Provider Press

March 2012 / Vol. 16, No. 1

For the health of all.

Enhancements to Blue Distinction Centers® Program

There are four enhancements being implemented at the renewal of each of the Blue Distinction Centers (BDC) Programs (spine, knee and hip, bariatric, cardiac, complex and rare cancers, and transplants) over the next two years. The four enhancements are:

1. Quality thresholds are being raised.
2. Additional criteria are being added relative to patient safety and quality outcomes.
3. Cost-of-care criteria are being added into the evaluation process.
4. In 2014, Hospital-Based Physicians and Key Specialists (those likely to provide services related to the Blue Distinction Center specialty care designation) will be required to have in-network status.

Blue Distinction® is a national designation program that recognizes facilities that demonstrate expertise in delivering quality specialty care — safely, efficiently, and cost effectively. The Program was built on a foundation of quality, and the program will continue this focus; in fact, existing quality thresholds will be raised and there will be an increased emphasis on additional criteria related to patient safety and quality outcomes.

In an effort to meet changing market demand, the Program will also add cost-of-care criteria into the evaluation process. Exact measures are still being developed, but Blue Cross wants to provide the BDCs and network providers with advance notice of these upcoming changes.

All facilities currently designated as BDCs must have in-network status. A new requirement, scheduled to begin in 2014, will better protect Blue members from incurring unexpected out-of-network charges when choosing Blue Distinction Centers for their specialty care. This requirement is that all Hospital-Based Physicians and Key Specialists (who are likely to provide services related to the Blue Distinction Center specialty care designation) will be required to have in-network status, except as prohibited by law. With the spine and also knee and hip redesignations in process, this will be an option for providers. Those facilities that choose to comply early will receive a special notation on the National Provider Finder stating this benefit to members.

Contact Lois Schmidt at **(651) 662-4830** or Lois_Schmidt@bluecrossmn.com if you have questions.

Note: Designation as Blue Distinction Centers means these facilities' overall experience and aggregate data met objective criteria established in collaboration with expert clinicians' and leading professional organizations' recommendations. Individual outcomes may vary. To find out which services are covered under your health plan at any facilities, please call Blue Cross and Blue Shield of Minnesota.

Provider Press

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

Inside preview

FYI

Publications available online

The following is a list of Quick Points and Bulletins published from December 2011, to February 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
QP22-11	High-Technology Diagnostic Imaging program update
QP23-11	Change for members for special transportation services
QP25-11	Minnesota Health Care Programs – Billing requirements for explanation of findings (90887)
QP26-11	Availity completing their HIPAA 5010 system migration
QP1-12	Important notice on 5010 claim submission to Blue Cross and BlueLink TPA
QP2-12	Knee replacement pre-certification/pre-authorization review requirements
QP3-12	Revision: Lessons learned for HIPAA 5010 transactions
Bulletins	**Title**
P24-11	Collection and handling of specimens for PMAP members and MinnesotaCare members only
P25-11	MN Clinic Fax Referral Program name change
P26-11	Home telemonitoring services
P27-11	January 2012 HCPCS code updates
P1-12	Specialized maintenance therapy for PT/OT/SLP excluded for MHCP members
P2-12	Changes for DME and O&P providers
P3-12	Update to Attachment B: Definition of outpatient health services categories
P4-12	Medical necessity criteria vendor change
P5-12	Changes to Blue Plus MHCP prior authorization list
P6-12	MHCP screening requirements for providers of children's and adult mental health services and chemical dependency assessments

Provider Demographic Change Form

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

E-mailed to Provider_Data@bluecrossmn.com

Faxed to **(651) 662-6684**

Mailed to:

Blue Cross and Blue Shield of Minnesota
PDO, R316
P.O. Box 64560
St. Paul, MN 55164-0560

Quality Improvement

Controlling blood pressure in members with diabetes

Blue Plus is working together with 4 other health plans (HealthPartners, Medica, Metropolitan Health Plan and UCare) on a performance improvement project to increase the proportion of members with diabetes who have blood pressure in control as indicated by the Health Plan Employer Data and Information System (HEDIS) Comprehensive Diabetes Care (140/90 mmHg blood pressure measure in adults ages 18 through 75).

In 2010, there was a change to the Institute for Clinical Systems Improvement (ICSI) and American Diabetes Association (ADA) blood pressure guideline for patients with diabetes. Hypertension for people diagnosed with diabetes was 130/80; however, this guideline was changed to 140/90.

Interventions

The interventions for this project focus on broad engagement of members and providers, as well as working closely with an individual clinic.

Some of the member interventions executed in 2011 included:

- Care Coordinator involvement in reaching out to high-risk members
- Two educational postcards. One on the importance of tracking blood pressure, which included a tear-off card to encourage eligible members to frequently record their blood pressure and bring it to their next doctor's appointment. The second was focused on management and had a tear-off for members to write down questions to bring to their next doctor's visit.
- A letter informing eligible members about medication therapy management services (MTMS) encouraging them to call their health plan's customer service department to learn how to enroll in the program.

Provider interventions included four internet-based trainings.

- Managing Blood Pressure to Goal in Adults with Diabetes
- Physician-Pharmacist Team Approach to Treating Hypertension in the Diabetic Patient
- Promoting Accurate Measurement and Self-Management in Blood Pressure
- Special Needs Population Seriously Mentally Ill: Importance of Hypertension Management

Each provider training is about 30 minutes long. Check out the provider toolkit with resources and education for providers and members at: **http://stratishealth.org/pip/blood-pressure.html**.

The individual clinic working with Blue Plus is working to ensure people are accurately diagnosed with hypertension and appropriately treated. As part of their goal the clinic focused on education

continued on page 4

Quality Improvement

Controlling blood pressure continued from page 3

on the accuracy of taking blood pressures, utilizing the internet-based training listed above.

2011 Results

HEDIS data from our public programs members was aggregated. Compared to the collaborative's baseline, the MinnesotaCare/PMAP population increased their BP control by 11.35% relative improvement rate (RIR), the MSHO/MSC+ population increased their BP control by 3.32% RIR. The collaborative has met and exceeded our 3% RIR goal for MinnesotaCare, PMAP, MSHO, MSC+ products.

Recent MN Community Measurement data has proven that the Blue Plus clinic has also made improvements. In 2010, the clinic had a 47% rate of BP control for their diabetic population, which has increased to 69% in 2011. The results from all five clinics working with the health plans in the collaborative were also combined. The overall collaborative clinic improvement as reported by MN Community Measurement went from 48% in 2010 to 75% 2011. However, the current state clinic rates have also increased from 58% in 2010 to an average of 83% in 2011. We hope to continue to provide meaningful interventions as well as meet our goals as this project continues.

If you have any questions about this project please e-mail Kristen Schroeder at Kristen_Schroeder@bluecrossmn.com.

Quality Improvement (QI) Program

The Blue Cross and Blue Shield of Minnesota and Blue Plus QI program annually carries out many projects to improve members' health. The QI core documents describe our QI program description, new and current projects in 2012 and an evaluation of projects carried out in 2011. The QI program has projects that attempt to improve the rates of preventive health services, such as immunizations and mammograms, reduce the occurrence of acute diseases like flu, or improve the outcomes of chronic diseases such as diabetes or heart disease. It includes quality of clinical care, quality of service, patient safety and collaborative initiatives. If you'd like to learn more about the quality improvement program or to request copies of QI core documents, please call Pam Dempsey at **(651) 662-7271** or **1-800-382-2000,** ext. **27271.**

Quality Improvement

Clinical practice guidelines

At Blue Cross and Blue Shield of Minnesota and Blue Plus, we believe that 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 Blue Cross and Blue Shield of Minnesota and Blue Plus member's health plan.

The clinical practice guidelines section can be reviewed on our provider website at **providers.bluecrossmn.com**, forms & publications, manuals, Blue Cross and Blue Shield of Minnesota Provider Policy and Procedure Manual, Chapter 3 - Quality Improvement.

Recently updated ICSI guidelines:

- **Preventive Services for Adults**
- **Preventive Services for Children and Adolescents**
- **Lipid Management**
- **Acute Coronary Syndrome**

Patient and Family Guidelines

ICSI has available sets of guidelines for patients and families. To view or print, visit **icsi.org** and click on "For Patients and Families."

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

April HCPCS

Just when you thought it was safe to take a deep breath and relax from implementing the January HCPCS code updates, here come some more. The HCPCS changes for April 1, 2012, have already been posted on the CMS website at **http://www.cms.gov/HCPCSReleaseCodeSets/02_HCPCS_Quarterly_Update.asp** under "C-codes April 2012" and "Other Codes Effective April 1, 2012."

This update is definitely not as large as the annual January update, but as of this publication there are 22 discontinued and 10 added codes. Any additional code changes for April 1, 2012, may be forthcoming. Blue Cross will issue a bulletin closer to the April effective date with the codes.

Fracture care in the ED

Only the physician who corrects the fracture should bill the fracture care/code. Management of a fracture in the emergency department (ED), such as applying a sling or boot, is not considered fracture care and should not be billed as such. The ED provider should bill the appropriate evaluation and management (E/M) and the application of the splint, when applied by the ED provider.

Unit submission reminder

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

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

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

Correct submission of units is supported by Minnesota Statutes, § 62J.536 and instructions are found in the Minnesota Uniform Companion Guide, A.3.4.2 Units (basis for measurement).

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 should providers bill claims for out-of-area members?
Providers should bill claims for out-of-area members the same way they bill claims for their Blue Cross members. When submitting the claim:

- The member ID numbers should be reported exactly as shown on the member ID card. Do not add, omit or alter any characters from the member ID number.
- Indicate on the claim any payment you collected from the patient.

What should you do if you haven't received a response to your initial claim submission?

Do not send duplicate claims. Sending another claim or having your billing agency resubmit claims automatically actually slows down the claims payment process and creates confusion for the member. We suggest you wait at least 30 days before resubmitting a claim. If you have a question regarding the status of an outstanding claim, you can submit an electronic 276 HIPAA request or access **Availity.com** if you have registered with Availity.

Availity is an independent company providing claims administration services.

Are providers required to cooperate with the member's Blue plan pre-authorization/pre-certification programs?

While out-of-area BlueCard members are currently responsible for obtaining pre-authorization or pre-certification from their Blue plans, most providers choose to handle this obligation on the member's behalf.

- It is recommended that when verifying member eligibility and benefits, providers request information on pre-authorization and pre-certification, care management/utilization management and concurrent review, as required for inpatient or outpatient services.

continued on page 8

BlueCard

What is the BlueCard® Program? continued from page 7

- Members may be held financially responsible if necessary approvals are not obtained and the claim is denied, and the provider may be forced to manage debt collection.

Which plan's Medical Policy applies for out-of-area members?
Only a member's Blue plan Medical Policy applies to BlueCard claims. The member's Blue plan Medical Policy applies to the interpretation and determination of medical necessity, medical appropriateness, investigational/experimental care, and clinical reviews as related to administration of the member's benefits and coverage.

Should a member's Blue plan ever directly contact an out-of-area provider?
The member's Blue plan should contact an out-of-area provider only to solicit, clarify or confirm clinical information for the purpose of performing case management or disease management activities.

How much can a contracted provider bill an out-of-area Blue member?
Providers should bill only for applicable deductibles, copays, coinsurance, noncovered services and/or medical management penalties specifically indicated as "Patient Responsibility" on the remittance advice for such out-of-area Blue plan member. The provider cannot, in any event, bill the out-of-area member for the difference between billed charges and the locally negotiated allowance.

What criteria is used to determine whether the charge associated with a rendered service is a member or a contracting provider's liability?

The criteria used to determine the provider's liability is specific to the provider's contract. If the provider's contract explicitly states the provider will not be reimbursed for a specific service, and cannot bill the member, the provider is liable for the charge.

The criteria used to determine the member's liability is specific to the member's benefit contract. If the member's benefit explicitly states the service is not covered, the member is liable for the charge.

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.

Medical and Behavioral Health Policy Update

Medical and Behavioral Health Policy Activity

Policies Policies Effective: 01/30/12 Notification Posted: 10/27/11

Policies developed

Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency in Multiple Sclerosis

- The identification and subsequent treatment of chronic cerebrospinal venous insufficiency (CCSVI) in patients with multiple sclerosis is considered investigative due to a lack of clinical evidence demonstrating an impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Not Applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Ovarian and Internal Iliac Vein Embolization for Treatment of Pelvic Congestion Syndrome

- Embolization of the ovarian and internal iliac veins for treatment of pelvic congestion syndrome is considered investigative due to a lack of evidence demonstrating an 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.

Mechanical Embolectomy for Treatment of Acute Stroke

- Mechanical embolectomy is considered investigative in the treatment of acute stroke due to a lack of clinical evidence demonstrating an impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Not applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Acoustic Cardiography

- Acoustic cardiography is considered investigative for the diagnosis of heart failure and for the optimization of cardiac resynchronization therapy (CRT) hemodynamic parameters due to a lack of clinical evidence demonstrating an impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Not applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Policies revised

Hematopoietic Stem-Cell Transplantation for Primary Amyloidosis

- The policy title has been revised from "Hematopoietic Stem-Cell Transplantation for Primary Amyloidosis or Waldenstrom Macroglobulinemia" to "Hematopoietic Stem-Cell Transplantation for Primary Amyloidosis".
- Please note: This policy has been split into two separate policies. Criteria for Waldenstrom Macroglobulinemia is now reflected in the policy, "Hematopoietic Stem-Cell Transplantation for Waldenstrom Macroglobulinemia".
- The policy has been updated to include the following statement:
- Allogeneic hematopoietic stem-cell transplantation for the treatment of primary systemic amyloidosis is considered investigative due to a lack of evidence demonstrating an impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Yes.

Hematopoietic Stem-Cell Transplantation for Waldenstrom Macroglobulinemia

- The policy has been updated to include the following statements:

Medical and Behavioral Health Policy Update

- Autologous hematopoietic stem-cell transplantation may be considered medically necessary as salvage therapy for chemosensitive Waldenstrom macroglobulinemia.
- Allogeneic hematopoietic stem-cell transplantation for the treatment of Waldenstrom macroglobulinemia is considered investigative due to a lack of evidence demonstrating an impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Yes.

Gene Expression Profiling for the Management of Breast Cancer Treatment

- The policy has been updated with the following statements:
- Use of the 21-gene RT-PCR assay (i.e., Oncotype DX™) to determine recurrence risk for deciding whether or not to initiate adjuvant chemotherapy may be considered medically necessary in patients with breast cancer who meet all the following criteria:
  - Unilateral, non-fixed tumor; AND
  - Hormone receptor positive (that is ER-positive or PR-positive); AND
  - HER2-negative; AND
  - Tumor size 0.6 – 1 cm with moderate/poor differentiation or unfavorable features OR tumor size larger than 1 cm; AND
  - Node negative OR no lymph nodes with micrometastases greater than 2 mm; AND
  - Patient will be treated with adjuvant endocrine therapy (e.g., tamoxifen or aromatase inhibitors).
- The use of other gene expression assays [e.g., MammaPrint®, MammoStrat™, THEROS Breast Cancer IndexSM (which includes THEROS H/ISM and THEROS MGISM), Breast Onc PxTM and the PAM50 Breast Cancer Intrinsic Classifier] for any indication is considered investigative due to a lack of evidence establishing that these tests are better than conventional risk assessment tools in predicting disease recurrence.
- Pre-Certification/Pre-Authorization: No. However, services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial may result if criteria are not met.

Policies inactivated

- **Influenza Virus Vaccine Live, Intranasal (FluMist)**
- **Lung Volume Reduction Surgery**
- **Ventricular Reduction Surgery**

Medical and Behavioral Health Policy Activity

Policies Effective: 02/27/12 Notification Posted: 11/23/11

Policies developed

Skilled Nursing Facility (SNF) Care

- I. Initial Request: SNF care may be considered medically necessary when all of the following criteria are met:
  1. The services provided require a skilled nursing facility level of care and cannot be provided in a less intensive setting.
  2. The services provided require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists, and speech-language pathologists or audiologists.

Medical and Behavioral Health Policy Update

3. Services are provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the patient and to achieve the medically desired result.
4. Services are provided under a plan of care established and periodically reviewed by a physician.
5. The required services must be appropriate for the treatment of the illness or injury with the expectation that the condition of the patient will improve in a reasonable and generally predictable period of time, or the services must be necessary for the establishment of a safe and effective maintenance program.
6. One or more of the following types of skilled services are required:
   - Skilled nursing services are those services necessary when the member's condition continues to require skilled assessment, treatment and management/modifications on a daily basis and whose condition is potentially or acutely unstable and requires frequent and ongoing monitoring and assessment. OR
   - Rehabilitative services are therapies performed to increase or enhance the member's functional mobility or status. These may include:
     - Physical therapy
     - Occupational therapy
     - Speech therapy
     - Respiratory therapy
7. The skilled nursing services must be provided on a daily basis (seven days per week).
8. Rehabilitative services must be provided at least five days per week.

- II. Concurrent Review: Continued SNF care may be considered medically necessary, when all of the following criteria are met:
  1. All the section I criteria continue to be met. AND
  2. Documentation of the progress toward long term and short term goals, and the expected length of treatment is provided. This may include:
     - Nursing assessments and progress notes.
     - Rehabilitation therapy assessments and progress notes.
- III. SNF care is considered not medically necessary in the following situations, including but not limited to:
  - Services do not meet the medically necessary criteria above.
  - Rehabilitation services in which there is no improvement in the level of functioning within a reasonable period of time or has reached a plateau.
  - Services that are solely performed to preserve the present level of function or prevent regression of functions for an illness, injury, or condition that is resolved or stable.
  - The member refuses to participate in the recommended treatment plan.
  - Solely to allow respite for caregivers or member's family.
  - Care is initially or becomes custodial (see definition).
    - Custodial Care is primarily for the purpose of assisting the individual in the activities of daily living such as assistance in getting out of bed, walking, bathing, dressing, feeding, and supervision of medication that ordinarily would be self-administered, or in meeting personal rather than medical needs, which are not specific therapy for an illness or injury, is not skilled care, and does not require the continuous attention or supervision of trained, licensed medical personnel.
      - In determining whether an individual is receiving custodial care, factors considered include the level of care and

Medical and Behavioral Health Policy Update

medical supervision required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation or rehabilitation potential.
  - The absence of a caregiver to perform a service does not cause custodial care to become a skilled service.
  - Custodial care is not reclassified as a skilled service when the member is unable to perform an activity independently or based only on the request of the patient or a family member.
- Pre-Certification/Pre-Authorization: Yes. Note: Please check benefit plan descriptions for coverage details regarding SNF or hospice care.

Policies revised

Autologous Chondrocyte Implantation and Other Cell-Based Treatments of Focal Articular Cartilage Lesions

- The policy has been updated to include the following statement:
- Autologous chondrocyte implantation may be considered medically necessary for the treatment of disabling full-thickness articular cartilage defects of the knee caused by acute or repetitive trauma, in patients who have had an inadequate response to a prior surgical procedure, when all of the following criteria are met:
  - Adolescent patients should be skeletally mature with documented closure of growth plates (e.g., 15 years or older). Adult patients should be too young to be considered an appropriate candidate for total knee arthroplasty or other reconstructive knee surgery (e.g., younger than 55 years);
  - Size of the cartilage lesion is greater than 1.5 cm^2;
  - Focal, full-thickness (grade III or IV) unipolar lesions on the weight bearing surface of the femoral condyles or trochlea;
  - Documented minimal to absent degenerative changes in the surrounding articular cartilage (Outerbridge Grade II or less), and normal-appearing hyaline cartilage surrounding the border of the defect;
  - Presence of persistent symptoms (e.g., pain, swelling and catching/locking) that significantly limit activities of daily living;
  - Presence of stable ligaments (if ligaments are unstable, documentation should be provided as to how this condition will be addressed);
  - No malalignment present (if malalignment is present, documentation should indicate planned concurrent correction of alignment).
- 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. If autologous chondrocyte implantation surgery is performed and medical necessity criteria are not met, any associated procedures will not be covered. This includes, but is not limited to, professional, facility, and anesthesia services, as well as supplies.

Osteochondral Allografts and Autografts in the Treatment of Focal Articular Cartilage Lesions

- The policy has been updated to include the following statements:
- Osteochondral allograft transplantation may be considered medically necessary for the treatment of symptomatic full-thickness cartilage defects caused by acute or repetitive trauma, in patients who have had an inadequate response to a prior surgical procedure, when all the following criteria are met:
  - Adolescent patients should be skeletally mature with documented closure of growth plates (e.g., 15 years or older). Adult patients should be too young to be considered an appropriate candidate for total knee arthroplasty or other reconstructive knee surgery (e.g., younger than 55 years);
  - Size of the cartilage lesion is greater than 1.5 cm^2;
  - Focal full-thickness (grade III or IV) cartilage lesions on the weight-bearing surface of the femoral condyles (medial or

Medical and Behavioral Health Policy Update

lateral) or trochlea;
  - Documented minimal to absent degenerative changes in the surrounding articular cartilage (Outerbridge grade II or less) and normal-appearing hyaline cartilage surrounding the border of the defect;
  - Presence of persistent symptoms (e.g., pain, swelling and catching/locking) that significantly limit activities of daily living;
  - Presence of stable ligaments (if ligaments are unstable, documentation should be provided as to how this condition will be addressed);
  - No malalignment present (if malalignment is present, documentation should indicate planned concurrent correction of alignment).
- Osteochondral Autografts: Osteochondral autograft transplantation (OATS or autologous mosaicplasty), using one or more cores of osteochondral tissue may be considered medically necessary for the treatment of symptomatic full-thickness cartilage defects caused by acute or repetitive trauma, in patients who have had an inadequate response to a prior surgical procedure, when all the following criteria are met:
  - Adolescent patients should be skeletally mature with documented closure of growth plates (e.g., 15 years or older). Adult patients should be too young to be considered an appropriate candidate for total knee arthroplasty or other reconstructive knee surgery (e.g., younger than 55 years);
  - Size of the cartilage lesion is 1.0 - 2.0 cm^2;
  - Focal full-thickness (grade III or IV) cartilage lesions on the weight-bearing surface of the femoral condyles (medial or lateral) or trochlea;
  - Documented minimal to absent degenerative changes in the surrounding articular cartilage (Outerbridge grade II or less) and normal-appearing hyaline cartilage surrounding the border of the defect;
  - Presence of persistent symptoms (e.g., pain, swelling and catching/locking) that significantly limit activities of daily living;
  - Presence of stable ligaments (if ligaments are unstable, documentation should be provided as to how this condition will be addressed);
  - No malalignment present (if malalignment is present, documentation should indicate planned concurrent correction of alignment).
- 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. If osteochondral allografting or autografting surgery is performed and medical necessity criteria are not met, any associated procedures will not be covered. This includes, but is not limited to, professional, facility, and anesthesia services, as well as supplies.

Extracranial Carotid Angioplasty / Stenting

- The policy title has been revised from "Carotid Angioplasty/Stenting" to "Extracranial Carotid Angioplasty/Stenting".
- All of the policy statements have been updated as follows:
- Extracranial carotid angioplasty with associated stenting and embolic protection may be considered medically necessary for patients who require revascularization AND who are either:
  - Symptomatic with a carotid stenosis of 50% or higher as documented by catheter angiography or 70% or higher as documented by noninvasive imaging OR
  - Asymptomatic with a carotid stenosis of 80% or higher, AND

Medical and Behavioral Health Policy Update

  - Patient meets one or more of the following criteria:
    A. Patient has an anatomic contraindication for carotid endarterectomy such as prior radiation treatment to the neck, neck surgery, spinal immobility, tracheostomy or lesions that are surgically inaccessible (e.g., lesions above level C2 or below the clavicle, lesions obstructed by neck tumor, high bifurcation requiring mandibular dislocation); OR
    B. Patient is at high risk for adverse events from CEA. Anatomic features and/or comorbid conditions that are associated with high risk include but are not limited to:
      - Contralateral carotid occlusion
      - Previous CEA with recurrent stenosis
      - Contralateral laryngeal nerve palsy
- 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. Coverage is limited to procedures using FDA-approved carotid stenting systems performed at a CMS-approved carotid artery stenting facility.

Policies inactivated

Fetal Fibronectin Enzyme Immunoassay

Medical and Behavioral Health Policy Activity

There was no policy activity for December 2011.

Medical and Behavioral Health Policy Activity

Policies Effective: 04/30/12 Notification Posted: 01/26/12

Policies developed

Implantation of Intrastromal Corneal Ring Segments

- Implantation of intrastromal corneal ring segments may be considered medically necessary for the treatment of keratoconus in patients 21 years of age or older who meet the following criteria:
  - The patient has experienced a progressive deterioration in their vision, such that they can no longer achieve adequate functional vision with contact lenses or spectacles; AND
  - Corneal transplantation is the only alternative to improve their functional vision; AND
  - The patient has a clear central cornea with a corneal thickness of 450 microns or greater at the proposed incision site.
- Pre-Certification/Pre-Authorization: No. All interventions performed for refractive purposes only, including corneal ring implantation, are generally contractually excluded.

Medical and Behavioral Health Policy Update

Policies revised

Psychological and Neuropsychological Testing

- All of the policy statements have been updated as follows:
- I. Psychological and/or Neuropsychological Testing
  - Psychological testing and/or neuropsychological testing may be considered medically necessary when all of the following criteria have been met in addition to criteria specific to the type of testing listed in sections II and III:
    1. Testing is supervised and interpreted by a physician or by a PhD or master's-level licensed psychologist;
    2. Results of testing will be used to facilitate the individual's treatment by helping to establish the diagnosis of, and develop or modify a treatment plan for, a psychiatric or neuropsychological disorder;
    3. Testing instruments and time allotted for testing are appropriate for and limited to the unique clinical presentation of the individual; AND
    4. The most current versions of validated and reliable psychological and neuropsychological testing instruments are utilized, or if an older version is used, there is specific rationale for use of that version.
- II. Psychological Testing
  - Psychological testing may be considered medically necessary when testing is required for any of the following criteria in addition to those listed in section I:
    - To aid in differential diagnosis of a mental health condition when a individual's symptoms and presentation are not readily attributable to a particular psychiatric diagnosis despite previous comprehensive psychiatric/psychological evaluation and the questions answered by testing will improve diagnostic clarity and efficacy of treatment planning; OR
    - To develop or modify a treatment plan when an individual who has received mental health treatment intervention is not achieving the expected results and appropriate revisions or alternatives are unclear.
- III. Neuropsychological Testing
  - Neuropsychological testing may be considered medically necessary when testing is required for any of the following criteria in addition to those listed in section I:
    - To evaluate the extended pediatric age range (birth to 21) when there is a suspected delay or impairment in the development of cognitive skills or neurocognitive functioning; OR
    - To evaluate an individual who has experienced a significant change in mental status, behavior change or memory disturbance that is felt to be secondary to congenital or acquired brain injury or disease; OR
    - To assess baseline psychological or neurocognitive function prior to a procedure that has a high likelihood of resulting in psychological or neurocognitive change. Examples include but are not limited to:
      - Resection of brain tumors and arteriovenous malformations,
      - Surgical resection of seizure foci in epilepsy,
      - Solid organ transplantation, OR
      - Stem cell transplantation.
- IV. Psychological and/or neuropsychological testing is considered not medically necessary for the following:
  - Solely for diagnosis or management of chronic fatigue syndrome.
  - Solely for diagnosis or management of attention-deficit/hyperactivity disorder (ADHD) in the absence of other signs or symptoms suggestive of other mental health or neurocognitive disorders which meet medical necessity requirements for testing.

Medical and Behavioral Health Policy Update

  - Baseline testing in the absence of signs/symptoms of injury or illness.
  - Solely for presurgical assessment unless the criterion for baseline testing prior to surgery listed above is met.
  - Testing is performed while an individual is abusing substances or having acute withdrawal symptoms.
  - Testing is predominately for academic or educational purposes.
- V. Brief rating scales, screening tools and questionnaires, including self administered or self scored inventories, that can be done as part of a professional visit are considered incidental to the visit and should not be charged for separately. Rating scales and checklists are used to augment a clinician's evaluation of the patient. Examples of instruments considered incidental to a professional visit include, but are not limited to, the CAGE questionnaire, Beck Depression Inventory (BDI), pain assessment scales, the Patient Health Questionnaire (PHQ-9), and the Mini-Mental State Examination.
- Pre-Certification/Pre-Authorization: Yes. Psychological and/or neuropsychological testing in some settings is subject to the member's contract benefits. The member's benefit language should be verified.

Infliximab

- The policy has been updated to include the following statements:
- Use of infliximab may be considered medically necessary for the following FDA-approved indications:
  - Rheumatoid Arthritis
    - Used in combination with methotrexate, for reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in patients with moderately to severely active rheumatoid arthritis.
  - Crohn's Disease
    - For reducing signs and symptoms and inducing and maintaining clinical remission in adult and pediatric patients who are six years of age or older with moderately to severely active Crohn's disease who have had an inadequate response to conventional therapy.
    - For reducing the number of draining enterocutaneous and rectovaginal fistulas and maintaining fistula closure in adult patients with fistulizing Crohn's disease.
  - Ankylosing Spondylitis
    - For reducing signs and symptoms in patients with active ankylosing spondylitis.
  - Psoriatic Arthritis
    - For reducing signs and symptoms of active arthritis, inhibiting the progression of structural damage, and improving physical function in patients with psoriatic arthritis.
  - Plaque Psoriasis
    - Patient has moderate to severe psoriasis with either of the following:
      - Greater than 5% of body surface area with plaque psoriasis; OR
      - Less than or equal to 5% body surface area with plaque psoriasis involving sensitive areas or areas that would significantly impact daily functioning (e.g., palms, soles of the feet, head/neck, or genitalia) AND
    - Dermatologist or physician with expertise in treating moderate to severe psoriasis prescribes the therapy; AND
    - Patient must have documented failure of treatment with phototherapy (UVB or PUVA) OR topical and systemic therapy (methotrexate, cyclosporine, or acitretin) OR have a medical contraindication to these treatments.
  - Ulcerative Colitis
    - For reducing signs and symptoms, inducing and maintaining clinical remission and mucosal healing, and eliminating corticosteroid use in adult patients with moderately to severely active ulcerative colitis who have had

Medical and Behavioral Health Policy Update

an inadequate response to conventional therapy.
  - For reducing signs and symptoms and inducing and maintaining clinical remission in pediatric patients who are six years of age or older with moderately to severely active ulcerative colitis who have had an inadequate response to conventional therapy.
- Other uses of infliximab are considered investigative, including, but not limited to:
  - Age-related macular degeneration;
  - Alcoholic hepatitis;
  - Arthritis (other than rheumatoid arthritis and psoriatic arthritis);
  - Behcet syndrome;
  - Behcet syndrome uveitis;
  - Cancer cachexia;
  - Depression;
  - Diabetic macular edema;
  - Endometriosis;
  - Erythrodermic or exfoliative psoriasis;
  - Giant cell arteritis;
  - Graft-versus-host disease;
  - Intra-articular injections;
  - Juvenile idiopathic arthritis;
  - Juvenile idiopathic arthritis-associated uveitis;
  - Kawasaki syndrome;
  - Polyarteritis nodosa;
  - Polymyalgia rheumatica;
  - Renal cell carcinoma;
  - Sacroiliitis;
  - Sarcoidosis;
  - Sclerosing cholangitis;
  - Sjogren syndrome;
  - Systemic lupus erythematosis;
  - Systemic necrotizing vasculitides;
  - Systemic sclerosis;
  - Takayasu's Arteritis
  - Wegener's granulomatosis.
- 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. 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.

Ventricular Assist Devices and Total Artificial Hearts

- The policy has been updated to include the following statement:

Medical and Behavioral Health Policy Update

- Percutaneous ventricular assist devices (pVADs) are considered investigative for all indications, 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.

Policies inactivated

Human Papillomavirus Vaccine

- Coverage for the HPV vaccine is based on recommendations from the Advisory Committee on Immunization Practices (ACIP) and is addressed through the preventive health benefit. Therefore, a medical policy is no longer needed.

Policies reviewed with no changes in October/November 2011 and January 2012

Acne Treatment/Skin Rejuvenation

Actigraphy

Allogeneic Hematopoietic Stem-Cell Transplantation for Genetic Diseases and Acquired Anemias

Altered Auditory Feedback for Treatment of Stuttering

Ambulatory Blood Pressure Monitoring (ABPM) (Sphygmomanometry)

Ambulatory Event Monitors and Mobile Outpatient Cardiac Telemetry

Anesthesia Services for Gastrointestinal Endoscopic Procedures

Anterior Eye Segment Optical Imaging

Autism Spectrum Disorders: Assessment

Autologous Hematopoietic Stem-Cell Transplantation for Malignant Astrocytomas and Gliomas

Automated External Defibrillator for Home Use

Axial (percutaneous) Lumbar Interbody Fusion (ALIF)

Balloon Catheter Therapy for Chronic Sinusitis

Bioimpedance Spectroscopy Devices for the Detection and Management of Lymphedema

Bone Morphogenetic Protein (BMP)

Breast Implants

Buprenorphine for Withdrawal and Treatment of Opioid Dependence

Communication Assist Devices

Computed Tomography (CT) to Detect Coronary Artery Calcification

Computed Tomography Angiography (CTA) for Evaluation of Coronary Arteries

Cooling/Heating Devices Used in the Outpatient Setting

CT Colonography (Virtual Colonoscopy)

Dermatoscopy

Durable Medical Equipment (DME)

Medical and Behavioral Health Policy Update

Electromagnetic Navigation Bronchoscopy
Electrotherapy/Electrotherapeutic Devices
Extracorporeal Shock Wave Treatment for Plantar Fasciitis and Other Conditions
Functional Neuromuscular Electrical Stimulation Devices
Genetic Testing for Familial Alzheimer's Disease
Growth Hormone Treatment
Hematopoietic Stem-Cell Transplantation for Acute Lymphoblastic Leukemia
Hematopoietic Stem-Cell Transplantation for Autoimmune Disease
Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia
Hematopoietic Stem-Cell Transplantation for Hodgkin Lymphoma
Hematopoietic Stem-Cell Transplantation for Miscellaneous Solid Tumors in Adults
Hematopoietic Stem-Cell Transplantation for Myelodysplastic Syndrome and Myeloproliferative Neoplasms
Laboratory Tests for Heart Transplant Rejection
Left Atrial Appendage Occluder Devices
Microarray-based Gene Expression Testing for Cancers of Unknown Primary
Monoclonal Antibody Therapy for Allergic Asthma
MRI-Guided High Intensity Focused Ultrasound Ablation of Uterine Fibroids and Other Tumors
Neurofeedback/Electroencephalogram (EEG)
Nutritional Support
Occlusion of Uterine Arteries as Treatment for Uterine Fibroids
Orthognathic Surgery
Oscillatory Devices for the Treatment of Cystic Fibrosis and Other Respiratory Disorders
Pegloticase (KRYSTEXXA)
Percutaneous Electrical Nerve Stimulation (PENS) or Percutaneous Neuromodulation Therapy (PNT)
Percutaneous Vertebroplasty, Kyphoplasty, and Sacroplasty
Peripheral Arterial Tonometry
Pneumograms
Prophylactic Mastectomy
Pulmonary Rehabilitation
Refractive Eye Surgery
Rosacea Treatment
Scanning Laser Technologies for Glaucoma Testing and Monitoring
Scar Excision/Revision
Selective Internal Radiation Therapy

Medical and Behavioral Health Policy Update

Serum Holo-transcobalamin as a Marker of Vitamin B12 Status

Spinal Cord Stimulation

Subtaler Arthroereisis

Suprachoroidal Delivery of Pharmacologic Agents

Thrombopoietin Mimetic Agents for Immune Thrombocytopenic Purpura

Transanal Endoscopic Microsurgery (TEMS)

Treatment for Severe Primary Insulin-Like Growth Factor-1 (IGF-1) Deficiency

Treatment for Temporomandibular Joint Disorder (TMD)

Treatment of Meniere's Disease

Treatment of Psoriasis (Phototherapy and Biologics)

Treatment of Pulmonary Arterial Hypertension with Prostacyclin Analogues, Endothelin Receptor Antagonists, or Phosphodiesterase Inhibitors

Treatment of Urinary Dysfunction

Tumor Markers, Urinary

T-Wave Alternans

Ultrasound-Guided High Intensity Focused Ultrasound Ablation for treatment of Prostate Cancer and Other Tumors

Uterine Activity Monitoring (Home, Ambulatory)

Wearable Cardioverter-Defibrillators as a Bridge to Implantable Cardioverter-Defibrillator Placement

Wheelchairs

FYI

Provider Manual Updates

The following is a list of Blue Cross and Blue Shield of Minnesota provider manuals that have been updated from December 2011, to February 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	Updated the language to this section in connection with annual review of policies and procedures
Provider Policy and Procedure Manual	Chapter 8 – Claims Filing	Licensed practical nurse and school nurse specialties have been termed and removed from this chapter
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines - Anesthesia	• HICF 1500 references deleted • Qualifying circumstances • Epidural anesthesia • 837P added
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines-Coding	Reimbursement of HCPCS codes, page 11-2
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines- Behavioral Health	Removed certified residential sex offender treatment facility from codes H2028 and H2029

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**
Provider services	**(651) 662-5200** or **1-800-262-0820**
Please verify these numbers are correctly programmed into your office phones.	

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.

03/12

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