirements for consumer protection, quality improvement and clinical results.

Blue Cross earned the Excellent Accreditation for two lines of business: our commercial preferred provider organization (PPO) plans and Medicaid-based health maintenance organizations (HMOs).

Based in Washington, D.C., NCQA is a nonprofit organization dedicated to driving improvement throughout the health care system. Its voluntary accreditation audits are conducted by teams of physicians and managed care experts, with the results made available to purchasers, regulators and consumers via the NCQA website.

NCQA Accreditation is more comprehensive and specific than other health plan accreditation. Performance results are reported in five categories:

- **Access and service** — Do members have access to the care and service they need?
- **Qualified providers** — Does the health plan assess each doctor's qualifications and what plan members say about its providers?
- **Staying healthy** — Does the health plan offer activities to help members maintain good health and detect illness early?
- **Getting better** — Does the health plan offer programs and activities for members to help them recover from an illness?
- **Living with illness** — Does the health plan offer programs and activities for members with chronic conditions to help them manage their chronic illness?

NCQA Accreditation provides employers and consumers with the ability to evaluate the quality of different health plans along a variety of important dimensions, and to make informed health care choices based on demonstrated quality and value rather than simply on cost. It's a way for individuals to know that the services provided by Blue Cross and Blue Shield of Minnesota are rated among the highest in the nation.

Provider Press

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

Inside preview

FYI

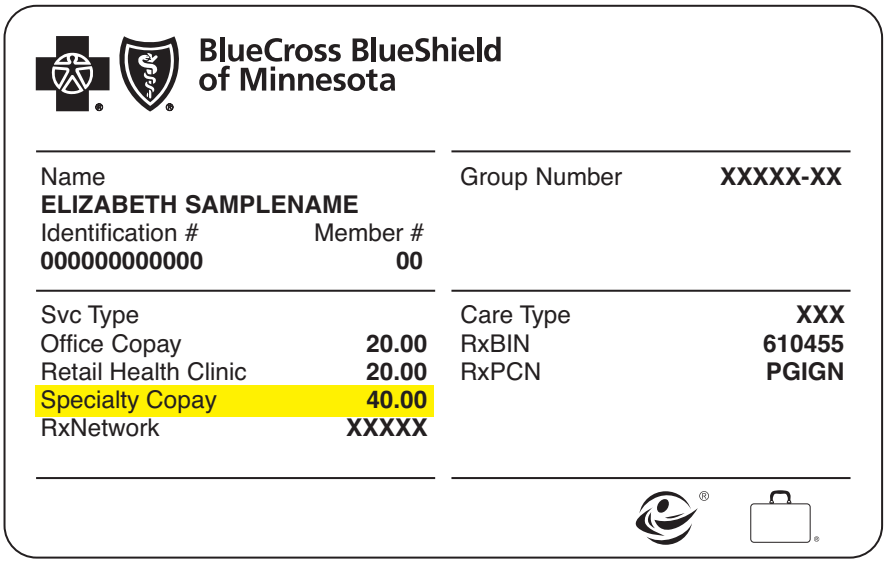
Publications available online

The following is a list of Quick Points and Bulletins published from March 2012, to May 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
QP4-12	Coverage section change to medical policy IV-85: Bone Morphogenetic Protein
QP5-12	Disclosure of Ownership Statement
QP6-12	2012 Platinum Blue℠ (Cost) claim review
Bulletins	**Title**
P7-12	Important notice – Blue Cross, Blue Plus® and BlueLink TPA prepare to move to HIPAA 5010 only
P8-12	Notification to Blue Cross is required when providers are not accepting new patients
P9-12	Claims processing change when additional information is requested
P10-12	April 2012 HCPCS code updates
P11-12	Blue Cross requirements regarding medical records
P12-12	Update to Attachment B: Definition of Outpatient Health Services Categories

Look for our new specialty physician copay

Effective July 1, 2012, a specialty physician copay will apply to some small group (2-50 employees) plans. Check for a specialty copay on the member's ID card; it will be $20.00 higher than the regular office visit copay. The specialty copay will apply to services that are received at an independent specialty clinic. It will not apply to a specialist who bills for services under a multispecialty clinic provider number, or independent pediatrician and ob/gyn clinics.



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

Provider Manual Updates

The following is a list of Blue Cross and Blue Shield of Minnesota provider manuals that have been updated from March 2012, to May 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
Blue Plus Manual	Chapter 3 - Government Programs	2011 documents updated for 2012 changes
Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines - Chiropractic	Effective date removed from MHCP requirements on page 10
Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines - Dental	Electronic claim format on page 3
Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines - Durable Medical Equipment	• New section/policy re: enrollment requirements when providing services to MHCP members • DME rental guidelines: large volume air compressors removed • Coding modifiers: revisions to the LL, RR, NR definitions • Billing for supplies: added "only" to first paragraph; corrected units reporting location; removed references (1500 HICF) claim form
Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines – Home Health, Home Infusion, Hospice	• PCA modifier information and requirements added, page 8 • Corrected and added coding to grid, page 10 • MHCP PA requirements added, page 15 • Prior Authorization verbiage updates, pages 11-2 and 11-14
Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines – Hospital Care	• Critical care: added instructions re: time increments • SNF billing for Blue Plus Government Program products (continued): added an "X' to the SNF Type of Bill-s/b 02XX • Added section for "medical necessity vendor"
Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines – Laboratory	• New section for collection and handling of specimens for PMAP and MinnesotaCare members • Genetic testing modifiers: added "as appropriate" • New section for Lab billed through the BlueCard program

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FYI

Provider Manual Updates continued from page 3

Manual name	Chapter number and title	Change
Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines – Medical Emergency	Extended/after-hours clinics: deleted "1500 HICF " and "UB-04"
Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines – Radiology Services	HTDI program information added, pages 5-7
Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines – Rehabilitative Services	• Physical therapy evaluation codes: revised guidelines re: submission of 97001-97002 with an E/M • Occupational therapy continued: removed dash between codes 97750 and 97755 and comma added. This is not a range of codes – there are only these two codes. • Occupational therapy evaluation codes: revised guidelines re: submission of 97003-97004 with an E/M • MHCP authorization process for PT, OT, ST: added effective date and information for specialized maintenance therapy and group numbers added to affected programs • Added section for "medical necessity vendor"
Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines – Surgical Services	• Lesions: corrected code range • Correct billing of Q1003 for Medicare Advantage products: deleted section as code no longer valid • Assistant surgeons: added "or clinical nurse specialist" • Multiple surgeries: corrected payment information – "billed" and "charge" deleted, "highest allowed" and "allowed" added

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

Enhanced Provider Finder kicks off integrated Blue Cross transparency tools

Blue Cross and Blue Shield of Minnesota is now offering more integrated online transparency tools to allow members to make smarter health care decisions. In early spring, Blue Cross launched a redesigned Provider Finder, a consumer-focused, intuitive web tool that enhances transparency by integrating national provider information and hospital cost and quality into one tool.

This initial rollout is just the beginning. More functionality will be added throughout the year and additional transparency information will be integrated as we evolve to meet our members' needs. Some of these enhancements include:

Quality:

- **Physician quality measurement and display** – Twenty physician performance measurements based on HEDIS metrics will be displayed to help assist members in selecting a provider. Information will come from national independent Blue plans.
- **Blue Physician Recognition** – Displays recognition to those providers who go above and beyond board certification requirements, such as completing performance improvement modules for their respective medical societies, Joint Commission accreditation, NCQA accreditation, etc.

Cost:

- **Member out-of-pocket estimator** – Displays an estimate for out-of-pocket liability for health care services nationwide – methodology and display are still in the design stage.
- **Alternate care settings** – Displays messaging to members to help them decide when to use urgent care centers, retail health clinics and walk-in doctor's offices for appropriate care, improved access and potential cost savings.

Member experience:

- **Patient review tool** – Allows members to read and write reviews on providers nationwide.

Provider Finder can be accessed on the public site at **bluecrossmn.com** by selecting "Find a doctor" or members can sign on to the online member center at **myBlueCrossmn.com**.

FYI

Personal Health Record resources

The Blue Cross and Blue Shield Association (BCBSA) and Blue Cross believe the personal health record (PHR) is an important consumer tool to enhance care coordination and improve the patient's ability to make a more informed health care decision.

BCBSA developed PHR brochures in collaboration with the following strategic messaging and distribution partners:

- American Cancer Society
- American College of Physicians (ACP)
- American Diabetes Association
- American Health Information Management Association
- American Heart Association
- American Osteopathic Association of Medical Informatics
- Medical Group Management Association (MGMA)

BCBSA provides PHR educational resources, including web pages and PDF files on their website at **bcbs.com** that offer introductory background, as well as links to new consumer and provider PHR brochures with in-depth information. These brochures include sample PHR screen shots and testimonials from patients and doctors. Enter "phr resources" and "phr brochures" in the search field of **bcbs.com** to access the various PHR educational resources.

The Blue Cross and Blue Shield Association is an association of independent Blue Cross and Blue Shield plans.

Disclosure of Ownership Statement

Blue Cross is working to make compliance with state and federal requirements as easy and convenient as possible for providers. Therefore, we have provided the Disclosure of Ownership Statement in your provider service agreement renewal packet of information. This form was included in renewal packets for providers whose provider service agreements are updated to be effective July 1, 2012. The information requested in the Disclosure of Ownership Statement is in accordance with the agreement between the State of Minnesota Department of Human Services and Blue Plus as necessary in order to support Minnesota Health Care Program subscribers. This information is also required pursuant to a legislative mandate applicable to all providers and all health plans serving Minnesota Health Care Program subscribers. One form is all you need to complete since the information and the single form requesting this information from providers may be used for all health plans in which the provider participates. A copy of this document is in your contract renewal packet and on the Blue Cross website at **providers.bluecrossmn.com** (under forms & publications - forms: clinical operations, MCHP Disclosure Statement).

MCHP Disclosure Statement

If you have any additional questions regarding the Disclosure of Ownership Statement, call provider services at **(651) 662-5200** or **1-800-262-0820** for assistance.

Quality Improvement

Chronic obstructive pulmonary disease (COPD) treatment a priority for Blue Plus

Spirometry testing increasingly used for diagnosis of COPD

"COPD is the 4th leading cause of death in the United States and causes serious, long-term disability. The number of people with COPD is increasing. More than 12 million people are currently diagnosed with COPD and an additional 12 million likely have the disease and don't even know it." *excerpt from 'Breathing Better With a COPD Diagnosis' published by U.S. Department of Health and Human Services, NIH and NHLBI*

Spirometry testing is used to make an objective measurement of airflow limitation, to discern the degree to which it is reversible, and to provide a definitive diagnosis of COPD. As the management differs for those with asthma as compared to those with COPD during later stages of the disease, it is important to have the correct diagnosis. Minnesota Community Measurement recently reported that in 2011, the statewide rate for Use of Spirometry Testing in the Assessment and Diagnosis of COPD is 39 percent. Specific clinic/provider group rates are available on page 97 of the MN Community Measurement 2011 Health Care Quality Report.

Blue Plus is collaborating with the American Lung Association (ALA) in Minnesota as well as other health plans - HealthPartners and Medica - to improve the use of spirometry testing for individuals with respiratory symptoms. As part of this project, Blue Plus encourages primary care clinicians to provide spirometry testing in their clinics. Literature notes that patients are most comfortable being tested in a clinic they know and trust. Training is available from ALA's affiliated COPD Coalition. **Visit American Lung Association - MN COPD Coalition to learn about an upcoming ALA spirometry course for COPD.**

The spirometry testing project focuses on adults 42 years of age and older. Beginning in early May 2012, Blue Plus will notify clinicians by letter about their patients who are Blue Plus members who have a new or newly active diagnosis of COPD in claims but have not had a spirometry test. Blue Plus will also contact the affected members and encourage them to talk to their physician about testing.

If you have questions about this project or would like further information, please contact Sheila Dalen, quality and health management project manager, via phone at **(651) 662-1170** or via e-mail at sheila_m_dalen@bluecrossmn.com.

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 **provider.bluecrossmn.com**, Forms & publications, manuals, Blue Cross and Blue Shield of Minnesota Provider Policy and Procedure Manual, Chapter 3 - Health Care Improvement.

Recently updated ICSI guidelines:

- **Immunizations**
- **Diagnosis and Management of Attention Deficit Hyperactivity Disorder in Primary Care for School-Age Children and Adolescents (ADHD)**

You may also contact Pam Dempsey via e-mail at Pamela_M_Dempsey@bluecrossmn.com, or via phone at **(651) 662-7271** or **1-800-382-2000**, ext. **27271** for more information.

Coding Corner

July HCPCS

Time marches on and so do the coding changes. All of the HCPCS changes for July 1, 2012, are not posted to the CMS website at the same time. First out is a file of "other" codes available on the HCPCS Quarterly Update site (**http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html**). Also, the CPT category III codes that become effective July 1, 2012, have been posted on the AMA's category III webpage at **http://www.ama-assn.org/resources/doc/cpt/cptcat3codes.pdf**. The new codes start with 0302T on page 5 of that PDF.

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

57 modifier clarification

Per our global surgical package policy, preoperative visits, which include a component of medical decision making, are included in the surgical package. The use of the -57 modifier is intended to indicate the initial decision for surgery, but is not separately reimbursable outside of the global package by the surgeon when performed during the preoperative period, generally within 24 hours of the surgery. If the surgeon decided to not perform the surgery, then Blue Cross would reimburse the surgeon an evaluation management (E/M) for their services since the global surgery package would not apply.

The use of the -57 modifier does not result in an enhanced reimbursement for the emergency room (ER) or other physician if it is used. Those practitioners are indicating that only after a consult with the surgeon the decision for surgery was made. The surgeon's reimbursement for that decision is encompassed in the global package when performed during the global surgical period.

Coding Corner

Assistance please

When Blue Cross denies assist-at-surgery services (surgical services appended with modifiers AS, 80, 81 or 82) providers may submit an appeal including the operative report. We want to remind you that the documentation must specifically indicate what the assist's surgical involvement was in the surgery, thus the necessity for the assist's charge. If this is not clear, the denial may be upheld.

Everyone together

Rather, every**thing** together – documentation that is. When submitting an appeal, be sure to include documentation for all services performed on that date of service. Including all applicable information completes the picture and helps us understand the extent of services the patient received.

Medical records reminder

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. On April 3, 2012, Provider Bulletin P11-12 entitled "Blue Cross requirements regarding medical records" was published. The bulletin includes requirements related to the maintenance of medical records, evaluation and management documentation and assistant surgeon documentation. 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.

How can providers obtain pre-authorization/pre-certification information for out-of-area members?

Member pre-authorization or pre-certification information can be obtained both electronically and telephonically.

1) General information on pre-authorization and pre-certification can also be found on our website at **providers.bluecrossmn.com**. Select Medical Policy and Pre-Certification Authorization Router and enter the three-letter prefix found on the member ID card.

2) In addition to eligibility and benefits, providers can contact **1-800-676-BLUE** to obtain pre-authorization or pre-certification information. When pre-authorization or pre-certification for a specific member is handled separately from eligibility verifications at the member's Blue plan, your call will be routed directly to the area that handles pre-authorization or pre-certification. You will choose from four options regarding the type of service for which you are calling:

   - Medical/surgical
   - Behavioral health
   - Diagnostic imaging/radiology
   - Durable/home medical equipment (D/HME)

If you are inquiring about *both* (eligibility and pre-authorization or pre-certification) through **1-800-676-BLUE**, your eligibility inquiry will be addressed first. Then you will be transferred, as appropriate, to the pre-authorization or pre-certification area.

Please note that if a pre-authorization and pre-certification determination is not provided at the time of the call, the determination may be communicated to a different area (i.e. facility's utilization management area) than the area that initiated the pre-certification request. Providers are encouraged to ask the

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BlueCard

What is the BlueCard® Program? continued from page 11

member's Blue plan about it when they call, to prevent duplicate requests.

3) With the submission of a 270 HIPAA Eligibility request through Blue Cross, the 271 Eligibility responses may indicate that a pre-authorization or pre-certification is required for an eligible service.

Why do members' Blue plans sometimes initially indicate that a service/ procedure is authorized or certified under an authorization or certification process, but when the service is adjudicated, determine the service to be noncovered/denied?

These discrepancies tend to occur when there are benefit limitations that restrict: who may render the service, where they are rendered, how they are billed, or the presence of a benefit maximum. Additional factors that may affect adjudication of a claim are preexisting conditions, additional services not included in the initial plan of treatment and/or a revised length of stay that does not match the prior authorization or pre-certification.

When obtaining pre-authorization or pre-certification, please provide as much information as possible, to minimize potential claims issues. Providers are encouraged to follow up immediately with a member's Blue plan to communicate any changes in treatment or setting to ensure existing authorization is modified or a new one is obtained, if needed. Failure to make the necessary notification or obtain prior authorization or a completed pre-certification may cause a delay or denial in claims payment. Please note that pre-authorization or pre-certification does not guarantee payment.

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 90 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 90 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: 05/29/12 Notification Posted: 02/23/12

Policies developed

BRAF Mutation Analysis

- Please note: BRAF Mutation Analysis was formerly addressed in the policy titled, "KRAS and BRAF Mutation Analysis". This policy has now been split into two separate policies. Criteria for KRAS mutation analysis is now reflected in the policy, "KRAS Mutation Analysis".
- BRAFV600 mutation analysis in tumor tissue of patients with unresectable or metastatic melanoma may be considered medically necessary to select patients for treatment with vemurafenib.
- BRAFV600 mutation analysis for all other patients with melanoma is considered investigative due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- BRAF mutation analysis is considered investigative for all other indications including analysis to predict non-response to monoclonal antibodies cetuximab and panitumumab in the treatment of metastatic colorectal cancer due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: No. Claims for these procedures, devices, pharmaceuticals or services are subject to retrospective review and denial, as investigational services are not eligible for coverage.

Policies revised

Autism Spectrum Disorders: Early Intensive Behavioral Intervention (EIBI)

- The policy has been updated to include the following statements:
- Early Intensive Behavioral Intervention (EIBI) for Autism Spectrum Disorders (ASDs) may be considered when all of the following criteria are met:
  - The member has a diagnosis of an Autism Spectrum Disorder (ASD) (DSM-IV-TR 299.00, 299.10, 299.80) and the components of the Diagnostic Assessment are completed as described in Medical Policy #X-43 Autism Spectrum Disorders: Assessment); AND
  - The member's behaviors are having an impact on his/her development, communication, or adjustment such that:
    - The member cannot adequately participate in home, school, OR community activities; OR
    - The member presents a safety risk to self or others; AND
  - Individualized Treatment Plan
    - A time-limited, individualized treatment plan (ITP) has been developed based on a diagnostic assessment that has occurred no more than 12 months preceding initiation of treatment. The ITP must be multidisciplinary in nature, member centered, family focused, community based, culturally competent and least intrusive. The ITP must be developed specifically for each member. Treatment plans that are templates, or generic to a particular program, are not acceptable. Content of the ITP must include all of the following:
      - Identification and detailed description of targeted behaviors/symptoms; AND
      - Objective, baseline measurement levels for each target behavior/symptoms in terms of frequency, intensity, and duration, including use of standardized autism measures; AND
      - A comprehensive description of treatment interventions and techniques specific to each of the member's targeted behaviors/symptoms, including documentation of number of service hours, in terms of frequency and duration, necessary for each intervention; AND

Medical and Behavioral Health Policy Update

  - Establishment of treatment goals and objective measures of progress for each intervention specified; AND
  - Strategies for generalization of learned skills; AND
  - A description of parental education methods, goals and support services; AND
  - Strategies for coordinating treatment with school-based special education programs; AND
  - Plans for transition through a continuum of treatments, services, and settings; AND
  - Measurable discharge criteria and a discharge plan; AND
- Evaluation of Progress
  - A summary document outlining the member's progress, based on the measures of progress established in the ITP, must be submitted to the Plan at least every 6 months; AND
  - Testing, supervised and interpreted by an independent, licensed Mental Health Professional* who is qualified to administer appropriate assessment instruments, must be administered at the time intervals described below. Testing must include standardized:
    - Intellectual testing, every 12 months; AND
    - Adaptive testing, every 6 months; AND
    - Communication testing, every 6 months; AND
    - Autism measures (e.g., ADOS, CARS, ADI-R), every 6 months; AND
  - If the member has reached maximal progress toward a specific treatment goal, the member may be re-evaluated for establishment of new treatment goals and transition to less intensive interventions. AND
- Provider Qualifications
  - At a minimum, the lead behavioral therapist, providing treatment and clinical supervision of EIBI must:
    - Meet the Minnesota Department of Human Services qualifications for Mental Health Practitioner **; AND
    - Hold an industry-recognized certification, such as that of a Board Certified Behavior Analyst; AND
  - Clinical supervision for unlicensed staff providing EIBI services must be provided by a Mental Health Professional* who is licensed to practice independently, and who is credentialed and approved by the Plan. Such supervision by the Mental Health Professional* must:
    - Include approval and review of the individual treatment plan (ITP) and case review of every member receiving clinical health services bimonthly (once every 60 days); AND
    - Include at least one hour of on-site observation during the first 12 hours of services provided to a member; AND
    - Include at least monthly on-site supervision, with on-site observation for at least one (1) hour per month of service to a member.
- *The Mental Health Professional must meet the Minnesota Department of Human Services qualifications, as set forth in Minn.Stat.245.4871, subds.26 and 27 (2011) and Minn.Stat.245.462, subds. 17 and 18 (2011).
- **The Mental Health Practitioner must meet the Minnesota Department of Human Services qualifications, as set forth in Minn.Stat.245.4871, subds.26 and 27 (2011).

- Pre-Certification/Pre-Authorization: Yes, only for Early Intensive Behavioral Intervention (EIBI) in which the level of treatment provided consists of more than nine (9) hours per week for intensive therapy. A week is defined as a period of seven consecutive days. Coverage is subject to the member's contract benefits. A summary of the components of the multidisciplinary Diagnostic Assessment as described in the Autism Spectrum Disorders: Assessment, Medical Policy # X-43, must be included with the authorization request.

Medical and Behavioral Health Policy Update

Botulinum Toxin

- All of the policy statements have been updated as follows:
- The use of botulinum toxin (A or B serotypes) may be considered medically necessary for the following:
  - Cervical dystonia (spasmodic torticollis; applicable whether congenital, due to child birth injury, or traumatic injury).*
  - Strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII (facial) nerve disorders in patients 12 years of age and above*
  - Upper limb spasticity*
  - Dystonia/spasticity in patients with any of the following diseases of the central nervous system:
    - Focal dystonias:
      - Focal upper limb dystonia (e.g., organic writer's cramp)
      - Oromandibular dystonia (e.g., orofacial dyskinesia, Meige syndrome)
      - Laryngeal dystonia (adductor spasmodic dysphonia)
      - Idiopathic (primary or genetic) torsion dystonia
      - Symptomatic (acquired) torsion dystonia
    - Spastic conditions:
      - Cerebral palsy
      - Spasticity related to stroke
      - Acquired spinal cord or traumatic brain injury
      - Hereditary spastic paraplegia
      - Spastic hemiplegia
      - Neuromyelitis optica
      - Multiple sclerosis or Schilder's disease
  - Esophageal achalasia in patients who have not responded to dilation therapy or who are considered poor surgical candidates
  - Sialorrhea (drooling) associated with Parkinson's disease
  - Chronic anal fissure
  - Prevention (treatment) of chronic migraine headache in the following situations**:
    - Initial 6-month trial in adult patients who:
      - meet International Headache Classification (ICHD-2) diagnostic criteria for chronic migraine headache (e.g. migraine headaches lasting at least 4 hours on at least 15 days per month; migraine headaches for at least 3 months); AND
      - have symptoms that persist despite adequate trials of at least 2 agents from different classes of medications used in the treatment of chronic migraine headaches, e.g. antidepressants, antihypertensives and antiepileptics. Patients who have contraindications to preventive medications are not required to undergo a trial of these agents.
    - Continuing treatment beyond 6-months:
      - Migraine headache frequency reduced by at least 7 days per month; OR
      - Migraine headache duration reduced at least 100 hours per month.
  - *FDA-approved indication for at least one of the agents.
  - **Only onabotulinumtoxinA has been studied and approved by the FDA for this indication.

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- The use of all botulinum toxin agents is considered cosmetic for the treatment of glabellar lines or wrinkles and other indications solely to improve appearance.
- All other uses of botulinum toxin are considered investigative, including, but not limited to:
  - Benign prostatic hyperplasia
  - Chronic low back pain
  - Chronic motor tic disorder, and tics associated with Tourette syndrome (motor tics)
  - Depressive disorders
  - Detrusor sphincteric dyssynergia (after spinal cord injury)
  - Gastroparesis
  - Headaches, except as noted above for prevention (treatment) of chronic migraine headache
  - Hirschsprung's disease
  - Interstitial cystitis
  - Joint pain
  - Lateral epicondylitis
  - Mechanical neck disorders
  - Myofascial pain syndrome
  - Neuropathic pain after neck dissection
  - Pain after hemorrhoidectomy or lumpectomy
  - Prevention of pain associated with breast reconstruction after mastectomy
  - Raynaud's disease/Raynaud's phenomenon
  - Sialorrhea (drooling), unless secondary to Parkinson's disease
  - Tinnitus
  - Tremors such as benign essential tremor (upper extremity)
- The use of assays to detect antibodies to botulinum toxin is considered investigative due to a lack of evidence demonstrating a beneficial impact on health outcomes.
- Pre-Certification/Pre-Authorization: Yes, only for chronic migraine headaches. Initial approval will be a for 6 month trial. Continued treatment beyond 6 months will require additional authorization.

Oral Fentanyl for Cancer-Related Pain

- All of the policy statements have been updated as follows:
- The use of oral fentanyl (i.e., Actiq®, Fentora™, Onsolis™, Abstral®, Fentanyl Buccal tablets, Subsys® sublingual spray) may be considered medically necessary for the FDA-approved indication:
  - Management of breakthrough cancer pain in patients who are already receiving and who are tolerant to opioid therapy* for their underlying persistent cancer pain.
  - *Patients considered opioid tolerant are those taking at least 60 mg oral morphine/day, at least 25 mcg transdermal fentanyl/hour, at least 30 mg of oral oxycodone daily, at least 8 mg oral hydromorphone daily or an equianalgesic dose of another opioid for a week or longer.
- The use of an oral fentanyl for any indication other than the FDA-approved indication is considered not medically necessary; appropriate alternative medications are available for treatment of non-cancer-related pain.
- Pre-Certification/Pre-Authorization: Yes. Coverage is subject to the member's pharmacy benefits. Coverage will be limited to 4 units per day, except when the following criteria are met:

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- The episodes of breakthrough pain cannot be controlled by modifying the dose of the long-acting opioid and
- The requested dose cannot be achieved using a lesser quantity of a higher strength (e.g., FentoraTM 8 x 100mcg could be achieved with 4 x 200mcg).

Genetic Testing and Counseling for Heritable Disorders

- The policy title has been revised from "Genetic Testing and Counseling" to "Genetic Testing and Counseling for Heritable Disorders".
- All of the policy statements have been updated as follows:
- I. Testing for Carrier Status
  - A. Carrier testing may be considered medically necessary when a parent or prospective parent is at high risk of being a carrier of a specific genetic disorder based upon family history as defined by one or more of the following and all of the criteria in section B are met.
    - An affected child is identified with an autosomal recessive or X-linked disorder and genetic testing is performed to determine the pattern of inheritance and to guide subsequent reproductive decisions; OR
    - One or both parents or prospective parents have a first or a second degree relative who is affected by a specific genetic disorder, or the first degree relative has an affected child with an autosomal recessive or X-linked disorder and genetic testing is performed to determine the pattern of inheritance to guide subsequent reproductive decisions or to guide medical management; OR
    - The parents or prospective parents are members of a racial or ethnic group with a high risk of a specific genetic disorder with an autosomal recessive pattern of inheritance; and genetic testing is performed to determine carrier status to guide subsequent reproductive decisions.
  - B. If one or more of the criteria in Section A (above) are met, parents or prospective parents must meet all of the following criteria:
    - A specific mutation, or set of mutations, has been established in the scientific literature to be reliably associated with the disorder;
    - The test will identify or rule out heritability of the condition and will provide information that established biochemical or other testing cannot provide.
    - Testing is accompanied by genetic counseling.
  - Genetic testing for carrier status is considered investigative when the criteria above are not met. There is a lack of clinical evidence demonstrating its impact on improved health outcomes.
- II. Presymptomatic Genetic Testing to Predict Risk of a Disorder
  - Presymptomatic genetic testing may be considered medically necessary in individuals with a reasonable expectation that the condition exists or may arise based on family history and a pedigree analysis and who have no signs or symptoms of a genetic disorder when all of the following criteria are met:
    - A specific mutation, or set of mutations, has been established in the scientific literature to be reliably associated with the disease; AND
    - The results of the genetic test will impact disease prevention, surveillance, or medical management of the individual; AND
    - The genetic test will likely result in an anticipated improvement in net health outcomes; AND
    - Testing is accompanied by genetic counseling.

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  - Predictive testing is considered investigative when the criteria above are not met. There is a lack of clinical evidence demonstrating its impact on improved health outcomes. Examples of these predictive tests include but are not limited to the 23andMe, deCODE T2™, deCODE AF™, deCODE MI™, and the deCODE Glaucoma™ tests.
  - Genetic testing of children to predict adult onset of disease is considered not medically necessary unless test results will guide current decisions concerning prevention and this benefit would be lost by waiting until the child has reached adulthood.
  - Genetic testing of an individual's entire genome for any indication in the absence of genetic counseling with pedigree analysis is considered investigative. There is a lack of clinical evidence that this type of testing improves health outcomes.
- III. Diagnostic Testing
  - Genetic testing may be considered medically necessary to diagnose a genetic disorder in individuals with signs or symptoms who meet all of the following criteria:
    - A specific mutation or set of mutations has been established in the scientific literature to be reliably associated with the disease; AND
    - A biochemical or other test is identified but the results are indeterminate, or the genetic disorder cannot be identified through biochemical or other testing (e.g. serum cholesterol testing for familial hypercholesterolemia or ultrasound screening for aortic disease in Marfan syndrome); AND
    - The results of the genetic test will impact the medical management of the individual with a resulting improvement in health outcomes; AND
    - Testing is accompanied by genetic counseling.
  - Genetic testing for diagnostic purposes in individuals not meeting the above criteria is considered investigative. There is a lack of clinical evidence demonstrating its 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.

Catheter Ablation for Treatment of Atrial Fibrillation

- The policy title has been revised from "Radiofrequency Catheter Ablation of the Pulmonary Veins for Treatment of Atrial Fibrillation" to "Catheter Ablation for Treatment of Atrial Fibrillation".
- All of the policy statements have been updated as follows:
- Transcatheter radiofrequency ablation may be considered medically necessary as a treatment for atrial fibrillation for the following indications:
  - Patients with symptomatic paroxysmal or persistent atrial fibrillation, who have failed antiarrhythmic medications, as an alternative to continued medical management; OR
  - Patients with class II or III congestive heart failure and symptomatic atrial fibrillation in whom heart rate is poorly controlled by standard medications, as an alternative to AV nodal ablation and pacemaker insertion
- Repeat transcatheter radiofrequency ablations may be considered medically necessary in patients with recurrence of atrial fibrillation and/or development of atrial flutter following the initial procedure.
- Transcatheter radiofrequency ablation for all other atrial fibrillation related conditions is considered investigative.
- Transcatheter cryoablation as a treatment for atrial fibrillation is considered investigative due to a lack of evidence demonstrating an impact on improved health outcomes.

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- 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.

Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Disorders in the Home

- The policy title has been revised from "Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Disorders" to "Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Disorders in the Home".
- All of the policy statements have been updated as follows:
- The use of HFCWO devices in the home setting may be considered medically necessary as an alternative to chest physiotherapy for airway clearance when standard chest physiotherapy and, if appropriate, use of vibratory positive expiratory pressure devices (i.e., Flutter or Acapella devices) have failed or cannot be performed in patients with the following conditions:
  - Cystic fibrosis, OR
  - Chronic bronchiectasis indicated by:
    - daily productive cough for at least 6 continuous months; OR
    - exacerbations occurring more than 2 times per year which require antibiotic therapy. OR
  - Chronic neuromuscular disorder* meeting all of the following criteria:
    - Patient has the ability to cough; AND
    - Patient has prior history of pneumonia.
    - *Chronic neuromuscular disorders include but are not limited to:
      - multiple sclerosis
      - cerebral palsy
      - hereditary muscular dystrophy
      - spinal muscular atrophy
      - myotonic disorders
      - quadriplegia
      - acid maltase deficiency
      - paralysis of the diaphragm
- Other applications of HFCWO devices are considered investigative including but not limited to use:
  - as an adjunct to chest physiotherapy
  - in other lung diseases, such as chronic obstructive pulmonary disease (COPD), in the absence of a confirmed diagnosis of bronchiectasis
  - in neuromuscular disorders not meeting the criteria above.
- The use of intrapulmonary percussive ventilation devices is considered investigative in the treatment of chronic pulmonary diseases, including but not limited to cystic fibrosis, bronchiectasis, and neuromuscular disorders in the home setting.
- Pre-Certification/Pre-Authorization: Yes. Submitted clinical documentation should address the patient selection criteria described above (e.g., clinic notes, hospital discharge summaries, radiologist's interpretations of imaging studies).

KRAS Mutation Analysis

- The policy title has been revised from "KRAS and BRAF Mutation Analysis" to "KRAS Mutation Analysis".

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- Please note: This policy has been split into two separate policies. Criteria for BRAF mutation analysis is now reflected in the policy, "BRAF Mutation Analysis".
- The policy has been updated to include the following statements:
- KRAS mutation analysis may be considered medically necessary to predict non-response to monoclonal antibodies cetuximab and panitumumab in the treatment of metastatic colorectal cancer.
- Use of KRAS mutation analysis is considered investigative for all other indications, including, but not limited to, its use to predict treatment non-response to the tyrosine-kinase inhibitor erlotinib and the monoclonal antibody cetuximab in non-small-cell lung carcinoma due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Yes. Claims for these procedures, devices, pharmaceuticals or services are subject to retrospective review and denial, as investigational services are not eligible for coverage.

Policies inactivated

Grenz Ray Therapy for Skin Conditions

Policies Effective: 07/02/12 Notification Posted: 03/30/12

Policies developed

None

Policies revised

Radiofrequency Ablation of Solid Tumors

- The policy title has been revised from "Radiofrequency Ablation of Solid Tumors, Excluding Liver Tumors" to "Radiofrequency Ablation of Solid Tumors".
- All of the policy statements have been updated as follows:
- Radiofrequency ablation may be considered medically necessary for the following indications:
  - Treatment of liver tumors under the following circumstances:
    A. Treatment of hepatocellular carcinoma (HCC) when all the following criteria are met:
      - The patient is not a candidate for surgical resection (e.g., due to location of the tumor(s) and/or comorbid conditions); AND
      - Presence of three (3) lesions or less; AND
      - Tumor size is ≤ 5 cm in diameter; AND
      - All tumor foci can be adequately treated by ablation.

    B. Treatment of hepatic metastases from colorectal cancer when all the following criteria are met:
      - The patient is not a candidate for surgical resection (e.g., due to location of the tumor(s) and/or comorbid conditions); AND
      - Absence of extrahepatic metastatic disease; AND
      - Tumor size is ≤ 5 cm in diameter; AND
      - All tumor foci can be adequately treated by ablation.

    C. Treatment of hepatic metastases from neuroendocrine tumors when all the following criteria are met:
      - Patient is not a candidate for surgical resection (e.g., due to location of the tumor(s) and/or comorbid conditions);

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AND
  - Systemic therapy has failed to control symptoms; AND
  - All tumor foci can be adequately treated by ablation.
- Treatment of localized renal cell carcinoma when tumor size is ≤ 4 cm and either of the following criteria are met:
  1. Preservation of kidney function is necessary (i.e., the patient has one kidney or renal insufficiency, defined as a glomerular filtration rate [GFR] of < 60 mL/min/m2) and standard surgical approaches would compromise kidney function; OR
  2. Patient is not considered a surgical candidate due to co-morbid disease.
- Treatment of an isolated peripheral non-small cell lung cancer tumor when all the following criteria are met:
  1. Surgical or radiation treatment with curative intent is considered appropriate based on stage of disease, but medical comorbidity renders the patient unfit for those interventions; AND
  2. Tumor size is ≤ 3 cm in diameter; AND
  3. Tumor(s) are located at least 1 cm from the trachea, main bronchi, esophagus, aorta, aortic branches, pulmonary artery and the heart.
- Treatment of tumors(s) metastatic to the lung when all the following criteria are met:
  1. Surgical or radiation treatment with curative intent is considered appropriate based on stage of disease, but medical cormorbidity renders the patient unfit for those interventions; AND
  2. No evidence of extrapulmonary metastases; AND
  3. Tumor size is ≤ 3 cm in diameter; AND
  4. No more than 3 tumors per lung; AND
  5. Tumor(s) are located at least 1 cm from the trachea, main bronchi, esophagus, aorta, aortic branches, pulmonary artery and the heart.
- Adjunctive treatment for palliation of pain in patients with osteolytic bone metastases when standard treatment (e.g., opioids, radiation therapy) has failed to provide adequate pain relief
- Treatment of osteoid osteoma, when standard treatment with nonsteroidal anti-inflammatory drugs has failed to provide adequate pain relief

- Radiofrequency ablation is considered investigative for treatment of all other solid tumors located outside the liver including, but not limited to, the following:
  - Benign breast tumors (e.g., fibroadenomas);
  - Malignant breast tumors;
  - Head and neck tumors;
  - Adrenal tumors;
  - Chordomas;
  - Ovarian tumors;
  - Pelvic/abdominal metastases of unspecified origin;
  - Initial treatment of painful bony metastases
- 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.

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Cryoablation of Solid Tumors

- The policy title has been revised from "Cryosurgical Ablation of Solid Tumors" to "Cryoablation of Solid Tumors".
- All of the policy statements have been updated as follows:
- Cryoablation may be considered medically necessary for the following indications:
  - Treatment of liver tumors under the following circumstances:
    1. Treatment of hepatocellular carcinoma (HCC) when all the following criteria are met:
       - The patient is not a candidate for surgical resection (e.g., due to location of the tumor(s) and/or comorbid conditions); AND
       - Presence of three (3) lesions or less; AND
       - Tumor size is ≤ 5 cm in diameter; AND
       - All tumor foci can be adequately treated by ablation.
    2. Treatment of hepatic metastases from colorectal cancer when all the following criteria are met:
       - The patient is not a candidate for surgical resection (e.g., due to location of the tumor(s) and/or comorbid conditions); AND
       - Absence of extrahepatic metastatic disease; AND
       - Tumor size is ≤ 5 cm in diameter; AND
       - All tumor foci can be adequately treated by ablation.
    3. As treatment of hepatic metastases from neuroendocrine tumors when all the following criteria are met:
       - Patient is not a candidate for surgical resection (e.g., due to location of the tumor(s) and/or comorbid conditions); AND
       - Systemic therapy has failed to control symptoms; AND
       - All tumor foci can be adequately treated by ablation.
  - Treatment of prostate cancer under the following circumstances:
    1. Primary treatment for clinically localized prostate cancer; OR
    2. Salvage treatment for recurrent prostate cancer following failed radiation therapy
  - Treatment of localized renal cell carcinoma when tumor size is ≤ 4 cm and either of the following criteria are met:
    1. Preservation of kidney function is necessary (i.e., the patient has one kidney or renal insufficiency, defined as a glomerular filtration rate [GFR] of < 60 mL/min/m2) and standard surgical approaches would compromise kidney function; OR
    2. Patient is not considered a surgical candidate due to co-morbid disease
- Cryoablation is considered investigative for treatment of all other solid tumors including, but not limited to, the following:
  - Benign breast tumors (e.g., fibroadenomas);
  - Malignant breast tumors;
  - Renal cell carcinomas in patients who are surgical candidates;
  - Pancreatic cancer;
  - Subtotal prostate ablation
- 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.

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Intravenous Anesthetics for the Treatment of Chronic Pain

- The policy title has been revised from "Intravenous Anesthetics for the Treatment of Chronic Neuropathic Pain" to "Intravenous Anesthetics for the Treatment of Chronic Pain".
- All of the policy statements have been updated as follows:
- Intravenous infusion of anesthetics (e.g., ketamine or lidocaine) for the management of chronic pain, including but not limited to chronic neuropathic pain and fibromyalgia, is considered investigative due to a lack of evidence demonstrating its safety and effectiveness for these indications.
- 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.

Microwave Ablation of Solid Tumors

- The policy title has been revised from "Microwave Thermotherapy for Primary Breast Cancer" to "Microwave Ablation of Solid Tumors".
- All of the policy statements have been updated as follows:
- Microwave ablation may be considered medically necessary for the following indications:
  - Treatment of liver tumors under the following circumstances:
    1. Treatment of hepatocellular carcinoma (HCC) when all the following criteria are met:
       - The patient is not a candidate for surgical resection (e.g., due to location of the tumor(s) and/or comorbid conditions); AND
       - Presence of three (3) lesions or less; AND
       - Tumor size is ≤ 5 cm in diameter; AND
       - All tumor foci can be adequately treated by ablation.
    2. Treatment of hepatic metastases from colorectal cancer when all the following criteria are met:
       - The patient is not a candidate for surgical resection (e.g., due to location of the tumor(s) and/or comorbid conditions); AND
       - Absence of extrahepatic metastatic disease; AND
       - Tumor size is ≤ 5 cm in diameter; AND
       - All tumor foci can be adequately treated by ablation.
    3. Treatment of hepatic metastases from neuroendocrine tumors when all the following criteria are met:
       - Patient is not a candidate for surgical resection (e.g., due to location of the tumor(s) and/or comorbid conditions); AND
       - Systemic therapy has failed to control symptoms; AND
       - All tumor foci can be adequately treated by ablation.
- Microwave ablation is considered investigative for treatment of all other primary and metastatic tumors including, but not limited to, the following:
  - Renal;
  - Lung;
  - Breast;
  - Adrenal.
- Pre-Certification/Pre-Authorization: No. 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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Treatment of Hereditary Angioedema

- The policy title has been revised from "Treatment of Hereditary Angioedema with CI Inhibitor or Plasma Kallikrein Inhibitor" to "Treatment of Hereditary Angioedema".
- The policy statements have been updated as follows:
- Prior to use of any pharmacologic agent, the patient must have a diagnosis of hereditary angioedema (HAE) confirmed by:
  - At least one of the following clinical manifestations:
    1. Recurrent self-limiting, non-inflammatory subcutaneous angioedema without urticaria lasting more than 12 hours; OR
    2. Recurrent, self-remitting abdominal pain without clear organic etiology lasting more than six hours; OR
    3. Recurrent laryngeal edema AND
  - Laboratory values on two separate occasions demonstrating one of the following:
    1. Low C1 Inhibitor level and low C1 inhibitor function (HAE Type I); OR
    2. Normal C1 Inhibitor level and low C1 inhibitor function (HAE Type II)
- Treatment of acute attacks:
  - If the criteria for HAE diagnosis are met, pharmacologic treatment may be considered medically necessary for the treatment of acute attacks in patients with:
    - Laryngeal or facial edema; or
    - Severe abdominal attacks AND
  - Only drugs which are FDA-approved for these indications are used (i.e., Berinert®, Kalbitor ®or Firazyr®)
- Short-term prophylaxis:
  - Prior to surgery, invasive medical procedures or substantial dental procedures such as tooth extractions in patients with a history of laryngeal edema may be considered medically necessary when the diagnostic criteria are met. Drugs used include androgens (e.g., danazol, stanozolol) and antifibrinolytics (tranexamic acid).
- Long-term prophylaxis:
  - If the criteria for HAE diagnosis are met, pharmacologic treatment may be considered medically necessary for long-term prophylaxis against angioedema attacks for adult and adolescent patients:
    - Who experience greater than one severe attack per month or are disabled more than 5 days per month or have laryngeal attacks; AND
    - Have a documented trial and failure, contraindication or intolerance to a 17-alpha alkylated androgen (i.e., Danazol®) or anti-fibrinolytic agents (e.g. tranexamic acid). AND
    - Only drugs which are FDA-approved for these indications are used (i.e., Danocrine® or Cinryze®)
- Use of a C1 esterase inhibitor (i.e., Cinryze®, Berinert®) or plasma kallikrein inhibitor (i.e., Kalbitor®), or bradykinin B2 receptor antagonist (i.e., Firazyr®) is considered investigative for all other indications including but not limited to use as a diagnostic agent to distinguish abdominal attacks of C1 inhibitor disorders from other abdominal pathologies.
- The combined use of a C1 Esterase Inhibitor (i.e., Cinryze®, Berinert®) and a plasma kallikrein inhibitor (i.e., Kalbitor®) is considered investigative.
- Pre-Certification/Pre-Authorization: Yes, ONLY for Cinryze and Berinert when used for prophylaxis. Emergent or acute use DOES NOT need prior authorization unless billed under the pharmacy benefit. Coverage of medications referred to in this policy are subject to a product-specific formulary, specialty drug program or other requirements. For questions related to specific contract benefits, please call the Customer Service number on the member's identification card.

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Percutaneous Facet Joint Denervation

- All of the policy statements have been updated as follows:
- Radiofrequency facet joint denervation
  - Non-pulsed radiofrequency denervation of cervical facet joints (C2-3 and below) and lumbar facet joints may be considered medically necessary when all the following criteria are met:
    - No prior spinal fusion surgery in the vertebral level being treated; AND
    - Non-radicular low back (lumbosacral) or neck (cervical) pain, suggestive of facet joint origin as evidenced by absence of nerve root compression as documented in the medical record on history, physical and radiographic evaluations; AND
    - Pain has failed to respond to three (3) months of conservative management with oral pain medications (e.g., non-steroidal anti-inflammatory medications, analgesics, muscle relaxants, or pharmacological therapy) AND at least one of the following therapies (as documented in the medical record):
      - Course of physical therapy, with weekly visits for a period of four (4) weeks; OR
      - Trial of chiropractic or osteopathic manipulation AND
    - No therapeutic intraarticular injections (i.e., steroids, saline, or other substances) for a period of at least 4 weeks prior to use of a diagnostic medial branch block; AND
    - Diagnostic block, with local anesthetic, of the facet nerve (medial branch block) or injection under fluoroscopic guidance into the facet joint has resulted in at least 50% reduction in pain for the duration of the specific local anesthetic used (e.g., bupivacaine or lidocaine); AND
    - If there has been a prior RF treatment, a minimum time of six (6) months has elapsed since prior RF treatment (per side, per anatomical level of the spine).
- Non-pulsed radiofrequency denervation is considered investigative for the treatment of chronic spinal/back pain for all uses that do not meet the criteria listed above, including but not limited to treatment of thoracic facet or sacroiliac (SI) joint pain.
- Pulsed radiofrequency denervation is considered investigative for the treatment of chronic spinal/back pain due to a lack of evidence supporting its impact on improved health outcomes.
- Other Percutaneous Techniques for Facet Joint Denervation
  - All other techniques for percutaneous facet joint denervation for treatment of chronic spinal/back pain are considered investigative due to a lack of evidence supporting an impact on improved health outcomes. These other techniques include, but are not limited to:
    - Laser; and
    - Cryodenervation.
- Pre-Certification/Pre-Authorization: Yes.

Treatment of Tinnitus

- The policy statement has been updated as follows:
- The treatment of tinnitus with tinnitus maskers, electrical stimulation, transmeatal laser irradiation, electromagnetic energy, transcranial magnetic stimulation, botulinum toxin injections, or tinnitus retraining is considered investigative due to the lack of clinical evidence demonstrating their impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Not applicable. Claims for these procedures, devices, pharmaceuticals or services are subject to retrospective review and denial, as investigational services are not eligible for coverage.

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Immune Globulin Therapy

- All of the policy statements have been updated as follows:
- Intravenous Immune Globulin
  - The use of intravenous immune globulin may be considered medically necessary in the treatment of the following conditions:
  - Immune System Disorders
    - Primary Immunodeficiencies
      - X-linked agammaglobulinemia (X-LA or Bruton's disease);
      - Common variable immune deficiency when the following criteria are met;
        - Significant and clearly documented recurrent infections (e.g., recurrent pneumonias, frequent episodes of bacterial sinusitis, and not just isolated chronic sinusitis); AND
        - Abnormally low levels (2 standard deviations below the age-adjusted mean) of at least two classes of serum immunoglobulins (IgG, IgM, IgA); AND
        - Onset of symptoms after two (2) years of age; AND
        - Exclusion of other possible causes of hypogammaglobulinemia; AND
        - A demonstrated impaired response to immunization with protein and/or polysaccharide antigens:
          - For protein antigens: Serum antibody titers to tetanus and/or diphtheria should be obtained before immunization with tetanus and/or diphtheria vaccine and then three to four weeks after immunization. An abnormal response is defined as less than a four-fold rise in antibody titer
          - For polysaccharide antigens: Serum antibody titers to pneumococcus should be obtained before immunizations and then three to six weeks after immunization with a polyvalent pneumococcal polysaccharide vaccine (such as Pneumovax). An abnormal response is defined as less than a four-fold rise in titer;
      - IgG subclass deficiencies
        - Significant and clearly documented recurrent infections (e.g., recurrent pneumonias, frequent episodes of bacterial sinusitis, and not just isolated chronic sinusitis); AND
        - Abnormally low levels of one or more IgG subclasses (2 standard deviations below the age-adjusted mean) in patients with normal levels of total IgG and IgM; AND
        - A demonstrated impaired response to immunization with protein and/or polysaccharide antigens:
          - For protein antigens: Serum antibody titers to tetanus and/or diphtheria should be obtained before immunization with tetanus and/or diphtheria vaccine and then three to four weeks after immunization. An abnormal response is defined as less than a four-fold rise in antibody titer
          - For polysaccharide antigens: Serum antibody titers to pneumococcus should be obtained before immunization and then three to six weeks after immunization with a polyvalent pneumococcal polysaccharide vaccine (such as Pneumovax). An abnormal response is defined as less than a four-fold rise in titer;
      - X-linked immunodeficiency with hyper IgM;
      - Immunodeficiency with thrombocytopenia and eczema (Wiscott-Aldrich syndrome);
      - Hyperimmunoglobulin E syndrome;
      - Severe combined immune deficiency;

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  - Cellular immunodeficiency with immunoglobulins (Nezelof syndrome);
  - Thymic hypoplasia (DiGeorge's syndrome);
  - Pediatric human immunodeficiency virus (HIV) Infection;
  - Kawasaki disease (mucocutaneous lymph nodes syndrome);
  - Acquired hypogammaglobulinemia caused from either of the following two malignancies:
    - Chronic lymphocytic leukemia
    - Multiple myeloma.
- Hematologic Disorders
  - Idiopathic thrombocytopenic purpura;
  - Neonatal alloimmune thrombocytopenia - as antenatal treatment in women who have previously had an infant with alloimmune thrombocytopenia or as neonatal treatment for the infant;
  - Warm antibody autoimmune hemolytic anemia, refractory to cortocosteroids and splenectomy.
- Musculoskeletal System and Connective Tissue Disorders
  - Dermatomyositis that has not responded to treatment with prednisone and immunosuppressant therapy (e.g., azathioprine, methotrexate);
  - Polymyositis that has not responded to treatment with prednisone and immunosuppressant therapy (e.g., azathioprine, methotrexate).
- Nervous System Disorders
  - Acute inflammatory demyelinating polyneuropathy (Guillain-Barré syndrome);
  - Chronic inflammatory demyelinating polyneuropathy (CIDP);
  - Myasthenia gravis
    - Myasthenic crisis (i.e., an acute episode of respiratory muscle weakness);
    - Myasthenia gravis in patients with chronic debilitating disease (e.g., restricted daily activities and symptomatic at rest or worse) despite treatment with cholinesterase inhibitors, or complications from or failure of steroids and /or azathioprine;
  - Multifocal motor neuropathy in patients with conduction block and anti-GM1 antibodies.
- Organ and Stem-Cell Transplantation
  - Prior to solid organ transplantation, for treatment of patients at high risk of antibody-mediated rejection, including highly sensitized patients and those receiving an ABO incompatible organ;
  - Following organ transplantation, for treatment of antibody-mediated rejection;
  - Following hematopoietic stem-cell transplantation, for treatment of related immunodeficiencies.
- The use of intravenous immune globulin (IVIG) in patients who are kidney transplantation candidates and are highly sensitized to human leukocyte antigens (HLA) will be reviewed on a case-by-case basis. This case-by-case review will focus on the clinical protocol being used by the treating physician.

- Subcutaneous Immune Globulin
  - The use of subcutaneous immune globulin (SCIg) therapy may be considered medically necessary for the treatment of primary immunodeficiencies (FDA-labeled indications), including the following:
    - Congenital agammaglobulinemia;
    - Severe combined immunodeficiency;
    - Wiskott-Aldrich syndrome;
    - X-linked agammaglobulinemia (XLA);

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  - Common variable immune deficiency (CVID) when the following criteria are met:
    - Significant and clearly documented recurrent infections (e.g., recurrent pneumonias, frequent episodes of bacterial sinusitis, and not just isolated chronic sinusitis); AND
    - Abnormally low levels (2 standard deviations below the age-adjusted mean) of at least two classes of serum immunoglobulins (IgG, IgM, IgA); AND
    - Onset of symptoms after two (2) years of age; AND
    - Exclusion of other possible causes of hypogammaglobulinemia; and
    - A demonstrated impaired response to immunization with protein and/or polysaccharide antigens:
      - For protein antigens: Serum antibody titers to tetanus and/or diphtheria should be obtained before immunization with tetanus and/or diphtheria vaccine and then three to four weeks after immunization. An abnormal response is defined as less than a four-fold rise in antibody titer.
      - For polysaccharide antigens: Serum antibody titers to pneumococcus should be obtained before immunizations and then three to six weeks after immunization with a polyvalent pneumococcal polysaccharide vaccine (such as Pneumovax). An abnormal response is defined as less than a four-fold rise in titer.
- The use of intravenous immune globulin or subcutaneous immune globulin is considered investigative in all other circumstances, including the following conditions:
  - Chronic fatigue syndrome;
  - Multiple sclerosis (relapsing-remitting and chronic, progressive);
  - Recurrent fetal loss;
  - Chronic sinus infections *(unless the sinus infection is a symptom of one of the primary immunodeficiencies listed above. Chronic sinus infection is common in most primary deficiencies listed, especially antibody deficiency with normal or near-normal immunoglobulins);
  - Inclusion body myositis;
  - Asthma;
  - POEMS syndrome (polyneuropathy, organeomegaly, endocrinopathy, monoclonal gammopathy, and skin changes);
  - Autistic spectrum disorders;
  - PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections);
  - Fisher syndrome.
- Pre-Certification/Pre-Authorization: Yes, for all indications except pre- and post-transplantation of solid organs and hematopoietic stem-cell transplantation. 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.
  - Common variable immunodeficiency and IgG subclass immunodeficiencies
    - Because reference ranges for serum immunoglobulin levels (e.g., IgG, IgA, IgM) vary among clinical laboratories, the age-adjusted reference ranges for the laboratory performing the tests should be included with the patient's results in the prior authorization documentation. This information is necessary to determine if the patient meets coverage criteria.

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Policies inactivated

Thermography
Home Prothrombin Time Monitoring
Anti-CCP Testing for Rheumatoid Arthritis

Policies Effective: 07/30/12 Notification Posted: 04/25/12

Policies developed

None

Policies revised

Percutaneous and Endoscopic Techniques for Disc Decompression

- The policy title has been revised from "Percutaneous Techniques for Disc Decompression" to "Percutaneous and Endoscopic Techniques for Disc Decompression".
- The policy statements have been updated as follows:
- Percutaneous and endoscopic techniques for decompression of the cervical, thoracic, or lumbar discs are considered investigative including, but not limited to:
  - Percutaneous discectomy
  - Endoscopic discectomy;
  - Laser discectomy;
  - Nucleoplasty (i.e., DISC nucleoplasty™).
- Pre-Certification/Pre-Authorization: Not applicable. Claims for these services are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Pressure-Reducing Support Surfaces

- Criteria for Group 3 surfaces have been changed to simplify the indications for subsequent approval of continued use of a Group 3 device. See below for policy statement changes.
- Group 3 Pressure Reducing Support Surfaces (E0194)
  - A Group 3 pressure reducing support surface (i.e., air-fluidized bed) may be considered medically necessary when all of the following criteria are met:
    - The member has a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure ulcer on the trunk or pelvis; AND
    - The member is bedridden or chair-bound as a result of severely limited mobility; AND
    - A trained adult caregiver is available to assist the member with activities of daily living (ADLs), fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments, and management and support of the air fluidized bed system and its problems such as leakage; AND
    - A physician directs the home treatment regimen, and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis; AND
    - All other alternative equipment has been considered and ruled out; AND
    - The air-fluidized bed is ordered by the member's attending physician based upon a comprehensive assessment

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and evaluation of the member after conservative treatment has been tried for at least one month without progression toward wound healing. Conservative treatment must include:

1. Frequent repositioning of member with particular attention to relief of pressure over bony prominences (usually every two hours); AND
2. Use of a Group 2 support surface to reduce pressure and sheer forces on healing ulcers and to prevent new ulcer formation; AND
3. Necessary treatment to resolve any wound infection; AND
4. Optimization of nutrition status to promote wound healing; AND
5. Debridement by any means, including wet-to dry gauze dressings; AND
6. Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering, while the wound heals.

- Continued Use of a Group 3 Device
  - The continued use of Group 3 device (i.e., air-fluidized bed) must have healing as the goal of treatment, and may be considered medically necessary when the treating physician re-certifies the following on a monthly basis:
    - Stage III or IV pressure sore on the trunk or pelvis;
    - Member is bedridden or chair bound as a result of severely limited mobility; AND
    - All other alternative equipment has been considered and ruled out.
  - After six months on a Group 3 support surface with no improvement in the member's condition, alternative treatments must be considered before additional monthly authorization.
- An air-fluidized bed is considered not medically necessary under any of the following circumstances:
  - The member has co-existing pulmonary disease; OR
  - The member requires treatment with wet soaks or moist wound dressings not protected with an impervious covering unless the member is undergoing aggressive treatment in a wound clinic and is showing measurable improvement.
- Pre-Certification/Pre-Authorization: Yes, ONLY as follows:
  - Group 2 items, every six months.
  - Group 3 items, monthly.
  - Rental vs. purchase information:
    - Group 1 items are eligible for rental or purchase.
    - Group 2 items are eligible for rental only and are considered purchased after 10 months of medically necessary rental.
    - Group 3 items are eligible for medically necessary rental only.
  - In the absence of a medical policy addressing a specific DME item, the medical criteria of the regional DME Medicare Administrative Contractor (MAC) will be used in determining the medical necessity of the item. Those policies are available by accessing the List of LCDs on the CMS Coverage Database.

Charged-Particle (Proton or Atomic Nuclei) Radiation Therapy

- The policy title has been revised from "Charged-Particle (Proton and Heavy-Charged Particle) Radiation Therapy" to "Charged-Particle (Proton or Atomic Nuclei) Radiation Therapy".
- The policy statements have been updated as follows:
- Charged-particle (proton or atomic nuclei) radiation therapy may be considered medically necessary in the following clinical situations:

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  - Primary therapy for melanoma of the uveal tract (iris, choroid, or ciliary body), with no evidence of metastasis or extrascleral extension, and with tumors up to 24 mm in largest diameter and 14 mm in height;
  - Postoperative therapy (with or without conventional high-energy x-rays) in patients who have undergone biopsy or partial resection of chordoma or low-grade (I or II) chondrosarcoma of the basisphenoid region (skull-base chordoma or chondrosarcoma) or cervical spine. Patients eligible for this treatment have residual localized tumor without evidence of metastasis.
- Charged-particle irradiation with proton beams may be considered medically necessary for treatment of localized prostate cancer (i.e., organ-confined [T1 and T2] with no radiographic evidence of metastasis).
- All other applications of charged-particle irradiation, including but not limited to proton beam therapy for non-small-cell lung cancer (NSCLC) at any stage or for recurrence, are considered investigative due to a lack of evidence demonstrating an impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Yes.

Policies inactivated

Bipolar Radiofrequency Stimulation and Ablation for Treatment of Musculoskeletal Conditions
Chemiluminescent Testing for Oral Cancer
Near-Infrared Imaging for Evaluation of Coronary Artery Plaques
Photodynamic Therapy for Oncologic Applications, including Barrett's Esophagus

Policies reviewed with no changes in February, March, and April 2012

Adoptive Immunotherapy

Allergy Testing and Treatment

Anesthesia-Assisted Opioid Withdrawal

Artificial Intervertebral Disc: Lumbar Spine

Automated Point-of-Care Nerve Conduction Tests

Biomarker Genes for the Detection of Lymph Node Metastases in Breast Cancer

Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure

Coverage of Routine Care Related to Cancer Clinical Trials

Detection of Circulating Tumor Cells in the Management of Patients with Cancer

Dialectical Behavior Therapy for Borderline Personality Disorder

Digital Breast Tomosynthesis

Electrical/Electromagnetic Stimulation for Treatment of Arthritis

Electrocardiographic (ECG) Body Surface Mapping

Endoluminal Ablation for Treatment of Varicose Veins/Venous Insufficiency

Endovascular Procedures (Angioplasty and/or Stenting) for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)

Extended Hours Home Care Skilled (Private Duty) Nursing

Eye Movement Desensitization and Reprocessing for Posttraumatic Stress Disorder

Full Body CT Scanning

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Genetic Testing for Helicobacter Pylori Treatment
Genetic Testing for Tamoxifen Treatment
Genetic Testing for Warfarin Dose
Hair Analysis
Hematopoietic Stem-Cell Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma
Hematopoietic Stem-Cell Transplantation for Multiple Myeloma
Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood
Hippotherapy
Hospital Beds
Humanitarian Use Devices
In Vitro Chemoresistance and Chemosensitivity Assays
Intra-articular Hyaluronan Injections for Osteoarthritis
Intradiscal Electrothermal Annuloplasty (IDET), Percutaneous Radiofrequency Annuloplasty (PIRFT), and Intradiscal Biacuplasty
Intravitreal Implant: Ganciclovir
Islet Transplantation
Ketamine for Treatment of All Mental Health and Substance-Related Disorders
Laparoscopic and Percutaneous Techniques for the Myolysis of Uterine Fibroids
Low-Density Lipid (LDL) Apheresis
Low-level Laser Therapy (cold laser) and Deep Tissue Laser Therapy
Lysis of Epidural Adhesions
Measurement of Exhaled Nitric Oxide and Exhaled Breath Condensate in the Diagnosis of Asthma and Other Respiratory Disorders
Meniscal Allografts and Collagen Meniscus Implants
Methadone Maintenance Treatment for Chronic Opioid Dependence
Multigene Expression Assay for Predicting Recurrence in Colon Cancer
Occipital Nerve Stimulation
Pathfinder TG Molecular Testing
Peripheral Nerve Stimulation of the Trunk or Limbs for Treatment of Pain
Pfeiffer Treatment Center Metallothionein Protein (MT) Assessment and Treatment Protocol
Photodynamic Therapy for Skin Conditions
Phototherapy for Seasonal Affective Disorder
Pneumatic Compression Devices in the Home Setting
Positron Emission Mammography
Prolotherapy

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Psychoanalysis
Quantitative Sensory Testing
Replacement of Amalgams
Retinal Telescreening Systems or Diabetic Retinopathy
Rhinomanometry and Acoustic/Optical Rhinometry
Rhinoplasty
Sacral Nerve Stimulation for Pelvic Floor Dysfunction
Saliva Hormone Tests for Menopause
Scintimammography/Breast-Specific Gamma Imaging/Molecular Breast Imaging
Skin Contact Monochromatic Infrared Energy Therapy
Squeeze Machine for Autistic Spectrum Disorder
Surface Electromyography (SEMG)
Surgical Interruption of Pelvic Nerve Pathways for Primary and Secondary Dysmenorrhea
Temporary Prostatic Stents
Tobacco Cessation Treatments
Transanal Radiofrequency Treatment of Fecal Incontinence
Transcranial Magnetic Stimulation
Wireless Capsule Endoscopy
Zoster Vaccine Live (Zostavax)

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

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

06/12

For the health of all.

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