Provider Press

June 2011 / Vol. 15, No. 2

Federal HIPAA 5010 compliance brings important changes to providers

In order to meet compliance with the new Health Insurance Portability and Accountability Act (HIPAA) regulations mandated by the federal government, Blue Cross has made several changes that will affect providers:

ProviderHub.com to Availity.com Transition:

Blue Cross will join several other Blue Plans nationwide in using the Availity Health Information Network, a multi-payer web portal to allow viewing of remittances, eligibility and benefits and claim status online.

- Starting in **mid 3rd quarter** *remittances* will no longer be viewable on provider web self-service (PWSS). In place of this viewer, the remittance information will be available on Availity. More information on specific dates will be forthcoming via Provider Quick Points.
- Eligibility & benefits and claim status viewing will remain available on PWSS until December 31, 2011, after which time they will be viewable only on Availity.

In order to access and view your HIPAA transactions, including remittances, you must be a registered user of **Availity**, the exclusive clearinghouse and HIPAA transaction portal service utilized by Blue Cross.

- If you currently use **providerhub.com** to view your remittances, you must register for the Availity Remit Reader **before June 30, 2011** to ensure continued access.

Visit **Availity.com** to register, and follow the prompts on the right hand side of the page. Registration is free and easy.

4010 to 5010 Transition:

Starting **3rd quarter and continuing through December 31, 2011** – if you submit a 4010A1 version electronic claim, Availity will automatically convert it to a compliant 5010 claim for processing by Blue Cross. Once adjudication is completed, Availity will return it to you in the remittance format that you are registered to receive from Availity. Availity's flexibility to up-convert and down-convert claims is an added convenience for you as we all make the transition to 5010.

All claims must be submitted in HIPAA 5010 format no later than **January 1, 2012**.

Paper remittances from Blue Cross will be unavailable after 2011.

System Readiness:

Contact your practice management system and clearinghouse (if it is not Availity) to ensure you have full readiness for this transition.

Availity LLC is an independent company providing claims administration services.

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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

Healthy Start® Prenatal Support

Healthy Start is a personal, phone-based support and education program for pregnant women. The program helps pregnant women learn what they need to know to have the healthiest pregnancy and healthiest baby possible.

An experienced obstetric nurse provides education, support and encouragement throughout a woman's pregnancy and during the postpartum period. Pregnant women also receive a valuable prenatal resource guide and access to web-based and/or paper educational materials, as well as a $50 VISA reward card for completing the program.

Women who participate in the Healthy Start program have a 29 percent lower incidence of preterm birth and a 26 percent lower incidence of low birth weight babies compared to national rates published by the National Center for Health Statistics.

The Healthy Start program was developed to complement the care you are providing. Healthy Start nurses should be considered an additional resource to help ensure the best outcomes for mom and baby. If you would like additional information or brochures for the program, please contact us directly using the contact information below.

Healthy Start is available to all fully insured members, Prepaid Medical Assistance Program (PMAP)/ MinnesotaCare members and most self-insured members.

If a Blue Cross member is expecting, please encourage her to take advantage of this highly rated program by calling the customer service number on the back of her member ID card or contact Healthy Start directly using the contact information below.

Phone: **(651) 662-1818** or toll-free at **1-866-489-6948**
E-mail: **healthy_start@bluecrossmn.com**
Website: **myhealthystart.org**

Healthy Start conducts an annual member satisfaction survey. Below are the results from the 2010 survey[1]:

- 99% of moms reported that enrolling in the program was easy
- 99% of moms reported that the conversations with their nurse helped them feel more supported during their pregnancy
- 98% of moms rated their overall level of satisfaction with the program from good to excellent
- 98% of moms rated the courtesy and sensitivity of their nurse from very good to excellent
- 93% of moms indicated that the educational resources helped them better prepare for what to expect during their pregnancy
- 92% of moms felt their participation made a healthy difference in their family's lives

[1] N=887 Survey conducted via survey monkey for members who completed the Healthy Start program from April to December 2010. Survey response rate is 25 percent.

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

Publications available online

The following is a list of Quick Points and Bulletins published from March 2011 to May 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
QP4-11	Correct billing of ambulance mileage for Medicare Advantage plans
QP5-11	New pre-service appeal form
QP7-11	Blue Cross prepares to send HIPAA 5010 835 Health Care Claim Payment Advice (remittance) transaction
Bulletins	**Title**
P7-11	Upcoming change to code editing processes
P7R1-11	Upcoming change to code editing processes - revised
P8-11	April 2011 HCPCS code updates
P9-11	Replacement claims requiring documentation

Member rights and responsibilities statements

Blue Cross, Blue Plus and Blue Advantage/MinnesotaCare member rights and responsibilities can be found online at **bluecrossmn.com**. Click on "Our Company," "Values," then "Learn More" under Member Rights and Responsibilities.

If you would like a copy of the statements mailed to you, contact Pam Dempsey at **pamela_m_dempsey@bluecrossmn.com** or by phone at **(651) 662-7271** or **1-888-878-0139, ext. 27271**. Please specify which statement(s) you would like, along with your name and mailing address.

HIPAA 5010 compliance, *continued from page 1*

Questions?

If you have any questions about registration for Availity, please visit **Availity.com**. If you have immediate concerns about this transition, please contact Blue Cross provider services at **(651) 662-5200,** toll-free at **1-800-262-0820** or e-mail **networks@bluecrossmn.com**.

FYI

Provider information changes

Did you know that you can download the necessary forms to make changes to your information? You can change or update:

- Address
- Add a practitioner to your group
- Remove a practitioner from your group
- Add a clinic or branch
- Request to become a behavioral health or chiropractic Select provider
- Request to become a Blue Plus provider
- Directory suppress a practitioner or remove suppression
- Report a practitioner or clinic name change
- Change tax ID
- Add a location as a result of a merger
- Submit and receive electronic transactions
- Add, remove or update Electronic Fund Transfers (EFT)
- Submit NPI number

For instructions and forms, go to **providers.bluecrossmn.com**, select "Administrative updates" under "What's Inside."

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

Provider appeals

In an effort to ensure a timely, consistent and accurate review of provider appeals, please review the reminders listed below:

- Please include all relevant medical record documentation on both pre- and post-services claim appeals.
- Please use the appropriate forms when filing your appeal. The Administrative Uniformity Committee (AUC) appeal form must be used for all post-service claim appeals. Information regarding a new Pre-Certification/Pre-Authorization Appeal Request Form was published on April 25, 2010, in Provider Quick Points QP5-11 entitled "New Pre-Service appeal form." To access the form go to **providers.bluecrossmn.com**, select "Forms and Publications" then select "forms: pre-certification/pre-authorization" from the drop-down menu.
- Provider post-service claim denials are reviewed by a physician or other medical professional.

Your assistance in following the appropriate appeals process will help ensure consistency and timeliness as well as allow for efficiencies throughout the process for both Blue Cross and your office.

FYI

Blue Distinction Centers for Cardiac Care®: Program criteria for 2012

The selection criteria and Request for Information (RFI) survey development for the 2012 Blue Distinction Centers for Cardiac Care program for facilities are now underway. The invitations to complete the RFI for the 2012 full RFI cycle are scheduled to be sent to facilities during the second quarter of 2012. All current designated facilities will be required to complete the RFI, as well as new facilities seeking designation. The Blue Distinction Centers for Cardiac Care will continue to require the following data registry requirements for the 2012 cycle:

- Facilities are required to have active participation in the American College of Cardiology's (ACC) National Cardiovascular Data Registry (NCDR) CathPCI Registry and must have reported all adult percutaneous coronary intervention (PCI) procedures performed at the facility **from January 1, 2011 through December 31, 2011.** During the RFI process, the facility will be required to submit the CathPCI Registry 2011Y4 report that includes all four quarters that passed the CathPCI Registry data quality reports checks.
- Facilities are required to have active participation in the Society of Thoracic Surgeons' (STS) National Adult Cardiac Surgery Database and the facilities' cardiac surgeons with surgical privileges must have reported all adult cardiac surgery procedures, specifically Coronary Artery Bypass Graft (CABG) surgeries performed at the facility **from January 1, 2011 through December 31, 2011.** During the RFI process, the facility will be required to submit the STS 2012 Harvest 1 site-specific report that includes the STS Composite Quality Overall Star Rating. (Facilities will be asked to only submit their own data and not STS aggregate data.)
- Facilities are required to have ongoing participation in both the ACC and STS registries in which the facility continues to submit all of its data for those specific reporting time periods, according to the respective ACC and STS data submission due dates.

For more information, visit the National Cardiovascular Data Registry website at **ncdr.com** or the Society of Thoracic Surgeons website at **sts.org**.

REMINDER: All current designated Blue Distinction Centers for Cardiac Care facilities must reapply for designation during the 2012 full RFI cycle. This cycle will also be open to those facilities that did not complete an RFI survey during a previous RFI process, or for those facilities which did not meet eligibility requirements.

Information on the Blue Distinction® program and additional updates related to the Blue Distinction Centers for Cardiac Care program selection criteria can be found at **bcbs.com**. Please

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FYI

Provider manual updates

The following is a list of Blue Cross and Blue Shield of Minnesota provider manuals that have been updated from March 2011 to May 2011. As a reminder, provider manuals are available online at **providers.bluecrossmn.com**. To view the manuals, select "Forms and 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 11 – Coding Policies and Guidelines, Behavioral Health	• Behavioral health for professional billers • Intensive Residential Treatment Services (Medicaid Government Programs only) • Adult Non-Residential Crisis Services (Public Programs Members only) • Psychiatric consultation to Primary Care Practitioners • Units for Public Programs Members • Psychological and Neuropsychological testing • DIAMOND project • Pre-certification and concurrent review for inpatient/residential mental health and substance use disorder services • Professional behavioral health coding information • Behavioral health for Institutional (837I) billers

Centers for Cardiac Care, *continued from page 5*

periodically check this site for additional selection criteria for the 2012 RFI Cycle.

If you have any questions, please contact Lois Schmidt at **(651) 662-4830** or toll-free at **1-888-878-0139, ext. 24830** or by e-mail at **lois_schmidt@bluecrossmn.com**.

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

Quality Improvement

Quality improvement (QI) program

The Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) 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 finally 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 and 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**.

Annual clinical practice guideline mailing

In June, Blue Cross will send out an annual mailing that includes 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 in Chapter 3 at **providers.bluecrossmn.com**, select "Forms & publications" then "manuals" in the drop-down menu to access the 2011 Provider Policy & Procedure Manual.

Medical necessity decisions

All denial decisions are made by licensed, board-certified physician reviewers, licensed consulting psychologists, or licensed chiropractors, as appropriate. Peer reviewers are available by telephone to discuss utilization review decisions based on medical necessity. To discuss a medical or behavioral health necessity decision with a physician or other reviewer, call the telephone number listed on the notification letter.

Review UM criteria

Blue Cross and Blue Plus utilization management (UM) programs use written utilization review criteria to make medical necessity determinations. Upon request, any Blue Cross or Blue Plus practitioner may review the clinical criteria used to evaluate an individual case. Medical and behavioral health policies are available for your use and review on the Blue Cross website at **providers.bluecrossmn.com**.

Quality Improvement

Clinical practice guidelines

At Blue Cross, we believe that the use of clinical practice guidelines is a key component of health care improvement. Each year our Quality Council approves the adoption of select guidelines that are used to support various programs and initiatives. The guidelines do not substitute for sound clinical judgment; however, they are intended to assist clinicians in understanding key processes for improvement efforts.

Please note that some treatment and management options recommended in clinical practice guidelines may not be covered benefits under a member's health plan.

The clinical practice guidelines section can be reviewed on our provider website at **providers.bluecrossmn.com**. It can be found under "Forms & publications," then click "manuals" in the drop-down menu, "2011 Provider Policy and Procedure Manual," Chapter 3 -- Quality Improvement, "Clinical Practice Guidelines."

Recently updated Institute for Clinical Systems Improvement (ICSI) guidelines:

- Immunizations
- Prevention and Management of Obesity in Adults and Mature Adolescents
- Stable Coronary Artery Disease

Patient and family guidelines

The Institute for Clinical Systems Improvement (ICSI) has available sets of guidelines for patients and families. To view or print, visit **icsi.org** and click on "Guidelines & More."

You may also contact Pam Dempsey via e-mail at **pamela_m_dempsey@bluecrossmn.com**, or by phone at **(651) 662-7271** or **1-888-878-0139, ext. 27271** for more information.

Utilization management statement

Utilization management (UM) decision making is based only on appropriateness of care and service and on existing coverage provisions. Blue Cross does not compensate providers, practitioners or other individuals making UM decisions for denial of coverage or services. We do not offer incentives to decision makers to encourage denial of coverage or services that would result in less than appropriate care.

This statement is intended to inform and remind providers, practitioners, their employees and supervisors, upper management, medical directors, UM directors or managers, licensed UM staff and any other personnel who make UM decisions of this philosophy and practice.

Quality Improvement

After-hours access requirements

To meet regulatory and accreditation requirements, Blue Cross periodically checks over-the-phone instructions that members receive when calling providers after normal business hours.

As a Blue Cross provider, you are required to have a phone number that is answered 24 hours a day, by a person or an answering system, that provides members with:

1. Name of clinic.
2. An acceptable callback time frame if the patient is directed to leave a message.
3. Specific instructions on what to do in an emergency (such as hang up and call 911).
4. What to do in a nonemergency when the member needs medical advice. Include the name and phone number (with area code) of the individual or clinic the member should call. This location must also have a detailed message or a person answering the phone that will provide the member with instructions on obtaining medical care or advice.

Please review these requirements. The requirements are listed in the online 2011 Provider Policy and Procedure Manual (Chapter 3, Quality Improvement, page 3-6). The manual is available at **providers.bluecrossmn.com**, select "Forms & publications" then "manuals" in the drop-down menu.

If you have questions, contact Pam Dempsey at **pamela_m_dempsey@bluecrossmn.com** or by phone at **(651) 662-7271** or **1-888-878-0139, ext. 27271.**

Quality Improvement

2010 practitioner satisfaction survey for continuity and coordination of medical care

A practitioner satisfaction survey was conducted in late 2010 and included all practitioner specialties. The content of this report analyzes the frequency and usefulness of verbal and written communications from care sites, as well as satisfaction with feedback received from practitioners.

Continuity and coordination of care between care settings, such as hospital to ambulatory clinic, and transitions of care from specialists to primary care practitioners (PCPs) are fraught with potential safety issues for all Blue Cross members.

An external vendor programmed and hosted the online survey that produced a sample study of 5,475 practitioners and office managers from the Blue Cross provider network. A database was established by combining known e-mail addresses used by network management and provider services staff. Duplicates were removed. A total of 1,470 responses were received resulting in a response rate of 27 percent. (See chart below.)

The measurements and summary of responses received are as follows:

Measurement 1: *How satisfied are you with the feedback you receive from the practitioners?*

Overall, practitioners and office managers were satisfied with the feedback they received from all 13 types of practitioners assessed in measurement 1, with 11 of them rating above 90 percent and all of them above the established performance goal of 80 percent.

Measurement 2: *How useful is the information in the verbal or written communication (paper or electronic) from the care sites?*

Respondents report that the information shared is sometimes or usually useful in providing care to their members. Information relating to a consultation ranked the most useful at 97 percent while walk-in retail health clinic ranked the lowest at 73 percent.

Measurement 3: *How often do you receive verbal or written (paper or electronic) communications, such as discharge summaries, progress notes or consult letters from the care sites?*

Despite the high satisfaction level and reported usefulness of the information shared between providers and practice

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	Practitioners	Office Managers	QI Coordinators	Other
% Respondents	29% (423/1470)	40% (591/1470)	2% (36/1470)	29% (420/1470)

Data collection time period: November 11, 2010 to December 6, 2010.

Quality Improvement

Satisfaction survey, *continued from page 10*

sites, the frequency in which verbal or written communication occurred fell significantly below Blue Cross' performance goal of 80 percent for all 11 care sites.

First opportunity for improvement for measurement 3:

Improve the percent of primary care providers reporting emergency department (ED) discharge summary communications.

Barriers: Hospitals lack consistent policies regarding inclusion of PCP name and contact info in patient medical records and communications systems with which to send ED visit summaries to PCPs. Providers often lack the time to verbally communicate with PCPs, even if they know who the PCP is and how to reach him/her. Often, it is incumbent upon the ED physician to indicate that a discharge summary should be sent and to whom; otherwise, it is documented/dictated but not sent.

Recommendation: Send a letter to all Blue Cross contracted hospital contacts to encourage them to establish a consistent, embedded process for communicating the reason for the visit, tests performed and pending, new/adjusted medications and recommended follow-up to the appropriate PCP.

Second opportunity for improvement for measurement 3:

Improve the percent of primary care providers reporting timely, actionable inpatient hospital discharge summary communications.

Barriers: Hospitals lack consistent policies regarding inclusion of PCP name and contact info in patient medical records and communications systems with which to send hospital discharge summaries to PCPs. Hospitalists and other inpatient providers often lack the time to verbally communicate with PCPs, even if they know who the PCP is and how to reach him/her. Often, it is incumbent upon the inpatient physician to indicate that a discharge summary should be sent and to whom; otherwise, it is documented/dictated but not sent.

Recommendations: Communicate study findings via the provider newsletter, encouraging them to establish a consistent, embedded process for communicating the reason for the inpatient admission, discharge diagnoses, consultations, key tests and procedures performed, pending studies, prior and new/adjusted medications and recommended follow-up to the appropriate PCP. Provide resources and validated tools to assist with identification of patients at high risk of re-admission and key interventions to improve timely communication and follow-up with PCP, medication reconciliation, etc.

Additionally, embed potentially preventable readmissions (PPRs) quality metrics in the 2011 provider system aligned incentive contracts. Incent providers through contracted quality

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Quality Improvement

Satisfaction survey, *continued from page 11*

improvement initiatives to reduce and improve continuity of care through the use of system tools such as appropriate medication usage, and timely follow-up of members.

Patient-centered medical home

Since coordination of care is a key component of any medical home program, Blue Cross asked a number of questions in the current survey to assess the likelihood of seeing more medical home providers in its network and/or if practice sites have already implemented a component of medical homes, such as condition registries to support care management.

- About two in five respondents (19 percent) report their clinics plan to become medical home providers. Eight percent of respondents expect their clinics to become medical home providers within the next 12 months.
- Based on the survey, roughly two in five respondents (19 percent) indicate their clinics have population-based registries that can track patients enrolled in a medical home and both monitor and report their outcomes.
- Diabetes is the most common type of population-based registry, followed by immunizations. More than three in five respondents with a population-based registry report having a diabetes registry (74 percent) and/or an immunization registry (65 percent). More than half report having a registry for asthma (58 percent), depression (57 percent), and/or cardiovascular disease (57 percent).

Opportunity for improvement:

Increase and leverage the number of clinics certified as patient-centered medical home (PCMH) to improve care delivery.

Barriers: Most providers, even those with robust electronic health records (EHRs) lack robust data registries to assist in identification and monitoring of members with specific conditions that require care management to close clinical gaps in care, identify barriers to effective care and provide additional coordination of care.

Recommendations: Develop and implement comprehensive Blue Cross PCMH strategy in 2011 to include outcome analysis.

In summary, Blue Cross has an opportunity to increase the frequency of information being shared from across sites of care and from practitioner to practitioner. In particular, improved communication from EDs and hospital providers to PCPs, verbally and/or via timely and actionable discharge summaries, can prevent unnecessary hospital readmissions. A second significant opportunity is to implement a medical home initiative to increase the number of medical homes in the provider network certified by the State of Minnesota.

A follow-up practitioner satisfaction survey will be conducted again in 2011.

Coding Corner

July HCPCS changes

The Centers for Medicare & Medicaid Services (CMS) and the American Medical Association (AMA) have issued a few coding changes effective July 1, 2011. Watch for the upcoming July HCPCS bulletin for details and codes.

Level of service selection

When choosing an evaluation and management (E/M) level of service, the documentation used to achieve the level must be pertinent to that day's visit. Diagnoses or complaints noted but not treated during the visit cannot be counted toward the E/M level selection. For example, if a patient presents for a sinus infection but states they recently had a back strain that is being treated by another practitioner, the back strain diagnosis cannot be counted toward the E/M level selection.

Unlisted code reminder

When submitting a code that is by definition unlisted, not otherwise classified or not elsewhere classified, a narrative and/or documentation must be submitted describing the service or item. Your claim will be subject to rejection or denial if this information is not submitted.

Documentation hints

Each service billed must be supported by documentation in the patient's medical record. If you need to submit these medical records with your claim and/or appeal we want to remind you that if we cannot read or understand the documentation, the service may be subject to denial. Following are a few hints that may be helpful:

- If using acronyms or abbreviations unique to your specialty or practice, please send a legend with any submitted documentation. We keep copies of this information on file to help in future review of documentation.
- If the signature is hard to read, you can send a typed and signed legend so we can recognize the signature. We keep copies of this information on file to help in future review of documentation.
- If the documentation is handwritten, it must be legible

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: 02/23/2011 Notification Posted: 02/23/2011

Policies developed

None

Policies revised

Continuous or Intermittent Glucose Monitoring in Interstitial Fluid

- The policy title has been updated to include the terms "Intermittent" and "Interstitial Fluid." The term "Real-Time" has been removed.
- **ALL** policy statements have been revised as follows:
- **Intermittent Monitoring: (Applicable CPT codes: 95250, 95251)**
  Intermittent monitoring of glucose levels in interstitial fluid (up to 72 hours) may be considered medically necessary for patients with type 1 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 device proposed for use has received FDA approval for the age of the patient (See Coverage section for FDA approval information.) AND the patient meets all of the following criteria:
  - Type 1 diabetes; AND
  - Insulin injections are required three or more times per day or a medically necessary insulin pump is used for maintenance of glucose control; AND
  - 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:
    - 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).
- Continuous glucose monitoring systems may be considered medically necessary during pregnancy in individuals with diabetes when adequate metabolic control is not achieved as described above or when fasting hyperglycemia (greater than 150 mg/dL) or recurring episodes of severe hypoglycemia (less than 50 mg/dL) occur.
- All other uses of intermittent or continuous monitoring of glucose levels in interstitial fluid including but not limited to use in patients with type II diabetes and closed loop systems that do not require direct patient interaction are considered investigative.
- 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.

Medical and Behavioral Health Policy Update

Policies inactivated

None

Policies Effective: 04/13/2011 Notification Posted: 04/13/2011

Policies developed

None

Policies revised

Zoster Vaccine Live (Zostavax)

- The policy has been updated with the following statement:
- The administration of the live, attenuated zoster vaccine may be considered medically necessary for the prevention of herpes zoster in individuals 50 years of age and older.
- The remainder of the policy is unchanged.
- Prior authorization: No.

Policies inactivated

None

Policies Effective: 05/10/2011 Notification Posted: 03/29/2011

Extended Hours Home Care Skilled (Private Duty) Nursing

Extended hours of skilled nursing may be considered medically necessary when:

I. ALL of the following criteria are met:

A. The member must have a skilled nursing care need. Extended hours of skilled nursing is provided to meet the skilled needs of the member only; not for the convenience of the family caregiver.

B. The member must have a medically complex, or medically fragile condition that requires frequent (multiple times each day) nursing assessments and monitoring with changes in the plan of care and treatment goals in accordance with the individual's condition.

C. The member's skilled care needs can not be met through an intermittent skilled nursing visit.

D. The complexity of the member's treatment plan requires the skills of a registered nurse (RN) or licensed practical nurse (LPN) working under the supervision of an RN.

E. The required services must be appropriate for the treatment of the illness or injury.

F. The services are ordered by a professional practitioner, in accordance with their scope of practice (i.e. MD, DO) who is involved in the oversight of the individual's care and is included as part of a written treatment plan for a covered medical condition.

G. The services are provided in the member's private residence, not an inpatient or skilled nursing facility.

H. When determining the number of hours of coverage in a 24 hour cycle, approval must be based on an assessment and supporting documentation that describes the complexity and intensity of the member's care and the number and frequency of skilled nursing interventions needed.

Medical and Behavioral Health Policy Update

I. Other considerations include the family or caregiver's abilities. The goal should be to make the member and family as independent as possible and to gradually decrease nursing care hours as the member's medical condition improves and/or the family/caregiver have been taught and demonstrate the skills and ability to carry out the plan of care. The member and family should be made aware of this goal prior to the initiation of services and to expect that the number of extended hours of skilled nursing services approved will decrease with eventual termination of the extended hours of skilled nursing services.

J. A member who needs extended hours of skilled nursing is normally unable to leave home without being accompanied by a licensed nurse. The need for nursing care to participate in activities outside the home is not a basis for authorizing extended hours of skilled nursing services or expanding the hours needed for extended hours of skilled nursing services.

K. A nurse may accompany the member when the member's normal life activities (such as a child attending school) take the member outside the home. The medical needs of the member must meet the criteria requiring extended hours of skilled nursing. The term "normal life activities" does not include coverage of extended hours of skilled nursing when the member is receiving medical care in an inpatient facility, outpatient facility, hospital, physician's office or other medical care setting.

II. Extended Hours of Skilled Nursing for Greater Than 16 Hours/Day

In most cases, extended hours of skilled nursing services generally consist of 8 or more continuous hours, but typically not more than 16 hours per day. More than 16 hours per day of extended hours of skilled nursing care may be considered medically necessary when the criteria in Section I are met and in the following circumstances:

- Member is being transitioned from an inpatient setting to home.
- Member becomes acutely ill and the additional skilled nursing care will prevent a hospital admission. Consideration may be given for up to 24 hours a day of extended hours of skilled nursing services for a 3 day period.

III. Extended Hours of Skilled Nursing for Members Requiring Mechanical Ventilation:

Extended hours of skilled nursing may be considered medically necessary for members who are on a ventilator for respiratory insufficiency at home when the primary care physician or specialist has agreed to the home care plan and all of the following criteria are met:

A. Mechanical ventilation for life support is needed for at least 6 continuous hours a day.

B. The person is expected to be or has been ventilator dependent for 30 consecutive days.

Note: For members on a ventilator, home nursing up to 24 hours per day for up to three weeks upon an initial discharge from an inpatient setting as a transition to home may be considered medically necessary. Thereafter, up to 16 hours of home nursing per day is considered medically necessary.

IV. Concurrent Review

Continued extended hours of skilled nursing care may be considered medically necessary, when *all* of the following criteria are met:

A. All the criteria in Section I or III continue to be met.

B. Documentation that the home care nurse, in consultation with the physician, has completed follow-up and outcome reassessments, at least each 60 days, which include *all* of the following:

- A statement of goals including long and short term goals and need for continuing medically complex home care.
- The nursing and other adjunctive therapy progress notes indicating that necessary interventions or adjustments

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have been made.
- 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 medically complex home care needs.

C. Written documentation by the physician specifying the medical necessity, according to the criteria above, is required. Requested documentation may include, but is not limited to:
- A completed Form CMS-485 – Home Health Certification and Plan of Care
- Home care records
- A current physician's order, renewed at least every 60 days

V. Extended hours of skilled nursing is considered not medically necessary in the following situations, including but not limited to:

A. A caregiver is not available for training. Or, the caregiver is unwilling, or unable to comply with the plan of care.
B. The nurse providing care may not be the member's spouse, natural or adoptive child, parent, foster parent, sibling, grandparent or grandchild. This also includes any person with an equivalent step or in-law relationship to the member.
C. The member may not be in an acute inpatient hospital, inpatient rehabilitation, skilled nursing facility, intermediate care facility or a resident of a licensed residential care facility except as stated in the benefit chart.
D. In the school setting, the level of need still must be determined. All other criteria and limitations must be addressed.
E. Solely to allow respite for caregivers or member's family.
F. Custodial care (see definition)

- Prior authorization: Yes.

Policies Effective: 05/31/2011 Notification Posted: 02/24/2011

Policies developed

None

Policies revised

KRAS and BRAF Mutation Analysis
- The policy title has been updated with the term "BRAF."
- The policy has been updated with the following statements:
- BRAF mutation analysis is considered investigative to predict non-response to monoclonal antibodies cetuximab and panitumumab in the treatment of metastatic colorectal cancer due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- Use of KRAS mutation analysis is considered investigative for all other indications, including, but not limited to, its use to predict treatment non-response to the tyrosine-kinase inhibitor erlotinib and the monoclonal antibody cetuximab in non-small-cell lung carcinoma due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- The remainder of the policy is unchanged.
- Prior authorization: Yes, ONLY for KRAS mutation analysis.

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- Prior authorization for BRAF mutation analysis: 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.

Oral Fentanyl for Cancer-related Pain

- Revised the policy statement to include Abstral® and the generic form of Fentora (Fentanyl Buccal tablets) as examples of an oral fentanyl.
- The remainder of the policy is unchanged.
- Prior authorization: Yes.

Botulinum Toxin

- The policy has been updated with the following statements:
- Prevention (treatment) of chronic migraine headache in the following situations**:
  - Initial 6-month trial in adult patients who:
    - meet International Headache Classification (ICHD-2) diagnostic criteria for chronic migraine headache (e.g. migraine headaches lasting at least 4 hours on at least 15 days per month; migraine headaches for at least 3 months); AND
    - have symptoms that persist despite adequate trials of at least 2 agents from different classes of medications used in the treatment of chronic migraine headaches, e.g. antidepressants, antihypertensives and antiepileptics. Patients who have contraindications to preventive medications are not required to undergo a trial of these agents.
  - Continuing treatment beyond 6-months:
    - Migraine headache frequency reduced by at least 7 days per month; OR
    - Migraine headache duration reduced at least 100 hours per month.

** Only onabotulinumtoxinA has been studied and approved by the FDA for this indication.

- The statement regarding headaches in the investigative section of the policy now reads as follows:
  - Headaches, except as noted above for prevention (treatment) of chronic migraine headache.
- The remainder of the policy is unchanged.
- Prior authorization: Yes, ONLY for chronic migraine headaches. Initial approval will be a for 6 month trial, for up to 2 courses of treatment. Continued treatment beyond 6 months will require additional authorization.

Transcranial Magnetic Stimulation

- The policy has been updated with the following statement:
- Transcranial magnetic stimulation is considered investigative as a treatment of depression and other psychiatric/ neurologic disorders, such as schizophrenia or migraine headaches, due to a lack of clinical evidence demonstrating a sustained impact on improved health outcomes.
- The remainder of the policy is unchanged.
- Prior authorization: Not applicable.

Scintimammography/Breast-Specific Gamma Imaging/Molecular Breast Imaging

- The policy title has been updated to include the term "Molecular Breast Imaging."
- The policy has been updated with the following statement:
- Scintimammography, breast-specific gamma imaging, and molecular breast imaging are considered investigative

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for all applications, including but not limited to, use as a screening procedure for breast cancer, as an adjunct to mammography, including imaging for women with radiodense breast tissue, or in staging the axillary lymph nodes.
- Prior authorization: Not Applicable. However, services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial may result if criteria are not met.

Policies inactivated

Correlated Audioelectric Cardiography

Policies Effective: 06/27/2011 Notification Posted: 03/23/2011

Policies developed

None

Policies revised

Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood
- The policy has been updated with the following statements:
- Tandem autologous-autologous hematopoietic stem-cell transplantation for the treatment of solid tumors of childhood is considered investigative due to a lack of evidence demonstrating an impact on improved health outcomes.
- Allogeneic (myeloablative or nonmyeloablative) hematopoietic stem-cell transplantation for treatment of pediatric solid tumors is considered investigative due to a lack of evidence demonstrating an impact on improved health outcomes.
- Salvage allogeneic hematopoietic stem-cell transplantation for neuroblastoma or other pediatric solid tumors that relapse after autologous transplantation or fail to respond is 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.

Endovascular Procedures (Angioplasty and/or Stenting) for Intracranial Arterial Disease (Atherosclerosis and Aneurysms)
- The policy title has been updated to include the reference for aneurysms.
- The policy has been updated with the following statements:
- Intracranial stent placement may be considered medically necessary as part of the endovascular treatment of intracranial aneurysms for patients when surgical treatment is not feasible and standard endovascular techniques do not allow for complete isolation of the aneurysm, e.g., wide-neck aneurysm (4mm or more) or sack-to-neck ratio less than 2:1.
- Intracranial stent placement is considered investigative in the treatment of intracranial aneurysms except as noted above due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- The remainder of the policy is unchanged.
- Prior authorization: No. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Immune Globulin Therapy
- The policy title has been updated; "replacement" has been removed from the title.

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- The following statements in the Immune Systems Disorders section of the policy regarding Primary Immunodeficiencies have been updated:
- Common variable immune deficiency (CVID) when the following criteria are met;
  - Significant and clearly documented recurrent infections (e.g., recurrent pneumonias, frequent episodes of bacterial sinusitis, and not just isolated chronic sinusitis and
  - Abnormally low levels (2 standard deviations below the age-adjusted mean) of at least two classes of serum immunoglobulins (IgG, IgM, IgA); and
  - Onset of symptoms after two (2) years of age; and
  - Exclusion of other possible causes of hypogammaglobulinemia; and
  - A demonstrated impaired response to immunization with protein and/or polysaccharide antigens:
    - For protein antigens: Serum antibody titers to tetanus and/or diphtheria should be obtained before immunization with tetanus and/or diphtheria vaccine and then three to four weeks after immunization. An abnormal response is defined as less than a four-fold rise in antibody titer
    - For polysaccharide antigens: Serum antibody titers to pneumococcus should be obtained before immunizations and then three to six weeks after immunization with a polyvalent pneumococcal polysaccharide vaccine (such as Pneumovax). An abnormal response is defined as less than a four-fold rise in titer;
- IgG subclass deficiencies
  - Significant and clearly documented recurrent infections (e.g., recurrent pneumonias, frequent episodes of bacterial sinusitis, and not just isolated chronic sinusitis); and
  - A demonstrated impaired response to immunization with protein and/or polysaccharide antigens:
    - For protein antigens: Serum antibody titers to tetanus and/or diphtheria should be obtained before immunization with tetanus and/or diphtheria vaccine and then three to four weeks after immunization. An abnormal response is defined as less than a four-fold rise in antibody titer
    - For polysaccharide antigens: Serum antibody titers to pneumococcus should be obtained before immunization and then three to six weeks after immunization with a polyvalent pneumococcal polysaccharide vaccine (such as Pneumovax). An abnormal response is defined as less than a four-fold rise in titer;
- The following statement has been removed from the policy: Exclusion of other possible predisposing conditions, such as allergy, gastroesophageal reflux, bronchopulmonary dysplasia, or exposure to an environment that may result in increased exposure to respiratory infections (e.g., a daycare center).
- The following statements in the subcutaneous immune globulin therapy (SCIg) section of the policy regarding primary Immunodeficiencies have been updated:
- Common variable immune deficiency (CVID) when the following criteria are met:
  - Significant and clearly documented recurrent infections (e.g., recurrent pneumonias, frequent episodes of bacterial sinusitis, and not just isolated chronic sinusitis); and
  - Abnormally low levels (2 standard deviations below the age-adjusted mean) of at least two classes of serum immunoglobulins (IgG, IgM, IgA); and
  - Onset of symptoms after two (2) years of age; and
  - Exclusion of other possible causes of hypogammaglobulinemia; and
  - A demonstrated impaired response to immunization with protein and/or polysaccharide antigens:
    - For protein antigens: Serum antibody titers to tetanus and/or diphtheria should be obtained before immunization

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with tetanus and/or diphtheria vaccine and then three to four weeks after immunization. An abnormal response is defined as less than a four-fold rise in antibody titer

- For polysaccharide antigens: Serum antibody titers to pneumococcus should be obtained before immunizations and then three to six weeks after immunization with a polyvalent pneumococcal polysaccharide vaccine (such as Pneumovax). An abnormal response is defined as less than a four-fold rise in titer.

- The remainder of the policy is unchanged.
- Prior authorization: Yes, for all indications except pre- and post-transplantation of solid organs and hematopoietic stem-cell transplantation.

Percutaneous Facet Joint Denervation

- The policy has been updated with the following statement:
- Diagnostic, block (2 separate blocks on different days), with local anesthetic *only (no steroids or other drugs)*, of the facet nerve (medial branch block) or injection under fluoroscopic guidance into the facet joint has:
- Resulted in at least 80% reduction in pain for the duration of the specific local anesthetic used (e.g., bupivacaine or lidocaine); and
- The remainder of the policy is unchanged.
- Prior authorization: Yes.

Policies inactivated

None

Policies Effective: 08/01/2011 Notification Posted: 04/29/2011

Policies developed

Positron Emission Mammography

The use of positron emission mammography (PEM) is considered investigative due to a lack of clinical evidence demonstrating its impact on improved health outcomes.

- Prior authorization: Not applicable.

Digital Breast Tomosynthesis

- Digital breast tomosynthesis is considered investigative in the screening or diagnosis of breast cancer due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- Prior authorization: Not applicable.

Peripheral Nerve Stimulation of the Trunk or Limbs for Treatment of Pain

Peripheral nerve stimulation of the trunk or limbs, including but not limited to stimulation of the radial, sciatic, and ileoinguinal nerves, is considered investigative for the treatment of all acute and chronic pain indications due to a lack of evidence demonstrating its impact on improved health outcomes.

Peripheral nerve (regional) field stimulation is considered i for the treatment of chronic pain due to a lack of evidence demonstrating its impact on improved health outcomes

- Prior authorization: Not applicable.

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Tesamorelin (EGRIFTA®)

Tesamorelin (Egrifta®) is considered investigative due to a lack of clinical evidence demonstrating its impact on improved health outcomes.

- Prior authorization: Not applicable.

Policies revised

Charged- Particle (Proton or Heavy Charged-Particle) Radiation Therapy

- The policy title has been updated to include the word Heavy Charged Particle.
- The policy has been updated to include non-small –cell lung cancer as a specific investigative indication for use of proton beam therapy.
- Prior authorization: Yes.

Pressure Reducing Support Surfaces

- The policy has been updated with the following statements:
- The term 'patient' has been replaced by 'member' throughout the description and policy sections.
- The prior authorization period for Group 2 surfaces has been changed form 3 months to 6 months and criteria for continued use after the initial 6-month authorization has been clarified.
- Criteria for Group 3 surfaces have been changed to clarify that the member must continue to meet medical necessity criteria for subsequent approval of continued use air-fluidized bed.
- Prior authorization: Yes, ONLY as follows:
  - Group 2 items, every six months.
  - Group 3 items, monthly.

  Rental vs. purchase information:
  - Group 1 items are eligible for rental or purchase.
  - Group 2 items are eligible for rental only and are considered purchased after 10 months of medically necessary rental.
  - Group 3 items are eligible for medically necessary rental only.
- In the absence of a medical policy addressing a specific DME item, the medical criteria of the regional DME Medicare Administrative Contractor (MAC) will be used in determining the medical necessity of the item. Those policies are available by accessing the List of LCDs on the CMS Coverage Database.

Sacral Nerve Stimulation for Pelvic Floor Dysfunction

Revised policy statement to include criteria for recent FDA approval for the treatment of chronic fecal incontinence.

- The remainder of the policy is unchanged.
- Sacral nerve stimulation or neuromodulation may be considered medically necessary for the treatment of chronic fecal incontinence in patients who meet **all** the following criteria:
- Fecal incontinence of greater than 2 incontinent episodes on average per week with duration greater than 6 months or for more than 12 months after vaginal childbirth; *and*
- Documented failure or intolerance of conventional therapy (e.g., dietary modification, the addition of bulking and pharmacologic treatment for at least a sufficient duration to fully assess its efficacy, and/or surgical corrective therapy performed more than 12 months [or 24 months in case of cancer] previously); *and*

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- Fecal incontinence is not related to a treatable medical or surgical condition (e.g., congenital anorectal malformation; visible sequelae of pelvic radiation; active anal abscesses and fistulae); *and*
- The patient is an appropriate surgical candidate for sacral nerve stimulation; and
- A percutaneous test stimulation with the device has provided at least a 50% reduction in incontinence symptoms.
- All other uses for sacral nerve stimulation or neuromodulation are considered investigative, including but not limited to, the treatment of chronic constipation or chronic pelvic pain.
- Prior authorization: Yes, only for placement of a permanent stimulator for chronic fecal incontinence. Services with specific coverage criteria may be reviewed retrospectively to determine if criteria are met. Retrospective denial of coverage may result if criteria are not met.

Meniscal Allografts and Collagen Meniscus Implants
Revised the policy statement regarding the use of meniscal allografts combined with other procedures such as autologous chondrocyte implantation (ACI), osteochondral allografts and osteochondral autografts.

Meniscal allograft transplantation may be considered **MEDICALLY NECESSARY** when performed in combination, either concurrently or sequentially, with autologous chondrocyte implantation, osteochondral allografting, or osteochondral autografting for focal cartilage lesions.

- The use of collagen meniscus implants is considered **INVESTIGATIVE** due to a lack of evidence demonstrating an impact on improved health outcomes.
- The remainder of the policy is unchanged.
- Prior authorization: No.

Policies inactivated

None

Policies reviewed with no changes in February, March and April 2011

- Adoptive Immunotherapy
- Allergy Testing and Treatment
- Anesthesia-Assisted Opioid Withdrawal
- Anti-CCP Testing for Rheumatoid Arthritis
- Artificial Intervertebral Disc: Lumbar Spine
- Automated Point-of-Care Nerve Conduction Tests
- Biomarker Genes for the Detection of Lymph Node Metastases in Breast Cancer
- Bipolar Radiofrequency Stimulation and Ablation (Coblation) for Treatment of Musculoskeletal Conditions
- Biventricular Pacemakers for Treatment of Congestive Heart Failure
- Chemiluminescent Testing for Oral Cancer
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure
- Coverage of Routine Care Related to Cancer Clinical Trials
- Cryosurgical Ablation of Solid Tumors
- Detection of Circulating Tumor Cells in the Management of Patients with Cancer

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- Dialectical Behavior Therapy for Borderline Personality Disorder
- Electrical/Electromagnetic Stimulation for Treatment of Rheumatoid Arthritis
- Electrocardiographic (ECG) Body Surface Mapping
- Endoluminal Ablation for Treatment of Varicose Veins/Venous Insufficiency
- Eye Movement Desensitization and Reprocessing for Posttraumatic Stress Disorder
- Full Body CT Scanning
- Genetic Testing for Helicobacter Pylori Treatment
- Genetic Testing for Hereditary Breast and/or Ovarian Cancer
- Genetic Testing for Tamoxifen Treatment
- Genetic Testing for Warfarin Dose
- Grenz Ray Therapy for Skin Conditions
- Hair Analysis
- Hematopoeitic Stem-Cell Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma
- Hematopoietic Stem Cell Transplantation for Multiple Myeloma
- Hippotherapy
- Home Prothrombin Time Monitoring
- Hospital Beds
- Humanitarian Use Devices
- Intra-articular Hyaluronan Injections for Osteoarthritis
- Intravenous Anesthetics for Treatment of Chronic Neuropathic Pain
- In Vitro Chemoresistance and Chemosensitivity Assays
- Intradiscal Electrothermal Annuloplasty (IDET), Percutaneous Radiofrequency Annuloplasty (PIRFT), and Intradiscal Biacuplasty
- Intravitreal Implant: Fluocinolone Acetonide
- Intravitreal Implant: Ganciclovir
- Islet Transplantation
- Ketamine for Treatment of All Mental Health and Substance-Related Disorders
- Laparoscopic and Percutaneous Techniques for the Myolysis of Uterine Fibroids
- Low -Density Lipid (LDL) Apheresis
- Low-level Laser Therapy and Deep Tissue Laser Therapy
- Lysis of Epidural Adhesions
- Measurement of Exhaled Nitric Oxide and Exhaled Breath Condensate in the Diagnosis of Asthma and Other Respiratory Disorders
- Methadone Maintenance Treatment for Chronic Opioid Dependence
- Microwave Thermotherapy for Primary Breast Cancer
- Multigene Expression Assay for Predicting Recurrence in Colon Cancer
- Near-Infrared Imaging for Evaluation of Coronary Artery Plaques
- Occipital Nerve Stimulation
- Pathfinder® Molecular Testing
- Percutaneous Techniques for Disc Decompression

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- Pfeiffer Treatment Center Metallothionein Protein (MT) Assessment and Treatment Protocol
- Photodynamic Therapy for Oncologic Applications, Including Barrett's Esophagus
- Photodynamic Therapy for Skin Conditions
- Phototherapy for Seasonal Affective Disorder
- Pneumatic Compression Devices
- Prolotherapy
- Psychoanalysis
- Quantitative Sensory Testing
- Radiofrequency Ablation of Solid Tumors, Excluding Liver Tumors
- Radiofrequency Catheter Ablation of the Pulmonary Vein for Treatment of Atrial Fibrillation
- Replacement of Amalgams
- Retinal Telescreening Systems for Diabetic Retinopathy
- Rhinomanometry and Acoustic/Optical Rhinometry
- Rhinoplasty
- Saliva Hormone Tests for Menopause
- Skin Contact Monochromatic Infrared Energy Therapy
- Squeeze Machine for Autistic Spectrum Disorders
- Surface Electromyography (SEMG)
- Surgical Interruption of Pelvic Nerve Pathways for Primary and Secondary Dysmenorrhea
- Temporary Prostatic Stents
- Transanal Radiofrequency Treatment of Fecal Incontinence
- Thermography
- Tobacco Cessation Treatments
- Treatment of Hereditary Angioedema with C1 Inhibitor or Plasma Kallikrein Inhibitor
- Treatment of Tinnitus
- Wireless Capsule Endoscopy

Claims Tips

Claims migration begins April 2012

Blue Cross is updating its claims systems to more efficiently comply with federal and state requirements, enable new business functionality in order to meet the growing demands of the marketplace, control costs and enable an expanded role as a health care company. Blue Cross' transition to a new claims system will begin its series of "go live" dates beginning in second quarter 2012. The new claims system will fully replace the STAR claims system by October 2013. There will be additional communications regarding specific impacts to providers as they are identified. We will also communicate information regarding the transition of groups closer to the go live date.

Please visit the **bluecrossmn.com** website for more information on the claims migration. If you have not already done so, sign up for the Really Simple Syndication (RSS) feed by selecting "Sign up for RSS feeds" in the "Tools & Resources" section of **providers.bluecrossmn.com** so you are alerted of new documents posted to our public website.

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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