Provider Press

September 2011 / Vol. 15, No. 3

Medicare crossover changes for mass adjustments related to the Affordable Care Act and 2010 Medicare Physician Fee Schedule (MPFS) changes

Over the next few months, all Blue Plans* will initiate the process to amend their Coordination of Benefits Agreements (COBA), to exclude most Medicare crossover mass adjustments related to the Affordable Care Act and the 2010 MPFS from directly crossing over from the CMS Coordination of Benefits Contractor (COBC) to the Blue Plan. This new approach for handling the high volume of these affected mass adjustments will ease the administrative burden for both the provider and the payer related to processing these mass adjustments. In the majority of cases these mass adjustments resulted in extremely small adjustment payments resulting in administrative costs exceeding the benefit and payment.

Note: This revision does not impact how the affected mass adjustments are currently processing for the Federal Employee Program (FEP).

*Each Blue Cross and Blue Shield Plan is an independent licensee of the Blue Cross and Blue Shield Association.

Publications available online

The following is a list of Quick Points and Bulletins published from June 2011, to August 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
QP8-11	Clarification to ancillary claims through BlueCard program (lab, DME and specialty pharmacy)
QP9-11	Minnesota Health Care Programs (MHCP) payment for vaccine administration code 90461
QP10-11	Infusion pumps for Minnesota Health Care Programs (MHCP) members
QP11-11	Blue Cross to implement new pricing system
QP3R1-11	New turnaround time process for urgent pre-certification /pre-authorization requests – revised
Bulletins	**Title**
P10-11	July 2011 HCPCS update
P11-11	Blue Cross and Blue Shield of Minnesota statement for providers
P12-11	To minimize disruption in posting your remittance, register with Availity now
P13-11	Update to Attachment B: Definition of outpatient health services categories
P14-11	Changes related to dialectical behavior therapy for some MHCP members
P15-11	High Technology Diagnostic Imaging (HTDI) program
P16-11	Important changes for the 2011Recognizing Excellence Initiative

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

Provider manual updates

The following is a list of Blue Cross and Blue Shield of Minnesota provider manuals that have been updated from June 2011, to August 2011. As a reminder, provider manuals are available online at **providers.bluecrossmn.com**. To view the manuals, select "Forms & publications" and then "manuals" in the drop-down menu. 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 3, Quality Improvement	Pages 3-12, 3-13, 3-17, 3-20 (clarifies current requirements)
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Pharmacy Services	• Quantity limits • Formulary exception process for Minnesota Health Care Programs • Over-the-counter drugs • Drug programs and specialty drugs • History • Step therapy program • Replaced formulary and non-formulary with preferred and non-preferred terminology
Blue Plus Manual	Chapter 3, Government Programs	• Added updated version of SecureBlue℠ (HMO SNP) and Blue Advantage Minnesota Senior Care documentation • Updated Claims Submission: Drugs and Claims Processing: Drugs
Blue Plus Manual	Chapter 5, Quality Improvement	Pages 5-10, 5-19, 5-20, 5-22, 5-23 (clarifies current requirements)

Coding Corner

October coding changes

October 1 is an important date for medical coding. First, that is the effective date for the added, revised, and invalid ICD-9-CM diagnoses and procedures for 2012. Second, are the anticipated HCPCS code changes for October 1. While no added, revised or discontinued codes have been issued by either the Centers for Medicare and Medicaid Services (CMS) or the American Medical Association (AMA) at this time, we will recognize and accept any changes that will be published by CMS or AMA for October 1.

A bulletin will be issued before the effective date with details, along with the new and deleted HCPCS codes, if any. ICD-9-CM codes will not be included in the bulletin.

76942 restrictions

Code 76942 represents ultrasonic guidance for needle placement (for example, biopsy, aspiration, injection, localization device), imaging supervision and interpretation. If multiple needle placements are performed, **regardless of different site or side of the body,** only one unit will be allowed regardless of the number of needle placements.

Modifier 25 invalid with PT and OT evaluations

The modifier -25 (significant, separately identifiable evaluation and management service by the same physician on the same day as the procedure or other service) is not valid with the physical therapy (PT) and occupational therapy (OT) evaluations and re-evaluation codes 97001-97004. The evaluation or re-evaluation codes will be allowed, as appropriate, when billed with other physical or occupational services on the same date. Because the modifier -25 is not valid with 97001-97004, if submitted, the service will be denied.

Claim edits updated

Blue Cross' coding edits are updated at minimum annually to incorporate new codes, code definition changes and edit rule changes. Our coding software was updated effective July 25, 2011, to incorporate all HCPCS additions and revisions effective January 2011. All claims submitted on or after July 25, 2011, regardless of service date, will be processed according to the updated version. Therefore you may see differences in service adjudication.

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, which 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:

- **Management of Labor**
- **Major Depression in Adults in Primary Care**
- **Healthy Lifestyles**
- **Heart Failure in Adults**

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.

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 aim 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 Amanda Allen-Bauer at **(651) 662-8986** or **1-888-878-0139, ext. 28986**.

Quality Improvement

Accessibility of services

Blue Cross recognizes that timely access to medical care is a major component of member satisfaction. As such, primary care provider (PCP) appointment accessibility and after-hours access is monitored annually to ensure members have access to medical care 24 hours a day, seven days a week. Blue Cross evaluates accessibility in a number of ways. Results from 2010 and 2011 studies are shown below.

2011 Member Satisfaction survey (based on 2010 dates of service):

Question	Blue Cross' Goal	Commercial PPO	Medicaid HMO
Got urgent care as soon as needed (% responding "Always" or "Usually")	85.0%	88.0%	90.1%
Got regular/routine appointment as soon as needed (% responding "Always" or "Usually")	85.0%	84.4%	88.3%

Blue Cross is meeting its internal goal of 85% member satisfaction with urgent care for its PPO and Medicaid members. Blue Cross saw a five percentage-point improvement in satisfaction for routine for its Medicaid population in 2011 but remains slightly below goal for the PPO population.

2010 Access and Availability Study

401 Blue Cross PPO and Blue Plus HMO members were called and asked about the timeliness of getting a routine, urgent and preventive care appointment and expectations.

Access and Availability Study
Blue Cross PPO and Blue Plus HMO Combined

Standard	Blue Cross' Goal	2010 Result
Same day illness/injury (urgent care) appointment	85%	55%
Routine appointment within 7 days of request	85%	50%
Preventive care appointment within 30 days of request	85%	74%

Although members are reporting a high rate of satisfaction with appointment accessibility and complaints specific to access are low, providers may not be meeting our internal appointment standards. Currently, our process does not collect objective appointment data by which a firm conclusion can be made; however, it is clear that member expectations on the timeliness of an appointment are much lower than Blue Cross' standards, and as a result, member satisfaction remains high.

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Quality Improvement

Accessibility of services, *continued from page 5*

After-hours access survey:

The telephonic after-hours access survey was conducted between 6 p.m. and 6 a.m. on weekdays, after 1 p.m. on Saturdays and all day on Sundays. Each PCP is required to provide access instructions for obtaining care 24-hours a day, 7 days a week, 365 days per year via a live person or answering system. These instructions must refer patients to either back-up participating providers, urgent care centers (where available) and/or to hospital emergency care. Additionally, the instructions must inform patients who leave a message of a call-back timeframe.

The 2010 after-hours access survey involved 561 PCPs. After the initial survey, 508 PCPs (91%) were in compliance and 51 PCPs (9.0%) were non-compliant with the requirements. The top reasons for noncompliance included after hours messages with only instructions to call 911 (37.2%) or no answer/no after-hours message. In July, letters were sent to the 51 PCPs who were non-compliant requesting them to rectify the issue.

Your Help is Needed

Blue Cross has adopted standards for appointments and after-hours access that are industry accepted and meet regulatory and accrediting requirements. We depend upon our providers to establish internal processes to meet these standards. Here are some suggestions on how to improve your performance.

- Establish a monitoring program to assess your clinic's performance.
- Call members with appointment reminders to decrease no shows and/or late arrivals
- Post standards and after-hours policy
- If you have an electronic medical record, capture date of request and date of appointment
- Share internal results with your members and staff
- Identify your opportunities and take action

Annual provider mailing

In June 2011, Blue Cross sent out an annual mailing that included a letter discussing information that is available to practitioners, as well as an updated Clinical Practice Guideline listing. Links to the guidelines can be found online at **providers.bluecrossmn.com**, forms & publications, manuals, Blue Cross and Blue Shield of Minnesota Provider Policy and Procedure Manual, Chapter 3 - Quality Improvement.

Quality Improvement

Transitions of care

Coordination between emergency department and primary care physicians

There has been a lot of research and much attention paid of late to the issue of preventable hospital readmissions. The Reducing Avoidable Readmissions Effectively (RARE) Campaign is yet another example of the Minnesota community joining together to address a common problem. For more information on RARE, go to **icsi.org/health_care_redesign_**. One of the key components to a safe and reliable discharge is to improve communication of essential information between the hospital provider(s) and the primary care practitioner (PCP) in a direct and timely fashion.

However, ineffective and potentially unsafe transitions of care can occur as patients move from any site of care to the next. This can even include when patients are referred from the clinic to the emergency department (ED), where often critical history and context of an established provider-patient relationship are lost. Due to the nature of the care setting and the acuity of illness, some patients may be particularly vulnerable when discharged from the ED to home. Unlike transitions between the hospital setting and home, though, little research has been done to look at the barriers to safe, effective and timely communication between the ED and the PCP.

An interesting article was published this past February by the National Institute for Health Care Reform that addresses this topic. In "Coordination Between Emergency and Primary Care Physicians," the authors surveyed 21 pairs of ED and PCPs in various practice types, sizes and locations. These surveys and interviews observed that the exchange of critical information too often does not occur between the ED and PCP, despite the many ways that we can communicate: telephone, fax, e-mail, text messaging, IM chat and the electronic health record (EHR). For the full article, visit **nihcr.org/ED-Coordination.html**.

Blue Cross performs its own annual provider satisfaction survey that has demonstrated PCPs perceive the quality of information as generally very good when received from the ED; however, there is still a large gap in the reliability of verbal or written communication (paper or electronic) received regarding patients seen in the ED. Our 2010 provider survey showed that only 54% of all practitioners reported that verbal or written (paper or electronic) communications, such as discharge summaries, progress notes and consult letters were "usually" and "sometimes" sent; whereas 26% of all respondents reported "never" receiving feedback.

And as with many other quality and safety gaps that exist in today's health care environment, the human element is

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Quality Improvement

Coordination, *continued from page 7*

only a small part of the equation. Despite best intentions of the individual provider, there are many barriers that exist as a result of today's busy, complicated, demanding practice environments:

- Absence of readily identifiable (or non-existent) PCP and/or contact information in the medical record
- Interruptions and disruptions to workflow and patient care
- Availability of patient's PCP and multitude of cross-covering providers unfamiliar with the patient
- Lack of time and reimbursement for time spent (and lost) in direct consultation
- The changing nature of medical practice and the loss of interpersonal relationships between clinic and hospital-based providers
- Unclear and extremely variable expectations and assumptions about how, when and under what circumstances to communicate directly
- Delays that occur in the process of dictation, transcription, fax and/or mail
- As a result of all the above, and more, a frequent reliance on patients and families to relay information to their PCP

Of course there are different levels of acuity and urgency among patients seen in the ED, and certainly not every patient's circumstances necessitate the need to call a PCP and possibly initiate the unwanted game of phone tag that leads to frustration and wasted time on everyone's part. Furthermore, one can hardly expect there to be a one-size-fits-all approach.

In lieu of the ideal situation – a shared EHR between the ED and PCP office in a fully-integrated health system – providers in other care delivery systems must look for appropriate and reliable processes to improve the safe, timely and effective communication between the ED and the PCP. Maintaining a database of PCPs and including the name and contact information of each patient's PCP in the medical record is a logical place to begin, if it is not already available. Finally, as with hospital discharges, the following information should be included in all ED to PCP discharge communications:

- Recommendations for follow up with PCP and/or specialist
- Any changes or additions to previous medication regimen
- Any abnormal or outstanding lab or imaging results
- Recommendations for additional testing

Blue Cross has set a goal of 80% of PCPs reporting that verbal or written communication from the ED is "usually" or "sometimes" sent. As our partners in improving the quality and experience of care of our members, we rely on our providers to help improve this process and reach our stated goal. We appreciate all your efforts in this regard.

Claims Tips

High-Technology Diagnostic Imaging reminder

The Institute for Clinical Systems Improvement (ICSI) — a leading non-profit organization with expertise in working with providers and health plans — is sponsoring an online decision support program designed to ensure appropriate use of certain High-Technology Diagnostic Imaging (HTDI). Along with other major Minnesota health plans, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) supports this important ICSI project and is implementing the HTDI program effective November 1, 2011.

This project supports improved health outcomes and reduced costs for physicians, consumers, employers and health plans. Some of the benefits of this program are:

Physicians will have an objective, evidence-based set of criteria to make decisions on when to employ HTDI technologies, without needing to check first with the health plan (in most cases).

The process will help ensure that members receive the appropriate test with immediate feedback, without incurring additional costs and the risk of unnecessary exposure to potentially harmful levels of radiation.

Physicians will follow nationally recognized, uniform guidelines designed and incorporated into the decision support tool.

Key Process changes

For its implementation of the decision support program, Blue Cross has entered a relationship with Nuance to provide the software solution called RadPort. This change could impact the processes you currently follow regarding data submission and decision support services for HTDI as described here:

Effective November 1, 2011, ordering physicians will be required to use a decision support system as part of their process for elective, outpatient HTDI procedures.

Physicians and clinic groups can implement the new RadPort software either in an Electronic Medical Record (EMR) integrated version or a web-based version.

Physicians and clinic groups who currently use an alternative decision support program for HTDI may continue to do so until further notice.

All providers must continue to follow the current HTDI guidelines found in the online Medical and Behavioral Health Policy manual.

Members covered by the program

Currently, this program includes select Blue Cross members in the Minnesota service area and surrounding counties in Wisconsin, South Dakota, North Dakota and Iowa.

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Claims Tips

Hospital pre-certification reminder for FEP members

As a reminder hospital inpatient admissions require pre-certification for FEP (Federal Employee Program) members. This requirement is not a change in process or benefits.

Once pre-certification has been obtained and the member is admitted to the inpatient facility (hospital), no additional pre-certification process is required for that admission, as long as the patient stay does not exceed the number of days initially approved and communicated in writing to the providers and members.

Blue Cross and Blue Shield of Minnesota Integrated Health Management nurses may also be contacting your utilization review or discharge planning staff for updates relative to length of stay, plan of care, and discharge plans for these members.

For pre-certification, please call **(651) 662-5270** or **1-800-528-0934** or fax to **(651) 662-7006**. For your convenience, you can find our pre-certification form on our website at **providers.bluecrossmn.com**.

High-Technology Diagnostic Imaging, *continued from page 9*

The EMR integrated RadPort software or the web-based version will display the member's name if they are included in the HTDI program. If the member name is not displayed in RadPort, the member is not included in the program at this time.

For more information

Please refer to Provider Bulletin P15-11 for specific procedures related to this program, and the HTDI information page posted at **providers.bluecrossmn.com**. You may also call provider services at **(651) 662-5200** or **1-800-262-0820**.

For specific questions about Nuance's RadPort software, or to schedule training and implementation of the tool, contact ICSI at **(952) 814-7067** or **htdi@icsi.org**.

Pharmacy Corner

Minnesota uniform form for prescription drug prior authorization requests and formulary exceptions

Pursuant to statutes, the State of Minnesota has developed the Minnesota Uniform Form for prescription Drug Prior Authorization (PA) Requests and Formulary Exceptions (Uniform Form).

The statute addressing formulary exceptions states: "Upon development of the form, all health care providers must submit requests for formulary exceptions using the uniform form, and all group purchasers must accept this form from health care providers." Additionally, as of January 1, 2011, the statute requires that "the uniform formulary exception form must be accessible and submitted by health care providers, and accepted and processed by group purchasers, through secure electronic transmissions." In order to comply with the law, providers requesting formulary exceptions should use the Uniform Form. The Uniform Form is located on the Minnesota Department of Health's website. A link to this form as well as additional instructions for completing and submitting requests is located at **providers.bluecrossmn.com** under Forms & Publications.

Pharmacy terminology change: preferred/non-preferred replaces formulary/non-formulary

Blue Cross and Blue Shield of Minnesota is changing terminology of prescription drugs from formulary/non-formulary to preferred/non-preferred. This change is consistent with other health care insurers. This is only a terminology change – the benefits will remain the same.

See the table below for a reference to what will be impacted by the terminology change:

Current terminology or phrases	Impacted by terminology change (yes or no)	future terminology
GenRx is a cost-effective **formulary** by maximizing the use of generic drugs.	no — GenRx is one of the formularies that Blue Cross offers.	—
closed **formulary**	yes	closed pharmacy benefit plan design
FlexRx **Formulary**	no	—
GenRx **Formulary**	no	—
non-formulary are drugs not on the preferred list of drugs, but could be covered under an open **formulary** benefit.	yes	**non-preferred drug** is a drug not on the preferred list of drugs, but could be covered under an open pharmacy benefit plan design.
open **formulary**	yes	open pharmacy benefit plan design

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

Pharmacy Corner

Blue Cross GenRx and FlexRx drug formularies

Blue Cross maintains two drug formularies, the GenRx formulary and the FlexRx formulary.

The GenRx formulary is designed to provide members with access to safe and cost-effective drugs while maximizing the use of generics. The GenRx formulary includes most generic drugs. It also includes selected brand drugs that the Pharmacy and Therapeutics Committee and/or Coverage Committee have determined are necessary to provide the best available agents for medical conditions requiring drug therapy.

The FlexRx formulary is designed to provide members with access to safe and effective medications at a reasonable overall cost. The Flex Rx formulary includes a broad range of generic and brand drugs. The Blue Cross Coverage Committee is responsible for final selection of drugs for these lists based on recommendations of an independent Pharmacy and Therapeutics (P&T)

Committee comprised of actively practicing physicians and pharmacists. The formulary is subject to periodic review and modification by these committees. Decisions to add or remove drugs from the Blue Cross formulary are made based on the medication's safety, efficacy, uniqueness and cost. Any participating health care provider may request the addition of a drug to the formulary. Written requests should be submitted to:

Blue Cross and Blue Shield of Minnesota
Attn: Coverage Committee
P.O. Box 64812, Route R4-18
Attention: Stephen Ritter, R.Ph.
St. Paul, MN 55164-0812

Supporting documents or information considered important for evaluation should accompany the request. A statement of disclosure of any conflict of interest should also be included.

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 Effective: 08/29/11 Notification Posted: 05/27/11

Policies developed

None

Policies revised

Sleep Disorder Testing in Adults

- Revised the hypertension policy criteria in the supervised polysomnography section of the policy to state: "Documented hypertension."
- Added "ECG or heart rate" as a channel to the policy statement on type III devices in the unattended (unsupervised) home sleep studies section of the policy.
- Added: "Repeat unattended (unsupervised) home sleep studies with a minimum of four recording channels (including oxygen saturation, respiratory movement, airflow, and ECG/heart rate) may be considered medically necessary in adult patients under the following circumstances:
  - To assess efficacy of surgery or oral appliances/devices; OR
  - To re-evaluate the diagnosis of OSA and need for continued CPAP, e.g., if there is a significant change in weight or change in symptoms suggesting that CPAP should be re-titrated or possibly discontinued. "
- The remainder of the policy is unchanged.
- Prior 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.

Bariatric Surgery

- "Open or laparoscopic sleeve gastrectomy" has been added to the list of surgical procedures that may be considered medically necessary in the treatment of morbid obesity when the criteria have been met.
- The remainder of the policy is unchanged.
- Prior Authorization: Yes, for all bariatric surgery and revisions / reoperations.

Treatment of Obstructive Sleep Apnea/Upper Airway Resistance Syndrome and Snoring

- The criteria for intraoral appliances have been removed from those continuous positive airway pressure (CPAP) and moved into separate criteria.
- The following section has been added:
- Intraoral appliances (e.g., mandibular advancing/positioning devices or tongue-retaining devices) may be considered medically necessary in patients with clinically significant OSA under the following conditions:
  - Mild to moderate OSA, defined by an apnea/hypopnea index (AHI) of at least 15 per hour, or an AHI of at least 5 events per hour in a patient with excessive daytime sleepiness or documented hypertension, AND
  - A trial with CPAP has failed or is contraindicated, AND
  - The device is prescribed by a treating physician, AND
  - The device is custom-fitted by qualified dental personnel, AND
  - There is absence of temporomandibular dysfunction, periodontal disease or severe sleep apnea.
- The following statement in the policy has been updated:

Medical and Behavioral Health Policy Update

- Bi-level positive airway pressure (BiPAP) may be considered medically necessary in patients with clinically significant obstructive sleep apnea and who have failed prior trial of CPAP or for whom BiPAP is found to be more effective that CPAP in the sleep laboratory.
- The remainder of the policy is unchanged.
- Prior authorization: Yes, for surgical procedures only.

Bone Growth Stimulators

- The following criteria in the Electrical Bone Growth Stimulators section of the policy have been revised.
- Invasive or noninvasive electrical bone growth stimulators may be considered medically necessary as an adjunct to lumbar and/or lumbosacral spinal fusion surgery in patients at high risk for fusion failure, defined as any one of the following criteria:
  - One or more previous failed spinal fusion(s);
  - Grade III or worse spondylolisthesis;
  - Fusion to be performed at more than two levels;
  - Current smoking habit;
  - Diabetes;
  - Renal disease;
  - Alcoholism;
  - Chronic steroid use.
- The following criteria in the Ultrasound Bone Growth Stimulators section of the policy have been revised:
- Low-intensity ultrasound bone growth stimulators may be considered medically necessary when used as an adjunct to conventional management (i.e., closed reduction and case immobilization) for the treatment of fresh (less than seven days old), closed fractures in skeletally mature individuals who are at high risk for nonunion due to any one of the following risk factors:
  - Comorbidities:
    - Current smoking habit; or
    - Diabetes; or
    - Renal disease; or
    - Alcoholism; or
    - Chronic steroid use.

    OR
  - Fracture characteristics:
    - Jones/5th metatarsal fracture; or
    - Navicular fracture (also called the scaphoid); or
    - Fractures associated with extensive soft tissue or vascular damage.
- The following statement has been updated in the list of investigative indications for low-intensity ultrasound bone growth stimulators: "Treatment of open fractures [e.g., as an adjunct (applied at the time of surgery or within 3 months) to open reduction internal fixation or osteotomy]."
- The remainder of the policy is unchanged.
- Prior authorization: Yes.

Medical and Behavioral Health Policy Update

Gene-Based Tests for Screening, Detection, and/or Management of Prostate Cancer

- The policy title has been updated; "Gene-Based" has replaced "Genetic-Based."
- The policy statement has been updated as follows.
- Gene-based tests for the screening, detection, and management of prostate cancer are considered investigative due to a lack of clinical evidence indicating their impact on improved health outcomes. These include, but are not limited to, the following tests:
  - Single-nucleotide polymorphisms (SNPs) for risk assessment;
  - PCA3 for disease diagnosis and prognosis;
  - TMPRSS fusion genes for diagnosis and prognosis;
  - Multiple gene tests (gene panels) for prostate cancer diagnosis; or
  - Gene hypermethylation for diagnosis and prognosis
- 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.

Epidermal Growth Factor Receptor (EGFR) Mutation Analysis for Patients with Non-Small Cell Lung Cancer (NSCLC)

- All policy statements have been updated as follows.
- Except as noted below, analysis of two types of somatic mutations within the EGFR gene – small deletions in exon 19 and a point mutation in exon 21 (L858R) – may be considered medically necessary to predict treatment response to erlotinib in patients with advanced NSCLC.
- Analysis of two types of somatic mutation within the EGFR gene – small deletions in exon19 and a point mutation in exon 21 (L858R) – is considered investigative for patients with advanced NSCLC of squamous cell-type. lack of clinical evidence indicating the impact of these tests on improved health outcome.
- Analysis for other mutations within exons 18-24, or other applications related to NSCLC is considered investigative due to a lack of clinical evidence indicating their impact on improved health outcome.
- Prior authorization: No. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Policies inactivated

None

Medical and Behavioral Health Policy Activity

Policies Effective: 09/26/11 Notification Posted: 06/27/11

Policies developed

Stem-Cell Therapy for Peripheral Arterial Disease

- Treatment of peripheral arterial disease, including critical limb ischemia, with injection or infusion of stem-cells concentrated from bone marrow aspirate is considered investigative due to a lack of clinical 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.

Medical and Behavioral Health Policy Update

Fecal Calprotectin Testing

- Measurement of fecal calprotectin has been proposed as a noninvasive tool for diagnosis and monitoring inflammatory bowel disease (IBD). Fecal calprotectin is a calcium- and zinc- binding protein that accounts for about 60% of the cytoplasmic protein of neutrophils. An increased level of leukocytes is an indicator of inflammation.
- Fecal calprotectin testing is considered investigative in the diagnosis and management of intestinal conditions, including the diagnosis and management of inflammatory bowel disease. There is 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.

Image-Guided Minimally Invasive Lumbar Decompression (IG-MLD) for Spinal Stenosis

- Image-guided minimally invasive lumbar decompression is considered investigative due to a lack of clinical 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.

Myoelectric Prostheses for the Upper Limb

- Myoelectric upper limb prosthetic components may be considered medically necessary when the following conditions are met:
  - The patient has an amputation or missing limb at the wrist or above (e.g., forearm, elbow, shoulder); AND
  - Standard body-powered prosthetic devices cannot be used or are insufficient to meet the functional needs of the individual (e.g., gripping, releasing, holding, and coordinating movement of the prosthesis); AND
  - The remaining musculature of the arm(s) contains the minimum microvolt threshold to allow operation of a myoelectric prosthetic device; AND
  - The patient has demonstrated sufficient neurological and cognitive function to operate the prosthesis effectively; AND
  - The patient is free of comorbidities that could interfere with function of the prosthesis (e.g., neuromuscular disease); AND
  - Functional evaluation indicates that with training, use of a myoelectric prosthesis is likely to meet the functional needs (e.g., gripping, releasing, holding, and coordinating movement of the prosthesis) of the individual. This evaluation should consider the patient's needs for control, durability (maintenance), function (speed, work capability), and usability.
- Myoelectric upper limb prosthetic components are considered not medically necessary under all other conditions.
- Prior authorization: Yes.

Belimumab

- This monoclonal antibody received FDA approval in March 2011 for the treatment of systemic lupus erythematosus (SLE).
- Use of belimumab may be considered medically necessary in adults (18 years of age or older) who have been diagnosed with systemic lupus erythematosus (SLE) AND who meet ALL of the following criteria:
- Positive test for serum antibodies, using the anti-nuclear antibody (ANA) test OR the anti-double-stranded DNA test, at two (2) independent time points. A serum antibody test is considered positive when:
  - Anti- nuclear antibody (ANA) titer ≥ 1:80;
  - Anti-double-stranded DNA ≥ 30 IU/mL;

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- Active disease, as indicated by a score of at least 6 on the Safety of Estrogens in Lupus Erythematosus National Assessment modification of the SLE Disease Activity Index (SELENA-SLEDAI);
- Patient is receiving a stable standard of care treatment regimen for SLE for at least 30 days. Standard of care treatment regimens comprise any of the following drug classes, alone or in combination:
  - Corticosteroids;
  - Antimalarials (e.g., hydroxychloroquine);
  - Non-biologic immunosuppressives (e.g., azathioprine, methotrexate);
- Absence of ALL of the following:
  - Severe active lupus nephritis, defined as either:
    - Proteinuria > 6 g/24 hour, or
    - Serum creatinine > 2.5 mg/dL
  - Hemodialysis within 90 days prior to the first dose of study drug;
  - Severe active central nervous system (CNS) lupus, including seizures, psychosis, organic brain syndrome, cerebrovascular accident, cerebritis or CNS vasculitis requiring therapeutic intervention within 60 days before initiation of belimumab;
  - Any chronic infection (e.g., chronic hepatitis, tuberculosis, pneumocystis carinii jiroveci pneumonia [PCP], cytomegalovirus, herpes simplex virus, herpes zoster, or atypical mycobacteria);
  - Hospitalization for treatment of infection or use of parenteral (intravenous or intramuscular) antibiotics (i.e., antibacterials, antivirals, antifungals, or anti-parasitic agents) within 60 days before initiation of belimumab;
  - Significant unstable or uncontrolled acute or chronic comorbid disease (i.e., cardiovascular, pulmonary, hematologic, gastrointestinal, hepatic, renal, neurologic, or infectious disease); for example, three or more courses of oral or intravenous steroids for asthma or atopic dermatitis within one year;
  - Malignant neoplasm within the last 5 years, excluding adequately-treated basal or squamous cell skin cancers and cervical carcinoma-in-situ;
  - Current treatment with other biologics or intravenous cyclophosphamide;
  - Live vaccine within 30 days before initiation of belimumab;
  - Pregnancy or breast-feeding;
  - Current drug or alcohol abuse or dependence, or a history of drug or alcohol abuse or dependence within 364 days prior to first dose of belimumab.
- Use of belimumab is considered investigative for all other indications, due to a lack of evidence demonstrating improved health outcomes for any condition other than SLE.
- Prior authorization: Yes. Initial approval will be for one year.
- Renewal of prior authorization should include documentation supporting sustained treatment-related response, such as substantial improvement in disease condition or a reduction in disease progression. Patients should also be monitored for new or worsening depression, suicidal thoughts, or other mood changes.

Fetal Surgery for Prenatally Diagnosed Malformations

- Vesico-amniotic shunting or open fetal surgery for bladder marsupilization as a treatment of urinary tract obstruction may be considered medically necessary in fetuses under the following conditions:
  - Evidence of hydronephrosis due to bilateral urinary tract obstruction; AND
  - Progressive oligohydramnios; AND

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  - Adequate renal function; AND
  - No other lethal abnormalities or chromosomal defects.
- Open in utero resection of malformed pulmonary tissue or placement of a thoraco-amniotic shunt may be considered medically necessary under the following conditions:
  - Congenital cystic adenomatoid malformation or bronchopulmonary sequestration is identified; AND
  - The fetus is at 32 weeks' gestation or less; AND
  - There is evidence of fetal hydrops, placentomegaly, and/or the beginnings of severe pre-eclampsia (i.e., the maternal mirror syndrome) in the mother.
- In utero removal of sacrococcygeal teratoma may be considered medically necessary under the following conditions:
  - The fetus is at 32 weeks' gestation or less; AND
  - There is evidence of fetal hydrops, placentomegaly, and/or the beginnings of severe pre-eclampsia (i.e., the maternal mirror syndrome) in the mother.
- In utero repair of myelomeningocele may be considered medically necessary under the following conditions:
  - Singleton pregnancy; AND
  - The fetus is at less than 26 weeks' gestation; AND
  - Myelomeningocele is present with an upper boundary located between T1 and S1 with evidence of hindbrain herniation; AND
  - No other lethal abnormalities or chromosomal defects have been identified.
- In utero repair of myelomeningocele is considered investigative in the following situations:
  - Severe kyphosis; OR
  - Risk of preterm birth (e.g., short cervix or previous preterm birth); OR
  - Maternal body mass index of 35 or more.
- Other applications of fetal surgery are considered investigative, including but not limited to the following, due to a lack of clinical evidence demonstrating an impact on improved health outcomes:
  - Temporary tracheal occlusion as a treatment of congenital diaphragmatic hernia; and
  - Treatment of congenital heart defects.
- Prior authorization: Yes.

Policies revised

Rituximab

- Revised and expanded to include a single list of the indications that are considered medically necessary.
- The policy title has been updated from "Rituximab for off-label non-cancer Indications" to "Rituximab."
- Rituximab may be considered medically necessary for the following indications:
- Chronic lymphocytic leukemia (CLL)
  - Non-Hodgkin's lymphoma (NHL) (e.g. AIDS-related B-cell lymphoma, Burkitt's lymphoma, B-cell lymphoma; high-grade B-cell lymphoma, chronic lymphocytic leukemia/small lymphocytic lymphoma, diffuse large B-cell lymphoma, follicular lymphoma and nodal marginal zone lymphoma, gastric mucosa-associated lymphoid tissue (MALT) lymphoma, lymphoblastic lymphoma, mantle cell lymphoma, non-gastric MALT lymphoma, post-transplant lymphoproliferative disorders, primary cutaneous B-cell lymphoma, and splenic marginal zone lymphoma)

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  - In combination with glucocorticoids in the treatment of Wegener's granulomatosis (WG) or microscopic polyangiitis (MPA) in adults
  - In combination with methotrexate for the treatment of adults with moderately-to severely-active rheumatoid arthritis who have had an inadequate response to one or more tumor necrosis factor (TNF) antagonist therapies
  - Acute lymphocytic leukemia
  - Central nervous system cancer – metastatic and primary lesions
  - Hairy cell leukemia
  - Hodgkin's lymphoma
  - Waldenström macroglobulinemia
  - Idiopathic thrombocytopenic purpura (ITP) in adults at risk of bleeding who have failed one line of therapy such as corticosteroids, IVIg or splenectomy.
- The use of rituximab for treatment of chronic ITP in children is considered investigative because safety of the drug has not been determined in those <18 years of age.
- The use of rituximab for treatment of all other conditions is considered investigative due to a lack of published clinical evidence establishing the role of rituximab in the treatment of these conditions. The remainder of the policy is unchanged.
- Prior authorization: Yes, for non FDA-approved non-cancer indications.

Minimally Invasive Lumbar Interbody Fusion

- The policy title has been revised from "Axial (Percutaneous) Lumbar Interbody Fusion (ALIF)" to "Minimally Invasive Lumbar Interbody Fusion."
- Minimally invasive interbody fusion of the lumbar spine may be considered medically necessary when one of the following approaches are used AND when the patient has met the criteria for lumbar fusion as defined in Medical Policy #IV-87, Spinal Fusion: Lumbar:
  - Anterior lumbar interbody fusion (ALIF);
  - Posterior lumbar interbody fusion (PLIF);
  - Transforaminal lumbar interbody fusion (TLIF).
- All other minimally invasive procedures for lumbar interbody fusion are considered investigative, including, but not limited to the following, due to a lack of evidence demonstrating an impact on improved health outcomes:
  - Laparoscopic anterior lumbar interbody fusion (ALIF);
  - Axial anterior lumbar interbody fusion (AxiaLIF®);
  - Lateral interbody fusion (e.g., XLIF®, DLIF).
- Prior authorization: Yes, only for anterior lumbar interbody fusion (ALIF), posterior lumbar interbody fusion (PLIF), and transforaminal lumbar interbody fusion (TLIF).
- Prior authorization: Not applicable for laparoscopic anterior lumbar interbody fusion (ALIF), axial anterior lumbar interbody fusion (AxiaLIF®), and lateral interbody fusion (e.g., XLIF®, DLIF).
- Any procedures (e.g., spinal fusion, allograft, instrumentation) performed in conjunction with the investigative procedures identified above, will not be covered. This includes, but is not limited to, professional, facility and anesthesia services as well as supplies.

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Biventricular Pacemakers for Treatment of Heart Failure

- The policy has been updated to include criteria for biventricular pacing in NYHA
- Class II heart failure along with updated information on FDA approvals for pacemakers.
- The policy title has been revised from "Biventricular Pacemakers for Treatment of Congestive Heart Failure" to "Biventricular Pacemakers for Treatment of Heart Failure."
- The use of biventricular pacemakers/cardiac resynchronization therapy with or without an accompanying implantable cardiac defibrillator (i.e., a combined biventricular pacemaker/ICD) may be considered medically necessary as a treatment of heart failure in patients who meet all of the following criteria:
  - NYHA Class III or IV
    - Left ventricular ejection fraction ≤35%;
    - QRS duration of ≥120–130* msec;
    - Patients treated with a stable pharmacological medical regimen prior to implant, such as an ACE inhibitor (or an angiotensin receptor blocker) and a beta blocker (or angiotensin receptor blocker), digoxin, and/or diuretics
  - NYHA Class II
    - Left ventricular ejection fraction ≤30%;
    - QRS duration of ≥120–130* msec;
    - Patients treated with a stable pharmacological medical regimen prior to implant, such as an angiotensin-converting enzyme (ACE) inhibitor (or an angiotensin receptor blocker) and a beta blocker (or angiotensin receptor blocker), digoxin, and/or diuretics
- * The FDA-labeled indications for QRS duration vary by device. For some devices, FDA approval is based on QRS duration of ≥130 (e.g., InSync® device) while for others it is based on QRS duration ≥120msec (e.g., CONTAK CD® CRT-D System). These differences in QRS duration arise from differences in the eligibility criteria in the trials on which the FDA approval is based.
- Biventricular pacemakers with or without an accompanying implantable cardiac defibrillator are considered investigative as a treatment of NYHA class I heart failure due to a lack of evidence demonstrating an impact on improved health outcomes.
- An intrathoracic fluid monitoring sensor is considered investigative as a component of a biventricular pacemaker due to a lack of evidence demonstrating an impact on improved health outcomes.
- The remainder of the policy is unchanged.
- Prior 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.

Respiratory Syncytial Virus (RSV) Prophylaxis

- The policy statement for prophylaxis in infants with congenital abnormalities of the airway or neuromuscular disease has been updated.
- Infants with congenital abnormalities of the airway or neuromuscular disease:
  - Less than two (2) years of age at onset of RSV season;
  - Infants have either congenital abnormalities of the airway or a neuromuscular condition that compromises handling of respiratory secretions.
  - Maximum of 5 monthly doses.
- The remainder of the policy is unchanged.

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- Prior authorization: Yes. The first dose of immune prophylaxis for RSV will be approved for administration on or after November 1.

Genetic Testing for Hereditary Breast and/or Ovarian Cancer

- All of the policy statements have been updated as follows:
- The policy title has been revised from "Genetic Testing for Hereditary Breast and/or Ovarian Cancer" to "Genetic Testing for Hereditary Breast and/or Ovarian Cancer (BRCA1, BRCA2 and CHEK2 Genes."
- Genetic testing of BRCA 1and BRCA2 may be considered medically necessary under any of the following circumstances:
  - Individual has a personal history of breast cancer including invasive cancer or ductal carcinoma in situ with ANY of the following:
    - Breast cancer diagnosed at age 45 or younger
    - Breast cancer diagnosed at age 46-50 AND one or more of the following:
      1. one or more first or second degree relatives (see definition in description) with breast cancer at age 50 or younger
      2. one or more first or second degree relatives with ovarian fallopian tube, or primary peritoneal cancer at any age
      3. with primary tumors in both breasts or clearly defined multiple tumors in one breast
      4. with limited family history
    - Triple negative breast cancer diagnosed before age 60. Triple negative breast cancers are estrogen and progesterone receptor negative and do not over express HER2 (sometimes referred to as HER2 negative).
    - Breast cancer diagnosed at any age with two or more first or second degree relatives with breast and/or ovarian, fallopian tube, pancreatic or primary peritoneal cancer at any age
    - Breast cancer diagnosed at any age with a personal history of ovarian, fallopian tube, or primary peritoneal cancer at any age
    - Breast cancer and of an ethnicity associated with higher mutation frequency (e.g., Ashkenazi Jewish)
    - Breast cancer with a first or second degree male relative with history of breast cancer
    - Personal history of male breast cancer
  - Individual is a member of a family with a known deleterious BRCA1 and/or BRCA2 mutation. For the purposes of this criterion, a family member is defined as a first or second degree relative or one or more additional relatives including great-grandparents, great-aunts, great-uncles, and first cousins. Individuals who meet this criterion are candidates for BRCA single-site analysis.
  - Personal history of ovarian, fallopian tube, or primary peritoneal cancer
  - Personal history of ovarian cancer at any age with two or more first or second degree relatives with breast and/or ovarian and/or pancreatic cancer at any age
  - Personal history of pancreatic cancer at any age with two or more first or second degree relatives with breast and/or ovarian and/or pancreatic cancer at any age
  - No personal history of breast, ovarian, fallopian tube, primary peritoneal or pancreatic cancer, but with a first or second degree relative meeting one or more of criteria above
- Testing for rearrangements of the BRCA1 and BRCA2 genes [BRAC®Analysis Rearrangement Test (BART)] may be considered medically necessary for individuals who:
  - meet one or more of the criteria for BRCA1 and/or BRCA2 testing, AND
  - have tested negative for mutations in BRCA1 and/or BRCA2 sequencing,
- Unless the criteria above are met, BRCA 1 and/or BRCA2 testing is considered investigative. There is a lack of clinical evidence demonstrating its impact on improved health outcomes.

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- Testing for CHEK2 genetic abnormalities (mutations, deletions, etc.) is considered investigative. There is a lack of clinical evidence demonstrating its impact on improved health outcomes.
- Testing for BRCA1 and/or BRCA2 mutations is considered investigative for individuals younger than age18.
- Prior authorization: Yes.

Policies inactivated

None

Policies reviewed with no changes in May and June 2011

- Allograft for Breast Reconstructive Surgery
- Artificial Intervertebral Discs: Cervical Spine
- Audiovisual Entrainment
- Auditory Integration Training
- Cardiovascular Disease Risk Assessment and Management: Laboratory Evaluation of Lipid Subclasses
- Cellular Immunotherapy for Prostate Cancer
- Compassionate Use
- Constraint-induced Movement Therapy for Motor Disorders in Children
- Corneal Topography/Computerized Corneal Topography
- Cranial Electrotherapy Stimulation
- Dalfampridine (Ampyra)
- Diastasis Recti Abdominis Repair
- Dynamic Spinal Visualization
- Dynesys® Spinal System and Lumbar Dynamic Stabilization
- Fetal Tissue Transplantation
- Hematopoietic Stem-Cell Transplantation in the Treatment of Germ-Cell Tumors
- Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma
- Homocysteine Testing in Risk Assessment and Management of Cardiovascular Disease
- Liposuction
- Lung Cancer Screening Using Computed Tomography (CT) or Chest Radiographs
- Mastopexy
- Measurement of Lipoprotein-Associated Phospholipase A@ (Lp-PLA2 in the Assessment of Cardiovascular Risk
- Measurement of Long Chain Omega-3 Fatty Acids as a Cardiac Risk Factor
- Microprocessor-Controlled Prostheses for the Lower Limb
- Nociceptive Trigeminal Inhibition – Tension Suppression System (NTI-tss) for Treatment of Headache
- Organ Transplantation: Allogeneic Pancreas
- Organ Transplantation: Heart
- Organ Transplantation: Heart/Lung
- Organ Transplantation: Kidney

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- Organ Transplantation: Liver
- Organ Transplantation: Lung and Lobar Lung
- Organ Transplantation: Small Bowel
- Organ Transplantation: Small Bowel/Liver And Multivisceral
- Orthopedic Applications of Stem Cell Therapy
- Palliative Care
- Positron Emission Tomography (PET): Cardiac Applications
- Prometa
- Re-Birthing Therapy (Also Known as Coercive Holding Therapy or Attachment Therapy)
- Signal-Averaged Electrocardiography
- Spider Veins/Dermal Telangiectasias
- Spinal Fusion: Lumbar
- Suit Therapy for Motor Disorders
- Surgical Treatment of Femoroacetabular Impingement
- Systems Pathology Testing for Predicting Risk of Recurrence in Prostate Cancer
- Transilluminated Powered Phlebectomy
- Traction Decompression of the Spine (VAX-D, LORDEX, DRX9000)
- Unicondylar Interpositional Spacer (Unispacer)
- Vacuum Therapy for Female Sexual Dysfunction

FYI

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:

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