Provider Press

December 2011 / Vol. 15, No. 4

For the health of all.

Blue Cross and Blue Shield of Minnesota announces two new High Performance networks

Two new High Performance networks which offer employers deeper savings while retaining open access to high quality providers have been developed for use with employer accounts for the upcoming 2012 benefit year.

The new networks, named Blue Performance Enhanced and Blue Performance Basic, are multi-tier and are based on provider Total Cost of Care calculations and discount savings respectively. Providers were assigned to Tier 1 or Tier 2 in each of the networks based on the data analysis methodologies summarized below.

Blue Performance Enhanced tier assignment methodology

In the Enhanced network, providers are assigned to Tier 1 or Tier 2 based on Total Cost of Care analysis as performed by a third party health information and analytics organization. Care Systems comprising both hospitals and clinics as part of the same system under one provider service agreement were assigned together into either Tier 1 or Tier 2.

To determine tier placement, a stratification line was set at a specific, optimized Total Cost of Care threshold. Providers with a lower Total Cost of Care than the threshold amount were placed in Tier 1. Providers with a higher Total Cost of Care than the threshold amount were placed in Tier 2. Providers with no Total Cost of Care data were defaulted to Tier 1 for 2012. However, as data access and analysis of specialists and independent hospitals become available, providers who were defaulted to Tier 1 the first year may find their position changing in future years. The network will be analyzed and updated annually, using the same methodology described above. This network is currently being offered to fully insured commercial employer accounts for use in the January 1, 2012 benefit year.

Blue Performance Basic tier assignment methodology

In the Basic network, providers are assigned to Tier 1 and Tier 2 based on their aggregate discount percentage. An optimum threshold was determined through analysis of current discount data and depending on whether the provider's current discount is greater than or less than this threshold, the provider is assigned to Tier 1 or Tier 2 respectively. The Basic network will also be analyzed and updated annually. This network is not currently being offered to employer accounts, but may be used in the future under specific circumstances.

Additional information

For information on your clinic or facility tier placement in the Blue Performance Enhanced network, go to **providers.bluecrossmn.com.**

continued on page 2

Provider Press

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

2012 Holiday schedule

Provider services will be closed on the following days in 2012:
Monday, January 2
Monday, May 28
Wednesday, July 4
Monday, September 3
Thursday, November 22
Friday, November 23
Monday, December 24
Tuesday, December 25

With the exception of the dates stated above representatives answering the provider services numbers are available to assist you 8 a.m. to 5 p.m. Monday through Thursday, and 9 a.m. to 5 p.m. on Friday.

Inside preview

FYI

Publications available online

The following is a list of Quick Points and Bulletins published from September 2011 to November 2011 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
QP12-11	Narcotic analgesic and combination pain medication quantity limits
QP13-11	Changes to Access Management Program
QP14-11	Lessons learned for the HIPAA transactions
QP14R1-11	Revision: Lessons learned for the HIPAA 5010 transactions
QP15-11	Information needed when submitting unlisted drug codes
QP16-11	Change in PCA billing requirements
QP17-11	Respiratory assist devices for Minnesota Health Care Programs (MHCP) members
QP19-11	Change in inpatient billing requirements for MinnesotaCare Basic Plus One members
QP20-11	Blue Cross and Blue Shield of Minnesota announces two new High Performance networks
Bulletins	**Title**
P17-11	October ICD-9-CM and HCPCS code updates
P18-11	Requirements for clinical supervision under the new Minnesota rule part 9505.0371
P19-11	Blue Cross changes no-cost claim entry tool vendor
P20-11	Modifier -73 reduction
P21-11	New pre-certification and concurrent review requirements
P22-11	Discontinuation of paper remittances- register with Availity now!
P23-11	Changes regarding coverage of EIBI services for Autism Spectrum Disorder for MHCP members

High Performance network, continued from page 1

As with Blue Cross and Blue Shield of Minnesota's other multi-tier network offerings, the network name will be visible on the front of the member's identification card. All provisions of your current Provider Service Agreement continue to apply to these new networks.

Questions?

If you have questions, please contact provider services at **(651) 662-5200** or toll free at **1-800-262-0820**.

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 September 2011 to November 2011. 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 1 – At Your Service	Clarification as to how to contact Utilization Management directly
Provider Policy and Procedure Manual	Chapter 4 – Care Management	Pre-certification/pre-authorization urgent request turnaround time changed from 24 hours to 72 hours to comply with U.S. Department of Labor requirements
Provider Policy and Procedure Manual	Chapter 8 – Claims Filing	Late charges exceptions added
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Modifiers section	• Modifier 73 guidelines added • Modifiers 80, 81 and 82 "physician assistant" added • Modifiers defined by Department of Human Services (DHS) - revisions to all modifiers
Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Medical Services section	• Information for Minnesota Health Care Programs (MHCP) payment for 90461 added • Discarded vial or package reporting removed

Quality Improvement

Upcoming 2012 HEDIS Chart Abstraction Season

In March 2012, Blue Cross will send an informational letter to clinics where chart abstraction services will be required to capture HEDIS® data. The data obtained from chart abstraction includes specific test results, blood pressure readings and information that does not show up in administrative claims alone. The combination of claims and chart abstraction data provides a more complete picture of the care given to our members. We appreciate all you do in helping us meet this important quality improvement goal.

HEDIS is a comprehensive set of performance indicators that ensures purchasers and consumers have the information they need to reliably compare the performance of managed health care plans and to help them select the best health plan for their needs. HEDIS is used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. Health plans also use HEDIS results themselves to see where they need to focus their improvement efforts.

The performance measures in HEDIS are related to many significant public health issues such as immunizations, cancer, heart disease, smoking, pre- and post-natal care and diabetes. In addition, HEDIS also includes a standardized survey of consumers' experiences that evaluates plan performance in areas such as customer service, access to care and claims processing. HEDIS measures are supported and maintained by the NCQA, an independent, not-for-profit organization dedicated to measuring the quality of America's health care.

"HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)."

For additional information on HEDIS, you may want to read our Provider Quick Points (QP19-10) entitled *Do you know what HEDIS can do for your clinic?* Available online at **providers.bluecrossmn.com**.

Coding Corner

ICD-10

Are you prepared? Are you tired of hearing about ICD-10? We know you've heard it before but it bears repeating. You can't be Dorothy, click your heels and wish you were in Kansas again (or back to ICD-9 as the case may be). October 1, 2013 is coming and the change to ICD-10 is going to have significant impact on providers starting with the way you document conditions and ask questions of the patient about their condition.

- Act now to educate yourself on what you will need to do differently and begin to prepare for use of the new code set.
- Talk to your vendor about upcoming changes and what you need to do to be ready to use ICD-10.
- Don't expect the date to change!

Like clockwork

At the time this article was written nary a 2012 HCPCS code was in sight. But by the time you read this the codes will be published and in hand. So just a reminder – the January 2012 HCPCS are coming.

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

And as always, we will accept all new and revised HCPCS codes with a date of service of January 1, 2012 or after. Likewise, we will reject all discontinued codes with a date of service of January 1, 2012 or after.

Modifier -57 reminder

The -57 modifier (decision for surgery) is used to indicate an evaluation and management (E/M) service resulted in the initial decision to perform surgery either the day before or the day of a major surgical procedure (90 day global period). Do not append this modifier when a minor surgical procedure (0, 10 day global period) is performed.

Modifier -57 should **not** be used to report an E/M service that was pre-planned or prescheduled the day before or the day of surgery, as the E/M would be included as part of the global surgical package. Patients are normally reevaluated on the date of the actual surgery to assure the service can be performed. That clearance would be included in the global period and should not be reported separately.

If appropriate, the modifier -57 may be appended to an E/M service, but the presence of the -57 modifier does not guarantee separate payment of the E/M. To assure the visit is supported, separate payment of the E/M may be considered only on appeal.

Pharmacy Corner

Narcotic analgesic and combination pain medication quantity limits

Introduction

Chronic pain is among the most common reasons for seeking medical attention and is reported by 20 to 50 percent of patients seen in primary care.[1,2] The consequences of under-treatment of pain can include decreased healing, increased costs and resource use, slower return to functioning and decreased quality of life.[3]

While prescription narcotic analgesic and combination pain medications are essential tools in the treatment of moderate to severe pain, these drugs have been associated with important problems including misuse, abuse, diversion and increased economic burden to society.[3] In 2001, the total cost of prescription opioid abuse was estimated at $8.6 billion, including workplace, health care and criminal justice expenditures. One study of commercially insured beneficiaries in the United States found that mean per-capita annual direct health care costs from 1998 to 2002 were nearly $16,000 for abusers of prescription and nonprescription opioids compared with approximately $1,800 for nonabusers who had at least one prescription insurance claim[3]. The challenge for clinicians is to prescribe and monitor response to opioid therapy in a way that balances their ability to relieve pain and improve function, while mitigating potential risks.[4]

Acting on our findings

As part of our continued efforts to evaluate and update our formularies, Blue Cross and Blue Shield of Minnesota recently reviewed narcotic analgesic and combination pain medications, considering safety and usage details, as well as FDA approved product labeling.

Based on our analysis of prescription claims, we identified the following factors:

- Thirteen percent of members prescribed these drugs, take doses greater than what is recommended according to FDA-approved labeling.
- Increased dosing frequency of combination products including acetaminophen, may increase the likelihood of exceeding the 4g maximum total dose of acetaminophen per day.

At the end of August, members and their providers received letters if prescribed medications exceeded the quantity limit threshold for those medications. Providers were asked to work with their patients to re-evaluate pain medication needs. Members received letters letting them know that their pain medication exceeded the quantity limits and asked them to work with their provider to re-evaluate their medication. Beginning October 1, 2011, members' pain medication prescriptions were filled up to the quantity limit, which gave them time to talk with their physician and decide on the best course of action.

In total, 3,339 provider and 4,159 member letters were mailed. To date, Blue Cross customer service and the pharmacy department have received a limited number of inquiries about this quantity

continued on page 7

Pharmacy Corner

Medication quantity limits, continued from page 6

limit intervention, indicating members and providers were able to have necessary conversations regarding pain medication therapy before the quantity limit went into effect.

Conclusion

Balancing the risks and benefits of pain management therapy can be challenging, and there may not be pain management support teams available in all communities. Within the references below, you may find practical information to assist you in the care of your patients who suffer from chronic pain. Public domain websites are provided as they were found to be available.

References

1. Elliott AM, Smith BH, Penny KI, et al. The epidemiology of chronic pain in the community. Lancet 1999: 354:1248.
2. Gureje O, Von Korff M, Simon EE, Gater R. Persistent pain and well-being: a World Health Organization Study in Primary Care. JAMA 1998; 280:147.
3. Strassels, SA. Subject Review: economic burden of prescription opioid misuse and abuse. J Manag Care Pharm. 2009;15(7):556-62. http://www.amcp.org/data/jmcp/556-562.pdf
4. Chou R. Review Article: 2009 Clinical guidelines for the American Pain Society and the American Academy of Pain Medicine on the use of chronic opioid therapy in chronic noncancer pain. Pol Arch Med Wewn. 2009;119 (7-8):469-477. http://tip.org.pl/pamw/issue/article/372.html

Additional Resources

1. VA/DoD Clinical Practice Guideline for management of opioid therapy for chronic pain; Department of Veterans Affairs and the Department of Defense. Prepared by the Management of Opioid Therapy for Chronic Pain Working Group, May 2010. (See Discontinue Opioid Therapy, pages 83-89 of the 159 pg. document). http://va.gov/PAINMANAGEMENT/docs/CPG_opioidtherapy_fulltext.pdf
2. CMS/Centers for Medicare and Medicaid Services. https://www.cms.gov/FraudAbuseforProfs/
3. Canadian Guideline for Safe and Effective Use of Opioids for Chronic Noncancer Pain. http://nationalpaincentre.mcmaster.ca/documents/opioid_guideline_part_b_v5_6.pdf
4. Recommendations Roadmap provides a summary of recommendations contained within the Guidelines http://nationalpaincentre.mcmaster.ca/opioid/cgop_b00_figure_01_recommendations_roadmap.html

   Within Recommendation 9, Table B-9.1: Opioid Suggested Initial Dose and Titration may provide helpful information when initiating a trial of opioid therapy for patients. http://nationalpaincentre.mcmaster.ca/opioid/cgop_b02_r09.html?tab=1

Pharmacy Corner

Reminder: Pharmacy Benefit for Aspirin, Calcium and Vitamin D for Seniors with Medicaid Coverage

Blue Plus has participated in two collaborative projects to increase the appropriate use of supplements:

- low dose aspirin for SecureBlue (MSHO) and Blue Advantage (MSC+) members with ischemic heart disease and diabetes mellitus and
- calcium and vitamin D for SecureBlue (MSHO) and Blue Advantage (MSC+) members who live in the community.

A pharmacy benefit is provided for these supplements for seniors with Medicaid coverage. When physicians, nurses and pharmacists prescribe covered supplements, you increase the likelihood of patients using them by reducing the financial barrier.

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

Medical and Behavioral Health Policy Update

Medical and behavioral health policies are available for your use and review on the Blue Cross and Blue Shield of Minnesota website at **providers.bluecrossmn.com**. From this site, there are two ways to access medical policy information depending on the patient's Blue Plan membership.

For out-of-area Blue Plan patients:

Select "Medical Policy PreCert/PreAuth Router" and click Go. You will be taken to the page where you select either medical policy or pre-certification/prior authorization and enter the patient's three-letter alpha prefix as found on their member identification card, and click Go. Once you accept the requirements, you will be routed to the patient's home plan where you can access medical policy or pre-certification/pre-authorization information.

For local Blue Cross and Blue Shield of Minnesota plan patients:

Select "Medical policy" (under the Tools & Resources), read and accept the Blue Cross Medical Policy Statement, and then select "View All Active Policies." You have now navigated to the Blue Cross and Blue Shield of Minnesota Medical and Behavioral Health Policy Manual, where there are several selections to assist with your inquiry.

The "What's New" section identifies our latest new or revised policies approved by Blue Cross' Medical and Behavioral Health Policy Committee at least 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

There was no policy activity for July, 2011.

Medical and Behavioral Health Policy Activity

Policies Effective: 11/28/11 Notification Posted: 08/24/11

Policies developed

Gene Expression Testing to Predict Coronary Artery Disease (CAD)

- Gene expression testing to predict coronary artery disease is considered investigative. There is a lack of clinical evidence demonstrating its impact on improved health outcomes.
- Prior 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

Phosphodiesterase-5 Inhibitors

- The policy has been updated to include the following statement:
- Coverage of medications referred to in this policy is 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.
- All of the policy statements have been updated as follows:
- The use of Viagra®, Cialis®, Levitra® or Staxyn® may be considered medically necessary for the FDA-approved indication of erectile dysfunction.
- The off-label use of Viagra®, Cialis®, Levitra®, or Staxyn® may be considered medically necessary for the following indications:
  - Raynaud's phenomenon, when the condition has been resistant to treatment with calcium channel blockers;
  - Preservation of erectile function following nerve-sparing radical retropubic prostatectomy, for one year post-surgery;
  - Female sexual dysfunction secondary to use of antidepressants.
- The off-label use of Viagra®, Cialis®, Levitra®, or Staxyn® for any other indication is considered investigative.
- Prior authorization: Yes, for the following indications:
  - On-label use of Revatio™ or Adcirca™ (e.g., for treatment of pulmonary arterial hypertension) and
  - Off-label use of any phosphodiesterase-5 inhibitor

Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease (GERD)

- The policy has been updated with the following statement:
- Use of the following transesophageal endoscopic therapies for gastroesophageal reflux disease (GERD) is considered investigative due to a lack of clinical evidence indicating their impact on improved health outcomes and their benefit compared to established alternatives:
  - Endoscopic gastroplasty/gastroplication;
  - Radiofrequency energy delivery;
  - Implantation of inert polymers or polymethylmethacrylate (PMMA) beads.
- Prior authorization: Not applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Medical and Behavioral Health Policy Update

Medical and Surgical Treatment of Gender Identity Disorder

- The policy has been updated to include criteria based on the "Standards of Care for Gender Identity Disorders, Sixth Version" published by the World Professional Association for Transgender Health (WPATH) and WPATH Clarification on Medical Necessity, 2008.
- All of the policy statements have been updated as follows:
- Treatment of gender identity disorder may be considered medically necessary when all of the following criteria have been met. These criteria are based on the "Standards of Care for Gender Identity Disorders, Sixth Version" published by the World Professional Association for Transgender Health (WPATH) and WPATH Clarification on Medical Necessity, 2008.
  1. There has been a persistent preoccupation lasting at least 2 years, with changing one's primary and secondary sex characteristics to those of the opposite sex.
  2. A comprehensive diagnostic evaluation has been completed by a psychiatrist, a clinical psychologist, or other licensed mental health professional* who is experienced in the evaluation and treatment of Transsexualism/ Gender Identity Disorder. The comprehensive evaluation included a chemical health assessment, and pertinent laboratory testing such as a urine drug screen and blood tests, if indicated. Based on the comprehensive evaluation, the individual meets the diagnostic criteria for Transsexualism per the International Classification of Diseases-10 (ICD-10) AND the diagnostic criteria for Gender Identity Disorder of Adulthood per the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV).
     - *Mental health professionals engaged in evaluation of the individual must have competence in the diagnosis of sexual and gender identity disorders, as well as in diagnosing possible comorbid disorders such as psychotic disorders, personality disorders, and substance related disorders. The diagnostician and primary treating clinician must have proven competence in general psychotherapy, sex therapy, and gender counseling / therapy. They must also meet the minimum licensing requirements for independent practice at the doctoral (Ph.D or M.D.) level.
     - *If the level of competence of the evaluating or treating mental professional is uncertain, the health plan will seek a second opinion from a known expert in the diagnosis and treatment of GIDs.
- Psychological treatment recommendations
  3. Components of treatment should include facilitation of identity formation, sexual identity management, and aftercare. It is highly recommended that all members who have GID actively participate in psychotherapy, psychosocial treatment, education, and/or supportive sessions related to gender transition.
  4. The number of psychotherapy sessions is based on the recommendations of the primary mental health professional in collaboration with the member.
  5. If chemical dependency is present, treatment must be completed and a minimum of three months of sobriety maintained prior to initiation of biological interventions.
  6. Treatment is begun for any co-morbid psychopathology prior to facilitation of identity formation. There must be substantial progress in managing these co-morbidities resulting in a positive prognosis based on psychological testing, clinical assessment, and clinical judgment before work is begun to foster identity development.
- Additional requirements for cross-sex hormone therapy:
  7. The member must be at an age and level of maturity at which he or she is likely to take hormones in a responsible manner. Cross-sex hormone therapy may begin as early as age16, but generally should not be considered prior to that age.

Medical and Behavioral Health Policy Update

8. Prior to receiving cross-sex hormone therapy, the member must have demonstrable knowledgeable of what cross-sex hormones medically can and cannot do; and their social benefits and risks.
9. The member must have had a real-life experience living in the desired gender role of six months for adolescents or at least three months for adults; or a period of psychotherapy specified by the mental health professional after the initial evaluation.

- Additional requirements for breast surgery:

10. The member is 18 years of age or older. If less than 18, surgery may be considered if the member has had 2 years of real-life experience.
11. A comprehensive treatment plan has been developed by the primary licensed mental health professional in collaboration with any other clinician(s) involved in diagnosis or treatment of the disorder. Co-morbid disorders are identified.
12. Substantial progress has been made in mastering identified problems leading to improving or continuing stable mental health (including satisfactory control of problems such as sociopathy, substance abuse, psychosis and/or suicidality). This progress is reflected in the progress report.
13. Male-to-female members have completed 18 months of documented hormone therapy prior to breast augmentation.
14. One letter of recommendation for the surgery is provided to a health plan representative from the primary treating clinician. The letter must address the progress toward achieving the goals and objectives contained in the individual's treatment plan and reasons for the recommended surgical treatment. It should also contain documentation of satisfactory progress in psychotherapy or substance-related treatment (if required). The health plan and the physician responsible for breast removal or augmentation must receive this letter and recommendations for surgery and the surgical treatment must be authorized by the health plan prior to its occurrence.

- Additional requirements for genital surgery

15. The member is 18 years of age or older.
16. Requirements in numbers 10 and 11 have been met.
17. The member must complete12 months of continuous full-time hormonal therapy with appropriate follow-up (including monitoring laboratory values) prior to genital surgery. Hormonal therapy may be administered only to those without a medical contraindication.
18. Twelve months of successful continuous full-time real-life experience living in the desired gender role must be documented.
19. If required by the mental health professional, regular active participation in psychotherapy throughout the real-life experience at a frequency determined jointly by the member and the clinician.
20. The member must be fully aware of the costs, required lengths of hospitalizations, likely complications, and the post surgical rehabilitation requirements of various surgical approaches.
21. Demonstrable progress has been made in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health. Examples of such progress include development of a positive support system and control of problems such as sociopathy, substance abuse, psychosis, and suicidality.
22. Demonstrable progress has been made by the member in consolidating gender
23. Two letters of recommendation from licensed mental health professionals have been obtained; one must be from a

Medical and Behavioral Health Policy Update

licensed doctoral level clinical psychologist or a psychiatrist. One of these clinicians must be the member's primary treating psychotherapist. These letters must be presented to the health plan and to the surgeon prior to genital surgery.

- Surgical procedures to alter the gender-specific appearance of a member who has undergone or is planning to undergo gender reassignment surgery, include but are not limited to:
  - Facial hair removal
  - Blepharoplasty
  - Face lift
  - Facial bone reconstruction
  - Rhinoplasty
  - Liposuction
  - Reduction thyroid chondroplasty
- These procedures are subject to contract definitions for medical necessity or cosmetic surgery benefits, unless otherwise specified in the benefit chart.
- Note: Gender-specific services may be medically necessary for transgender persons appropriate to their anatomy. These include but are not limited to the following:
  1. Routine pap smears should be performed as recommended if cervical tissue is present in female-to-male transgender persons. If mastectomy is not performed, mammograms should be performed as recommended.
  2. Male-to-female transgender persons treated with estrogen should follow the same screening guidelines for breast cancer as those for all women. Screening for prostate cancer should be performed as recommended for those persons who have retained their prostate.
- Prior authorization: Yes, for surgical procedures for reassigning biological sex. Treatments for the purpose of reassignment of biological sex are subject to the member's contract benefits. Some contracts have no benefits. In others, benefits are listed in the benefit charts.

Implantable Middle Ear Hearing Aids (Semi-Implantable and Fully Implantable) for Moderate to Severe Sensorineural Hearing Loss

- The policy title has been revised from "Semi-Implantable Middle Ear Hearing Aid for Moderate to Severe Sensorineural Hearing Loss" to "Implantable Middle Ear Hearing Aids (Semi-Implantable and Fully Implantable) for Moderate to Severe Sensorineural Hearing Loss".
- The policy has been updated to include fully implantable middle ear hearing aids.
- Semi-implantable and fully implantable middle ear hearing aids are considered investigative due to a lack of evidence demonstrating an impact on improved health outcomes.
- Prior authorization: Not applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Injectable Clostridial Collagenase for Fibroproliferative Disorders

- The policy has been updated with the following statements:
- The use of injectable clostridial collagenase may be considered medically necessary for the treatment of adults with Dupuytren's contracture with a palpable cord, when the contracture measures 20 degrees or more at either the metacarpophalangeal (MCP) joint or the proximal interphalangeal (PIP) joint (excluding the thumb). Injections may be administered up to 3 times per cord at intervals not less than 4 weeks.

Medical and Behavioral Health Policy Update

- Additional injections of clostridial collagenase for Dupuytren's contracture (beyond that described above) are considered investigative due to a lack of evidence demonstrating an impact on improved health outcomes.
- The remainder of the policy is unchanged.
- Prior authorization: Yes. According to the FDA labeling for Xiaflex®, injections may be administered up to 3 times per cord at intervals not less than 4 weeks. Only 1 cord may be injected at a time. If there are other cords with contractures, each cord is injected in sequential order.

Intravitreal Corticosteroid Implants

- The policy title has been revised from "Intravitreal Corticosteroid Implants: Fluocinolone Acetonide" to "Intravitreal Corticosteroid Implants".
- All of the policy statements have been updated as follows:
- Fluocinolone acetonide intravitreal implant approved by the U.S. Food and Drug Administration (i.e., Retisert®) may be considered medically necessary to treat chronic (duration of one year or more) non-infectious uveitis affecting the posterior segment of the eye.
- A dexamethasone intravitreal implant approved by the U.S. Food and Drug Administration (i.e., Ozurdex™) may be considered medically necessary for the treatment of:
  - Non-infectious ocular inflammation, or uveitis, affecting the posterior segment of the eye, *or*
  - Macular edema following branch or central retinal vein occlusion.
- Corticosteroid intravitreal implants are considered investigative for all other uses including, but not limited to, the treatment of diabetic macular edema due to the lack of clinical evidence demonstrating their impact on improved health outcomes.
- Prior authorization: Yes.

MRI of the Breast

- The policy has been updated to include the following statements:
- MRI of the breast may be considered medically necessary for the following indications:
  - Screening for breast cancer in individuals with:
    - A personal history of breast cancer; *or*
    - Radiation to the chest between age 10 and 30 years; *or*
    - A known BRCA1 or BRCA2 mutation or at high-risk of a BRCA1 or BRCA2 mutation due to a known presence of the mutation in relatives; *or*
    - Li-Fraumeni syndrome, including first-degree relatives; *or*
    - Cowden and Bannayan-Riley-Ruvalcaba syndromes, including first-degree relatives; *or*
    - Peutz-Jeghers syndrome, including first-degree relatives; *or*
    - A family history of breast cancer in two or more first-degree relatives (i.e., biologic parent, sibling, offspring); *or*
    - A family history of premenopausal breast cancer in at least one first-degree relative (i.e., biologic parent, sibling, offspring); *or*
    - Lifetime risk of breast cancer of 20% or greater as identified by models that are largely defined by family history (e.g., the Claus, Tyrer-Cusick, BRCAPRO or modified Gail model).
    - Note: If an MRI request is based on a model of lifetime risk for development of breast cancer, documentation should include the model used and the calculated lifetime risk.

Medical and Behavioral Health Policy Update

- Detection of a suspected occult breast primary tumor in patients with axillary nodal adenocarcinoma (i.e., negative mammography and physical exam).
- Presurgical planning in patients with locally advanced breast cancer before and after completion of neoadjuvant chemotherapy to permit tumor localization and characterization.
- Determination of the presence of pectoralis major muscle/chest wall invasion in patients with posteriorly located tumor.
- Evaluation of symptoms and/or physical findings suggestive of local complications (i.e., rupture/deflation, capsular contracture) of breast implants.
- MRI of the breast is considered not medically necessary in evaluation for possible rupture of silicone breast implants in asymptomatic individuals.
- All other applications of MRI of the breast are considered investigative including but not limited to:
  - Screening for breast cancer in average-risk patients.
  - Screening for breast cancer when the sensitivity of mammography is limited (e.g., dense breasts, implants).
  - Diagnosis of low suspicion findings (i.e., BI-RADS* category 1-3) on conventional testing not indicated for immediate biopsy and referred for short-interval follow-up. Abnormal findings on mammography are categorized according to the level of suspicion of the findings. Patients with low-suspicion findings are often recommended to undergo short interval follow-up after 3-6 months for a period of up to two years instead of immediate biopsy.
  - Diagnosis of a suspicious breast lesion (i.e., BI-RADS* category 4-5) in order to avoid biopsy.
  - Screening of women with history of lobular carcinoma in situ (LCIS) in the absence of other factors that confer a higher risk of breast cancer, atypical lobular hyperplasia (ALH) or atypical ductal hyperplasia (ADH).
  - Evaluation of nipple discharge.
- The remainder of the policy is unchanged.
- Prior Authorization: Yes, except in individuals with biopsy proven breast cancer. Current breast cancer screening guidelines state that for those patients who meet criteria, a mammography and MRI should be performed annually.

Policies inactivated

None

Medical and Behavioral Health Policy Activity

Policies Effective: 09/29/11 Notification Posted: 09/29/11

Policies developed

None

Policies revised

Implantable Cardioverter-Defibrillator

- All of the policy statements have been updated as follows:
- Adults: The use of an implantable cardioverter-defibrillator (ICD) may be considered medically necessary for the treatment of ventricular tachyarrhythmias and for the prevention of sudden cardiac death in adults (18 years of age or older) when one of the following indications is present:
  - History of cardiac arrest due to ventricular fibrillation (VF) or ventricular tachycardia (VT) neither of which is due to reversible or transient causes; *or*
  - Spontaneous sustained VT, in patients with structural heart disease; *or*

Medical and Behavioral Health Policy Update

- Spontaneous sustained VT, in patients without structural heart disease, that is not amenable to other treatments; *or*
- Syncope of undetermined origin with clinically relevant, hemodynamically significant, sustained VT or VF induced at electrophysiological study; *or*
- Left ventricular (LV) dysfunction due to prior myocardial infarction (MI) in patients who are at least 40 days post-MI, have a left ventricular ejection fraction (LVEF) less than or equal to 30%, and are in New York Heart Association (NYHA) Class I*; *or*
- Ischemic dilated cardiomyopathy (IDCM) with NYHA Class II* or III* heart failure, documented prior myocardial infarction (MI), at least 40 days post MI, and measured left ventricular ejection fraction (LVEF) less than or equal to 35%; *or*
- Non-ischemic dilated cardiomyopathy (NIDCM) with NYHA Class II or III heart failure, and measured LVEF less than or equal to 35%; *or*
- Nonsustained VT due to prior MI, LVEF less than or equal to 40%, and inducible VF or sustained VT at electrophysiological study; *or*
- Long QT syndrome with syncope and/or VT while receiving beta blockers; *or*
- Hypertrophic cardiomyopathy (HCM) with one or more of the following risk factors:
  - Prior cardiac arrest;
  - Family history of HCM-related sudden cardiac death (SCD) in at least one first-degree relative;
  - Unexplained syncope within the previous 12 months;
  - Spontaneous nonsustained VT;
  - Spontaneous sustained VT;
  - Abnormal blood pressure response to exercise;
  - LV wall thickness greater than or equal to 30 mm.
  - The use of an implantable cardioverter-defibrillator is considered investigative for all other indications in adults.
  - *New York Heart Association (NYHA) Functional Classification
    - Class I - No limitation of physical activity.
    - Class II - Slight limitation of physical activity.
    - Class III - Marked limitation of physical activity
    - Class IV - Unable to carry out any physical activity.
  - Pediatrics: The use of an implantable cardioverter-defibrillator may be considered medically necessary in children and adolescents (< 18 years of age) who meet any of the following criteria:
    - Survivors of cardiac arrest, after reversible causes have been excluded; or
    - Symptomatic, sustained ventricular tachycardia in association with congenital heart disease in patients who have undergone hemodynamic and electrophysiologic evaluation; or
    - Congenital heart disease with recurrent syncope of undetermined origin in the presence of either ventricular dysfunction or inducible ventricular arrhythmias.
  - The use of an implantable cardioverter-defibrillator (ICD) is considered investigative for all other indications in children and adolescents.
  - 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.

Medical and Behavioral Health Policy Update

Policies inactivated

None

Medical and Behavioral Health Policy Activity

Policies Effective: 01/03/12 Notification Posted: 09/29/11

Policies developed

Home Health Care

- I. Initial Requests: For initial requests: Home health care may be considered medically necessary when *all* of the following criteria are met:
  1. Be confined to the home (homebound).
     - Note: Homebound status not required for receiving palliative care services.
     - Homebound means that leaving home takes considerable and taxing effort or an individual is normally unable to leave the home unassisted. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by the state, or accredited to furnish adult day-care services in the state shall not disqualify an individual from being considered to be confined to his home. Any other absence of an individual from the home shall not disqualify him/her if the absence is of infrequent or of relatively short duration, including but not limited to religious services and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home. Homebound status is not determined by the lack of availability of transportation.
  2. Receiving services under a plan of care established and periodically reviewed by a physician;
  3. Be in need of skilled nursing care on an intermittent basis (up to 4 hours per visit and up to one visit per day) or physical therapy or speech-language pathology; or have a continuing need for occupational therapy.
  4. The required services must be appropriate for the treatment of the illness or injury.
  5. The services are provided in the member's private residence, not an inpatient or skilled nursing facility.
- II. Concurrent Review. For concurrent review: Continued home health 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 that the home care nurse, in consultation with the physician, has completed follow-up and outcome reassessments, at least every 60 days or more frequently according to the member's plan of care, which include all of the following:
     - A statement of goals including long and short term goals and need for home health care.
     - Documentation of education/training of the family and/or caregivers has been provided.
     - Expected course of the underlying disease and rehabilitation potential.
     - Identification of current and potential ongoing home health care needs, and
  3. Written documentation by the physician specifying the medical necessity, according to the criteria above, is required. Requested documentation must include, but is not limited to:
     - A completed Form CMS-485 – Home Health Certification and Plan of Care with the physician's order
     - Home care records

Medical and Behavioral Health Policy Update

- III. Home health care is considered not medically necessary in the following situations, including but not limited to:
  - If the member is in an acute inpatient hospital, inpatient rehabilitation, skilled nursing facility, intermediate care facility or a resident of a licensed residential care facility where skilled services are included.
  - Solely to allow respite for caregivers or member's family.
  - Homemaker services unrelated to enrollee's care except as incidental to a covered home health aide service.
  - Custodial care.
    - Custodial care is primarily for the purpose of assisting the individual in the activities of daily living such as assistance in walking, bathing, dressing, feeding, and supervision of medication that ordinarily would be self-administered, or in meeting personal rather than medical needs, which is not specific therapy for an illness or injury and 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 supervision required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation or rehabilitation potential.
- Pre-Certification/Pre-Authorization: Yes. Note: Please check benefit plan descriptions for coverage details regarding home care.

Laser and Photodynamic Therapy for Onychomycosis

- Use of the following therapies for onychomycosis is considered investigative due to a lack of evidence demonstrating an impact on improved health outcomes:
  - Laser treatment; and
  - Photodynamic therapy.
- 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.

Laboratory Testing to Allow Area Under the Curve (AUC) Targeted 5-Fluorouracil (5-Fu) Dosing for Patients Administered 5-Fu for Cancer

- OnDose™ testing or other types of assays for determining 5-fluorouracil area under the curve in order to adjust 5-FU dose for colorectal cancer patients or other cancer patients is considered investigative. There is lack of clinical evidence demonstrating its impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Not applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Policies revised

Hyperhidrosis Treatments

- Treatment of primary hyperhidrosis (axillary, palmar, plantar, or craniofacial) may be considered medically necessary in patients with one of the following indications in addition to those listed below for a specific focus of hyperhidrosis:
  - Presence of medical complications secondary to hyperhidrosis (e.g., acrocyanosis of the hands; history of recurrent skin maceration with bacterial or fungal infections; history of recurrent secondary infections; history of persistent eczematous dermatitis despite medical treatment with topical dermatological or systemic anticholinergic agents); *or*
  - Significant disruption of professional/personal life or significant functional impairment as a result of hyperhidrosis, as documented in the medical record.

Medical and Behavioral Health Policy Update

- Axillary Hyperhidrosis
  - The following treatments may be considered medically necessary for axillary hyperhidrosis:
    - Aluminum chloride 20% solution;
    - Botulinum toxin (intradermal injection) for severe primary axillary hyperhidrosis that is inadequately managed with topical agents in patients 18 years and older;
    - Endoscopic transthoracic sympathectomy (ETS) or surgical excision axillary sweat glands, when conservative treatment (i.e., aluminum chloride 20% solution) administered for a minimum of one month and botulinum toxin given sequentially or in combination) have failed.
  - Axillary liposuction or coagulation of sweat glands is considered investigative for axillary hyperhidrosis.
- Palmar Hyperhidrosis
  - The following treatments may be considered medically necessary for palmar hyperhidrosis:
    - Aluminum chloride 20% solution;
    - Botulinum toxin A (intradermal injection) for severe primary palmar hyperhidrosis that is inadequately managed with topical agents in patients 18 years and older;
    - Endoscopic transthoracic sympathectomy (ETS) when conservative treatment (i.e., aluminum chloride 20% solution) administered for a minimum of one month and botulinum toxin given sequentially or in combination have failed.
  - RimabotulinumtoxinB is considered investigative for treatment of palmar hyperhidrosis.
- Plantar Hyperhidrosis
  - Aluminum chloride 20% solution may be considered medically necessary for treatment of plantar hyperhidrosis.
  - The following treatments are considered investigative for plantar hyperhidrosis:
    - Botulinum toxin;
    - Endoscopic transthoracic sympathectomy.
- Craniofacial Hyperhidrosis
  - The following treatments may be considered medically necessary for craniofacial hyperhidrosis:
    - Aluminum chloride 20% solution;
    - Endoscopic transthoracic sympathectomy (ETS) when conservative treatment (i.e., aluminum chloride 20% solution administered for a minimum of one month) has failed.
  - Botulinum toxin is considered investigative for treatment of craniofacial hyperhidrosis.
- Iontophoresis
  - The use of iontophoresis in the home setting for any type of hyperhidrosis is considered self-help and ineligible for coverage.
- Pre-Certification/Pre-Authorization: Yes, only for endoscopic thoracic sympathectomy. However, other services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial of claims may result if criteria are not met.

Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting

- The policy title has been revised from "Non-Invasive Measurement of Left Ventricular End Diastolic Pressure (LVEDP)" to "Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting".
- The policy has been updated to include the following statement:
- In the ambulatory care and outpatient setting, cardiac hemodynamic monitoring for the management of heart failure utilizing thoracic bioimpedance, inert gas rebreathing, arterial pressure/Valsalva, or implantable direct pressure

Medical and Behavioral Health Policy Update

monitoring of the pulmonary artery is considered investigative due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Not applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Hematopoietic Stem-Cell Transplantation for Non-Hodgkin Lymphomas
- The policy has been updated with the following statements:
- For patients with non-Hodgkin's lymphoma (NHL) B-cell subtypes considered aggressive, either allogeneic stem-cell transplant (SCT) using a myeloablative conditioning regimen or autologous SCT may be considered medically necessary:
  - As salvage therapy for patients who do not achieve a complete remission (CR) after first-line treatment (induction) with a full course of standard-dose chemotherapy; *or*
  - To achieve or consolidate a CR for those in a chemosensitive first or subsequent relapse; *or*
  - To consolidate a first CR in patients with diffuse large B-cell lymphoma, with an age-adjusted International Prognostic Index score that predicts a high- or high-intermediate risk of relapse.
- For patients with mantle cell lymphoma:
  - Autologous SCT may be considered medically necessary to consolidate a first remission; *or*
  - Allogeneic SCT, myeloablative or reduced-intensity conditioning, may be considered medically necessary as salvage therapy; *or*
  - Autologous SCT is considered investigative as salvage therapy; *or*
  - Allogeneic SCT is considered investigative to consolidate a first remission.
- For patients with NHL B-cell subtypes considered indolent, either allogeneic SCT using a myeloablative conditioning regimen or autologous SCT may be considered medically necessary:
  - As salvage therapy for patients who do not achieve CR after first-line treatment (induction) with a full course of standard-dose chemotherapy; *or*
  - To achieve or consolidate CR for those in a first or subsequent chemosensitive relapse, whether or not their lymphoma has undergone transformation to a higher grade.
- Autologous SCT or allogeneic SCT is considered investigative:
  - As initial therapy (i.e., without a full course of standard-dose induction chemotherapy) for any NHL;
  - To consolidate a first CR for patients with diffuse large B-cell lymphoma and an International Prognostic Index score that predicts a low- or low-intermediate risk of relapse;
  - To consolidate a first CR for those with indolent NHL B-cell subtypes.
- For patients with peripheral T-cell lymphoma:
  - Autologous SCT may be considered medically necessary to consolidate a first complete remission in high-risk peripheral T-cell lymphoma*; *or*
  - Autologous or allogeneic SCT (myeloablative or reduced-intensity conditioning) may be considered medically necessary as salvage therapy; *or*
  - Allogeneic SCT is considered investigative to consolidate a first remission.
- *High-risk peripheral T-cell lymphoma is defined as one of the following histologic subtypes:
  - Nodal: peripheral T-cell lymphoma, not otherwise specified (PTCL-NOS), anaplastic lymphoma kinase negative anaplastic large cell lymphoma (ALK- ALCL) or angioimmunoblastic lymphoma (AIL). High-risk patients may also include the rare patient with ALK+ALCL who is refractory to conventional chemotherapy.

Medical and Behavioral Health Policy Update

  - Extranodal: T/NK cell lymphoma nasal type, enteropathy-type T-cell lymphoma, hepatosplenic T-cell lymphoma and subcutaneous panniculitis-like T-cell lymphoma.
- Pre-Certification/Pre-Authorization: Yes.

Progesterone Therapy to Reduce Preterm Birth In High-Risk Pregnancies

- All of the policy statements have been updated as follows:
- For women with a singleton pregnancy and prior history of spontaneous preterm birth before 37 weeks gestation, the following may be considered medically necessary:
  - Weekly injections of 17 alpha-hydroxyprogesterone caproate, performed in the office setting, initiated between 16 and 20 weeks of gestation and continued until 36 weeks 6 days.
  - Daily vaginal progesterone between 24 and 34 weeks of gestation.
- For women with a singleton pregnancy and a short cervix (less than 20 mm), the following may be considered medically necessary:
  - Daily vaginal progesterone initiated between 20 and 23 weeks 6 days of gestation and continued until 36 weeks 6 days.
- Progesterone therapy as a technique to prevent preterm delivery is considered investigative in pregnant women with other risk factors for preterm delivery, including but not limited to, the following:
  - Multiple gestations;
  - Positive tests for cervicovaginal fetal fibronectin;
  - Cervical cerclage; *or*
  - Uterine anomaly.
- 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.

Continuous or Intermittent Glucose Monitoring in Interstitial Fluid

- All of the policy statements have been updated as follows:
- Intermittent Monitoring: (Applicable CPT codes: 95250, 95251)
  - Intermittent monitoring of glucose levels in interstitial fluid for 3 to 5 days (professional glucose monitoring) may be considered medically necessary for patients with diabetes
    - That is poorly controlled as evidenced by unexplained hypoglycemic episodes, hypoglycemic unawareness, suspected postprandial hyperglycemia or recurrent ketoacidosis; *or*
    - Prior to insulin pump initiation to determine basal insulin levels.
- Continuous glucose monitoring: (Applicable HCPCS codes: A9276, A9277, A9278)
  - Continuous glucose monitoring systems (long-term monitoring of glucose levels in interstitial fluid, including real-time monitoring) may be considered medically necessary when the patient meets all of the following criteria:
    1. Type 1 diabetes; *and*
    2. Insulin injections are required three or more times per day or a medically necessary insulin pump is used for maintenance of glucose control; *and*
    3. Adequate metabolic control has not be achieved despite compliance with frequent self monitoring (4 or more fingersticks per day) and after multiple alterations in self-monitoring and insulin administration regimens to optimize care, as evidenced by at least one of the following:

Medical and Behavioral Health Policy Update

    - recurrent, unexplained, severe, symptomatic hypoglycemia (blood glucose levels less than 50 mg/dL) that puts the patient or others at risk; *or*
    - frequent nocturnal hypoglycemia, less than 50 mg/dL; *or*
    - discordant hemoglobin A1C and fingerstick blood glucose levels (i.e. patient with consistent normal fingerstick results, but high hemoglobin A1C levels).
- Note: The device used must be consistent with FDA approval for the age of the patient.
  - The CGMS® Gold™ and CGMS® iPRO™ have been FDA-approved for intermittent (professional) glucose monitoring. The following continuous or real-time systems have been approved:
    - Guardian® RT System and Paradigm® REAL-Time Revel System are approved by the FDA for use in individuals age seven and older.
    - DexCom Seven Plus® Real-Time Continuous Glucose Monitoring System and the FreeStyle Navigator® Continuous Glucose Monitoring System are approved by the FDA for use in adults age 18 and older.
  - Closed-loop systems, also called an artificial pancreas, consist of a continuous glucose monitor and pump combined into a single system that does not require direct patient interaction. None of these systems have been FDA approved and are currently under study.
- All other uses of intermittent or continuous monitoring of glucose levels in interstitial fluid including but not limited to closed loop systems that do not require direct patient interaction are considered investigative.
- Pre-Certification/Pre-Authorization: No.

Wound Healing: Vacuum-Assisted Wound Therapy in the Outpatient Setting

- The policy has been updated due to the addition/change and clarification of electrically powered and non-electrically powered vacuum assisted wound therapy.
- The policy has been updated with the following statements:
- Electrically powered vacuum assisted wound therapy may be considered medically necessary when the patient meets the following criteria categorized according to: 1) participation in a complete wound care program, *and* 2) presence of eligible conditions.
  1. Participation in a complete wound care program: A complete wound care program has been tried or considered and ruled out prior to the addition of vacuum assisted wound therapy to the overall management of wounds in *all* patients in *all* settings. Such a wound care program should include *all* of the following:
     - Documentation in the patient's medical record of evaluation, care, and wound measurements by a licensed medical professional; *and*
     - Application of dressings to maintain a moist environment; *and*
     - Debridement of necrotic tissue if present, without presence of fistula formation, macroscopic contamination or presence of malignant cells; *and*
     - Evaluation of and provision for adequate nutritional status; *and*
     - All underlying medical conditions have been stabilized or are under current management (i.e., diabetes, venous insufficiency).
  2. Eligible condition (patient must meet one of the following):
     - Stage III or IV pressure ulcers (see key terms below) at initiation of vacuum assisted wound therapy, who meet *all* of the following:
       - The patient has been appropriately turned and positioned; *and*

Medical and Behavioral Health Policy Update

  - The patient has used a group 2 or 3 support surface for pressure ulcers on the posterior trunk or pelvis (no special support surface is required for ulcers not located on the trunk or pelvis); *and*
  - The patient's moisture and incontinence have been appropriately managed; or
- Neuropathic ulcers who meet *all* of the following:
  - The patient has been on a comprehensive diabetic management program; *and*
  - Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities; *or*
- Ulcers related to venous or arterial insufficiency, who meet *all* of the following criteria:
  - Compression bandages and/or garments have been consistently applied; *and*
  - Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities; *and*
  - For initiation of therapy in the home setting, presence of the ulcer for at least 30 days; *or*
- Dehisced wounds or wound with exposed hardware or bone; *or*
- Post sternotomy wound infection or mediastinitis; *or*
- Complications of a surgically created wound where accelerated granulation therapy is necessary and cannot be achieved by other available topical wound treatment.

- Electrically powered vacuum assisted wound therapy is considered investigative when any of the following criteria are present:
  - Documentation of weekly assessment of the wound's dimensions and characteristics by a licensed health care professional indicate absence of adequate progress; *or*
  - Failure of progressive wound healing without intervening complications; *or*
  - In the judgment of the treating physician, adequate wound healing has occurred to the degree that vacuum assisted wound therapy may be discontinued; *or*
  - Other applications of vacuum assisted wound therapy not meeting the medical necessity criteria above.
- Non-electrically powered vacuum-assisted wound therapy is considered investigative due to a lack of evidence demonstrating in impact on improved health outcomes.
- Pre-Certification/Pre-Authorization: Yes, only for electrically powered vacuum-assisted devices and only when utilization will be greater than 90 days.

Policies inactivated

None

Policies reviewed with no changes in August and September 2011

Acupuncture
Advanced Glycation Endproducts (AGES) Measurement by Skin Autofluorescence
Amino Acid-Based Elemental Formulas
Biofeedback for Disorders Listed in the DSM-IV TR
Blepharoplasty and Brow Ptosis Repair
Bone-Conduction and Bone-Anchored Hearing Aids
Bronchial Thermoplasty
Chelation Therapy
Cochlear Implantation
Computerized Dynamic Posturography

Medical and Behavioral Health Policy Update

Deep Brain Stimulation
Excision of Redundant Skin or Tissue
Facet Arthroplasty
Gastric Electrical Stimulation
Gene Therapy
Genetic Testing for Congenital Long QT Syndrome
Growth Factors for Treatment of Wounds and Other Conditions
Gynecomastia
Hematopoietic Stem-Cell Transplantation for Acute Myeloid Leukemia
Hematopoietic Stem-Cell Transplantation for Breast Cancer
Hematopoietic Stem-Cell Transplantation for Epithelial Ovarian Cancer
Hyperbaric Oxygen Therapy
Hypnotherapy
Infusion of Vitamins, Minerals, and/or Nutrients
Magnetoencephalography/Magnetic Source Imaging
Natalizumab (Tysabri®)
Non-BRCA Breast Cancer Risk Assessment
Orthoptics or Vision Therapy
Otoplasty
Penile Plethysmography
Positron Emission Tomography (PET): Oncologic Applications
Positron Emission Tomography: Miscellaneous Applications
Quantitative Electroencephalogram (QEEG) or Brain Mapping for Mental Health or Substance-Related Disorders
Ranibizumab (Lucentis™)
Reduction Mammoplasty
Reproduction Treatments
Sclerotherapy for Varicose Veins of the Lower Extremities
Secretin Infusion Therapy for Autism
Single Photon Emission Computed Tomography (SPECT) for Cerebral Blood Flow in Behavioral Health Disorders
Sleep Studies/Polysomnograms in Children and Adolescents
Spinal Manipulation Under Anesthesia
Spinal Unloading Devices: Patient-Operated
Surgical Decompression for Treatment of Diabetic Neuropathy
Targeted Amino Acid Therapy for Mental and Substance-Related Disorders
Thermal Capsulorrhaphy
Thought Field Therapy
Vagus Nerve Stimulation
Wireless Gastric Motility Monitoring
Wound Healing: Electrostimulation and Electromagnetic Therapy
Wound Healing: Non-Contact Ultrasound Treatment
X STOP® Interspinous Process Distraction System and Interspinous Process Decompression

Quality Improvement

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 2011 and an evaluation of projects carried out in 2010. 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**.

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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12/11

For the health of all.

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