

Provider Press

March 2011 / Vol. 15, No. 1



Kids with high blood lead levels: Resources for parents and providers

Blue Plus is committed to preventing lead poisoning and reducing the blood lead levels in children who test high. There are numerous resources for physicians, for parents of children who test high for blood lead levels, and for families who want to test the lead levels of paint in their homes.

The following websites offer a range of patient and provider resources:

- health.state.mn.us/divs/eh/lead – Minnesota Department of Health
– Lead education materials for parents and providers
- src-mn.org/SRC_Id_SourcesLead.htm – Sustainable Resource Center
– Information on home lead testing
– Steps for lead safety in the home
– Advice on diminishing lead exposure
- co.dakota.mn.us/healthfamily/healthyliving/children/childandteencheckupsinformationforproviders.htm – the Dakota County website on Child & Teen Checkups (includes statewide resources)
– Referral forms to refer patients to Sustainable Resources Center for free in-home visits

We've added a "Results" line to the Blue Plus blood lead voucher. If a child's results are available at the time you sign the voucher, please include them on the voucher. Blue Plus Dedicated Nurses will reach out to parents whose kids have a high blood lead level to make sure that they know what steps to take to help lower their child's blood lead level and to remove any sources of lead exposure from their home.

Lead, even at low levels, is known to cause developmental delays, learning and attention problems, and other neurological problems in children who are poisoned at a young age. Blue Cross encourages physicians to test blood lead levels in children, especially those enrolled in Minnesota Health Care Programs, as recommended by the Minnesota Department of Health.

Provider Press

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

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Claims Tips

New turnaround time process for urgent pre-certification/pre-authorization requests

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) adopted new review timelines for urgent pre-certification/pre-authorization requests received on or after March 1, 2011.

According to the Patient Protection and Affordable Care Act, Blue Cross and its affiliates must perform a 24-hour turnaround for urgent pre-certification/pre-authorization requests when those requests meet criteria for urgency.

This new review timeline process applies to health services provided for members in all health plans other than Minnesota Health Care Programs and Medicare Programs.

The federal regulations define an urgent request as:

- Requires immediate action to prevent a serious deterioration of a member's health that results from an unforeseen illness or an injury, or
- Could jeopardize the ability of the individual to regain maximum function

based upon a prudent layperson's judgment, or

- In the opinion of the treating physician, would subject the individual to severe pain that cannot be adequately managed without the treatment being requested. An urgent condition is a situation that has the potential to become an emergency in the absence of treatment.

Requests not meeting the conditions for an urgent request will be considered non-urgent. Non-urgent requests will be reviewed within the timeframe listed in Minnesota Statute 62M.05 subd.3a (10 business days).

To learn more about this, go to **providers.bluecrossmn.com** and enter QP3-11 in the search field to access Provider Quick Points QP3-11 entitled "**New turnaround time process for urgent pre-certification/pre-authorization requests.**"

FYI

Publications available online

The following is a list of Quick Points and Bulletins published from December 2010 to February 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
QP26-10	Reminder: Providers must check eligibility electronically
QP27-10	Medicaid subrogation claims
QP2-11	Replacement claims – Upcoming change: Adjudication automation
QP2R1-11	Revision: Replacement claims – Upcoming change: Adjudication automation
QP3-11	New turnaround process for urgent pre-certification/pre-authorization requests
Bulletins	Title
P40-10	Minnesota Health Care Program (MHCP) changes in chiropractic therapy and outpatient physical, occupational and speech therapy authorization process
P41-10	2011 Federal Employee Program benefits exclude residential treatment centers
P42-10	Interpreter services quality initiative state statute
P43-10	January 2011 HCPCS code updates
P1-11	Blue Cross medical policy and pre-certification/pre-authorization requirements for psychological and neuropsychological testing
P2-11	Blue Cross medical policy and pre-certification/pre-authorization requirements for autism spectrum disorders: early intensive behavioral intervention (EIBI)
P3-11	High-Technology Diagnostic Imaging (HTDI) program - delay in implementation of new decision support program
P4-11	Step therapy program applied to growth hormone therapies
P5-11	Important update as Blue Cross prepares to receive HIPAA 5010 transactions
P6-11	MHCP members need to utilize Blue Distinction Centers for Bariatric Surgery

Provider Demographic Change Form

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

- E-mailed to **Provider_Data@bluecrossmn.com**
- Faxed to **(651) 662-6684**
- Mailed to:
Blue Cross and Blue Shield of Minnesota
PDO, S116
P.O. Box 64560
St. Paul, MN 55164-0560

FYI

Provider manual updates

The following is a list of Blue Cross and Blue Shield of Minnesota provider manuals that have been updated from December 2010 to February 2011. As a reminder, provider manuals are available online at providers.bluecrossmn.com. To view the manuals, select “forms and publications” then “manuals.” Updates to the manuals are documented in the “Summary of changes” section of the online manuals.

Manual name	Chapter number and title	Change
Provider Policy and Procedure Manual	Chapter 4 – Integrated Health Management	Topics updated/validated
Provider Policy and Procedure Manual	Chapter 5 – Health Care Options	Topics updated/validated
Provider Policy and Procedure Manual	Chapter 6 – Blue Plus	Topics updated/validated
Provider Policy and Procedure Manual	Chapter 7 – BlueCard®	Topics updated/validated
Provider Policy and Procedure Manual	Chapter 8 – Claims Filing	Topics updated/validated
Provider Policy and Procedure Manual	Chapter 9 – Reimbursement/ Reconciliation	Topics updated/validated
Provider Policy and Procedure Manual	Chapter 10 – Appeals	Topics updated/validated
Provider Policy and Procedure Manual	Chapter 11 – Coding policies and guidelines, Coding section	<ul style="list-style-type: none"> · Preventive care services · Preventive services required under the PPACA
Provider Policy and Procedure Manual	Chapter 11 – Coding policies and guidelines, Modifiers section	<ul style="list-style-type: none"> · Content changes to modifiers -24, -25, -51, -59, -76 and -77 · Added modifiers -81, -82 and -QJ to modifier chart · Content changes to modifiers defined by DHS
Provider Policy and Procedure Manual	Chapter 11 – Coding policies and guidelines, Anesthesia section	<ul style="list-style-type: none"> · Modifiers and descriptions updated · Time designation/submission 1500HICF form chart removed
Provider Policy and Procedure Manual	Chapter 11 – Coding policies and guidelines, Chiropractic section	<ul style="list-style-type: none"> · Maintenance or palliative care · Radiology coverage restriction
Provider Policy and Procedure Manual	Chapter 11 – Coding policies and guidelines, Durable Medical Equipment section	<ul style="list-style-type: none"> · Medicare Advantage DME Rental Guidelines · Waiver Claim Submission · Coding Modifiers · DME repairs and maintenance (excluding oxygen equipment) · Billing for supplies

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FYI

Provider manual updates, *continued from page 4*

Manual name	Chapter number and title	Change
Provider Policy and Procedure Manual	Chapter 11 – Coding policies and guidelines, Hospital SNF section	<ul style="list-style-type: none"> · Critical care · Hospital observation · SNF billing for Blue Plus Government Program products
Provider Policy and Procedure Manual	Chapter 11 – Coding policies and guidelines, Laboratory section	<ul style="list-style-type: none"> · Introduction · Standing orders · Papanicolaou tests · Repeat lab services
Provider Policy and Procedure Manual	Chapter 11 – Coding policies and guidelines, Maternity section	<ul style="list-style-type: none"> · Newborn care · Reproduction treatment
Provider Policy and Procedure Manual	Chapter 11 – Coding policies and guidelines, Medical emergency	<ul style="list-style-type: none"> · Emergency department services · Extended/after-hours clinics
Provider Policy and Procedure Manual	Chapter 11 - Coding policies and guidelines, Medical services	<ul style="list-style-type: none"> · Evaluation and Management · Preventive Medicine · Allergy Immunotherapy · Chemotherapy Administration · Injections · Health Care Home section added
Provider Policy and Procedure Manual	Chapter 11, Coding policies and guidelines, Public Programs	<ul style="list-style-type: none"> · Minnesota Health Care Program · Child and Teen Checkups · Public Health Nursing Services · Interpretive services
Provider Policy and Procedure Manual	Chapter 11 – Coding policies and guidelines, Radiology services	Comparison X-ray
Provider Policy and Procedure Manual	Chapter 11 – Coding policies and guidelines, Rehabilitation services	<ul style="list-style-type: none"> · Physical therapy procedures · Physical therapy evaluation codes · Occupational therapy evaluation codes · Massage and manual therapy exclusion · Speech therapy and evaluation · Hot and cold pack exclusion · MHCP PT, OT, ST authorization process
Provider Policy and Procedure Manual	Coding policies and guidelines, Surgical services	<ul style="list-style-type: none"> · General guidelines · Global surgical package · Fractures · Stand-by Services

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FYI

Provider manual updates, *continued from page 5*

Manual name	Chapter number and title	Change
Blue Plus Manual	Chapter 1 – Introduction to Blue Plus	<ul style="list-style-type: none"> · Provider web self-service · Calls not handled by provider services · Care management phone numbers and addresses · Other phone numbers and addresses · BLUELINE
Blue Plus Manual	Chapter 2 – Blue Plus members	Topics updated/validated
Blue Plus Manual	Chapter 3 – Government Programs	<ul style="list-style-type: none"> · SecureBlueSM (HMO SNP) MSHO-Care Coordination Delegation Guidelines for Community Members 2011 · SecureBlue MSHO-Care Coordination Delegation Guidelines for Members in Nursing Facilities 2011 · Blue Advantage Minnesota Senior Care Plus (MCS+)-Care Coordination Delegation Guidelines for Members in Nursing Facilities 2011 · Blue Plus MinnesotaCare group numbers · Blue Advantage (PMAP) / MSC+ and GA/GAMC
Blue Plus Manual	Chapter 4 – Referrals	<ul style="list-style-type: none"> · Process · Goals · Referrals not required · General overview · Referral tips · Referral network for Primary Care Clinics directory

Quality Improvement

Access and availability guidelines

This information can also be found 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 and the Blue Plus Manual, Chapter 5.

Telephone Care: During Office Hours

Rationale: Patients need telephone access to medical care with a response time based on the urgency of their symptoms.

Requirements: During office hours, members calling a provider will be assessed according to patient care needs by a physician or designee:

- Immediately for emergencies: 100% of the time
- Within 30 minutes for urgent issues, 85% of the time
- Within four hours for all other call types, 85% of the time

Telephone Care: Incoming Calls

Rationale: A timely response to incoming phone calls promotes patient satisfaction.

Requirements:

- Calls answered in six rings or less
- On hold two minutes or less

Telephone Care After Hours

Rationale:

Patients must have access to instructions for obtaining care 24 hours a day, 7 days a week, and 365 days a year. When patients call your facility outside of routine business hours, it is important that they are able to receive directions on how to obtain care and get answers to their questions. To achieve this, providers

must have a telephone number that is answered 24 hours a day by either a live person, or an answering system that will provide patients information as outlined below:

- The name of the clinic that the patient is calling is clearly stated.
- Specific instructions on what the patient should do if they feel their situation is a medical emergency. This is often stated, "If you feel this is a medical emergency, please hang up and dial 911."
- Information regarding who the patient should call if it is not a medical emergency, but feel they need medical advice. Be certain to include the name, area code and telephone number of the individual or clinic to whom they are being directed.
- If the patient is directed to leave a message, an acceptable call back time frame must be provided to the patient awaiting the return call.
- All instructions should be articulated slowly and clearly in terms understandable to non-health care professionals.

Additional tips:

- If you are using an electronic answering machine, minimize excess background noise when recording your message and make sure the recording volume is

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Quality Improvement

Access and availability guidelines, *continued from page 7*

set to an appropriate level.

- If you are instructing the patient to call another location, that location must also have a detailed message or someone answering the phone that will provide the patient with instruction on obtaining medical care or advice.
- It is recommended that you audit your message according to these guidelines outside of normal business hours to make certain you are in compliance with the requirements.

Requirements:

To provide all primary care patients access to a 24-hour telephonic resource that clearly articulates and identifies back-up coverage by another participating primary care physician; and referrals to urgent care centers, where available and/or to hospital emergency care. Additionally, incorporating standards for call-back times based on what is medically appropriate to each situation when the patient must leave a message.

Appointment Access

Rationale:

Members' concept of the quality of care they receive often begins when they make an appointment. Blue Cross also wants to ensure that members are able to schedule appointments within a timely manner, relative to the services they seek.

Requirements: Satisfaction – Primary Care Providers Only

Routine Care: 85% of members will usually or always be satisfied with when they get a routine care appointment (routine care is that which the member does not need to see a practitioner right away).

Urgent Care: 85% of members will usually or always be satisfied with when they get an urgent care appointment (urgent care is that which is needed right away for an illness, injury or condition).

Wait Times

Preventive Care: Within 30 days 85% of the time for well child exam, annual physical exam, etc.

Routine Primary Care: Within 7 days 85% of the time for non-urgent symptomatic conditions.

Urgent Care: Same day 85% of the time for medically necessary care which does not meet the definition of emergency care.

Emergency Care – Immediate 100% of the time for immediately life threatening illnesses, injuries and conditions.

Behavioral health access and availability guidelines

Rationale: Members' concept of the quality of care they receive often begins when they make an appointment. Blue Cross wants to ensure that members are able to schedule appointments in a timely manner commensurate with the level of care they need.

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Quality Improvement

Access and availability guidelines, *continued from page 8*

Requirements:

Routine initial appointments: 90% of requests within 10 business days. Routine care is defined as a circumstance in which the individual does not present either emergent or urgent conditions and requests clinical services.

Follow-up appointment: 90% of requests within 10 business days of the initial appointment.

Urgent appointment: 100% of requests within 24 hours. Urgent care is defined as a circumstance in which the individual presents no emergency or immediate danger to self or others; however, the individual, clinician or concerned party believes that the individual's level of distress and/or functioning warrants assessment as soon as possible. An urgent condition is a situation that has the potential to become an emergency

in the absence of prompt treatment.

Non-life-threatening emergency

appointment: 100% of requests within 6 hours. A non-life-threatening emergency is defined as a circumstance in which the individual is experiencing a severe disturbance in mood, behavior, thought or judgment. There may be evidence of uncontrolled behavior and/or deterioration in ability to function independently that could potentially require intense observation, restraint or isolation.

Emergency care: 100% of member requests immediately. An emergency is defined as a circumstance in which there is imminent risk of danger to the physical integrity of the individual; the individual cannot be maintained safely in his or her typical daily environment.

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 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, 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**.

Quality Improvement

Making your organization more health literate using the AHRQ universal precautions toolkit

Limited health literacy affects over one-third of patients, making them less safe and interfering with their ability to take care of their health. But health literacy is more than just a deficit of certain individuals. A recent national literacy survey found only 12% of adults to be proficient at accessing and using health information and services. If only about 1 in 10 people can use health systems proficiently, then health literacy is clearly a systemic problem, and not just an individual problem.

The Health Literacy Universal Precautions Toolkit produced by the Agency for Healthcare Research and

Quality contains practical tools and resources for making organizations more health literate. Use the toolkit to help you assess the health literacy of your organization and implement concrete strategies for improving communications and empowering patients to manage their own care.

You can learn more about and access the toolkit online at ahrq.gov/qual/literacy.

If you are interested in talking about the toolkit or have questions about health literacy, please contact Alisha Ellwood, project manager, Blue Cross at **(651) 662-0986** or **Alisha_Ellwood@bluecrossmn.com**.

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.

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

- Preventive Services for Adults
- Preventive Services for Children and Adolescents
- Hypertension Diagnosis and Treatment
- Diagnosis and Management of Diabetes Mellitus in Adults, Type II
- Diagnosis and Treatment of Chest Pain and Acute Coronary Syndrome

Patient and Family Guidelines

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

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

Coding Corner

Flu vaccines 2011

The influenza vaccine codes Q2035-Q2039 were added effective January 1, 2011, for Medicare to identify specific flu vaccine products. Additionally, Medicare instructed that the existing CPT vaccine code 90658 would no longer be allowed. While our Medicare Advantage plan will follow Medicare's requirements, commercial plans will continue to accept 90658 as well as the new flu vaccine codes. However, edits will be instituted.

Only one flu vaccine code will be accepted: 90658, Q2035, Q2036, Q2037 or Q2038. Code Q2039 should not be submitted. If the vaccine is not specific to the products noted in codes Q2035-Q2038, Blue Cross expects the code 90658 to be submitted in lieu of the unlisted code Q2039. As a general policy, claims may be subject to denial if an unlisted code is submitted when a definitive code exists. Such would be the case for code Q2039.

Q2035 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)

Q2036 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)

Q2037 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin)

Q2038 Influenza virus vaccine, split virus, when administered to individuals 3 years

of age and older, for intramuscular use (Fluzone)

Q2039 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)

90658 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use

Claims edit reminder

Blue Cross' coding edits are updated at minimum annually to incorporate new codes, code definition changes and edit rule changes. While all of the code additions and revisions effective January 2011 are being accepted, edits involving the code changes for 2011 are currently under development and review. Once the edits are loaded, all claims submitted after the implementation date of this update, regardless of service date, will be processed according to the updated version.

Speaking of flu vaccines

The American Medical Association (AMA) discontinued two vaccine codes on December 31, 2010. These administration and product codes were created last year emergently for the H1N1 pandemic. To lessen confusion because this year's annual influenza vaccine contains H1N1, the AMA discontinued the H1N1 specific codes 90470 and 90663. This was announced on the CPT website at ama-assn.org/ama1/pub/upload/mm/362/vaccine-codes.pdf. This change was effective January 1, 2011.

April HCPCS changes

The Centers for Medicare and Medicaid Services (CMS) has already issued a few coding changes effective April 1. Watch for the upcoming April HCPCS bulletin for details.

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 (Blue Cross) 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 plan patients:

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

The "What's New" section identifies our latest new or revised policies approved by Blue Cross' Medical and Behavioral Health Policy Committee at least 90 days ago. These policies are now effective, and providers should begin following these policies immediately. These policies also appear in the "Active Policy" section of the Medical and Behavioral Health Policy Manual.

The "Upcoming Policies" section lists new or revised policies approved by the Blue Cross Medical and Behavioral Health Policy Committee and are effective 90 days from the date they were posted to the "Upcoming Policies" section of the Medical and Behavioral Health Policy Manual.

The "Active Policy" section contains the entire list of policies effective at the time of your inquiry. Please note, DHS programs have a separate section titled "Coverage Guidelines for DHS Programs (MHCP Manual)."

The "Pre-Certification/Pre-Authorization" section identifies various services, procedures, prescription drugs, and medical devices that require pre-certification/pre-authorization. Please note, Commercial (including BlueLink TPA) and MN Government Programs have different pre-certification/ pre-authorization lists and requirements. These lists are not exclusive to medical policy services only; they encompass other services that are subject to pre-certification/pre-authorization requirements. For your convenience, links to the "Commercial Forms" and "BlueLink TPA Forms" have also been provided.

If you have additional questions regarding medical or behavioral health policy issues, call provider services at **(651) 662-5200** or **1-800-262-0820** for assistance.

Medical and Behavioral Health Policy Update

Medical and Behavioral Health Policy Activity

There was no policy activity for December 2010.

Policies Effective: 04/25/11 Notification Posted: 01/25/11

Policies developed

Bioimpedance Devices for Detection and Management of Lymphedema

- The use of bioimpedance spectroscopy in the diagnosis and management of patients with lymphedema, including its use in the detection of subclinical secondary lymphedema, is considered investigative due to a lack of 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.

Microarray-Based Gene Expression Testing for Cancers of Unknown Primary

- Gene expression profiling, including but not limited to the Pathwork® Tissue of Origin test and the Pathwork® test kit-FFPE, is considered investigative to evaluate the site of origin of a tumor of unknown primary, and to distinguish a primary from a metastatic tumor due to a lack of evidence supporting 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.

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

- The use of ultrasound-guided high-intensity focused ultrasound (HIFU) ablation for treatment of prostate cancer, or any other cancer, is considered investigative due to the lack of necessary regulatory approval from the U. S. Food and Drug Administration (FDA).
- Prior authorization: Not applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Policies revised

Thrombopoietin Mimetic Agents for Immune Thrombocytopenic Purpura

- Thrombopoietin mimetic agents are considered investigative in the use of thrombocytopenia due to chronic liver disease.
- The remainder of the policy is unchanged.
- Prior authorization: Yes.

Altered Auditory Feedback for Treatment of Stuttering

- Revised the policy statement for altered auditory feedback for treatment of stuttering; it is considered investigative due to a lack of evidence demonstrating an impact on improved health outcomes.
- Prior authorization: Not applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Spinal Cord Stimulation

- The policy has been updated with the following statement:
- Documentation from the patient's primary care physician or a mental health professional (i.e., psychiatrist or Ph.D. psychologist) that any identified mental health or chemical dependency disorders are being or have been addressed.

Medical and Behavioral Health Policy Update

- The remainder of the policy is unchanged.
- Prior authorization: Yes, for the trial stimulation and for the permanent implantation.

Ventricular Assist Devices and Total Artificial Hearts

- The policy has been updated with the following statements:
 - **Ventricular Assist Devices**
Implantable ventricular assist devices with FDA approval may be considered medically necessary as a bridge to recovery in patients with a potentially reversible condition, including but not limited to:
 - Cardiogenic shock;
 - Cardiomyopathy;
 - Myocarditis;
 - Following cardiac surgery when the patient cannot be weaned from cardiopulmonary bypass.
 - Implantable ventricular assist devices with FDA approval may be considered medically necessary as a bridge to heart transplantation in adults who meet one of the following criteria:
 - The patient is currently listed as a heart transplantation candidate and is not expected to survive until a donor heart can be obtained; OR
 - The patient is undergoing evaluation to determine candidacy for heart transplantation.
 - Implantable ventricular assist devices with FDA approval, including humanitarian device exemptions, may be considered medically necessary as a bridge to heart transplantation in children and adolescents who meet one of the following criteria:
 - The patient is currently listed as a heart transplantation candidate and is not expected to survive until a donor heart can be obtained; OR
 - The patient is undergoing evaluation to determine candidacy for heart transplantation.
 - Implantable ventricular assist devices with FDA approval may be considered medically necessary as destination therapy in patients with end-stage heart failure who are ineligible for heart transplantation and who meet one of the following criteria:
 - Symptoms of New York Heart Association (NYHA) class IV heart failure for 60 days; OR
 - Symptoms of NYHA class III/IV for at least 28 days and dependent on intra-aortic balloon pump for 14 days or IV inotropic agents, with two failed weaning attempts.
- 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.

Policies inactivated*

None

Medical and Behavioral Health Policy Update

Policies Effective: 05/02/11 Notification Posted: 01/31/11

Policy developed

Psychological and Neuropsychological Testing

• I. Psychological and/or Neuropsychological Testing

Psychological testing and/or neuropsychological testing may be considered medically necessary when *all* of the following criteria have been met in addition to criteria specific to the type of testing listed in sections II and III:

- Testing is ordered by a physician (primary care or specialist) or Ph.D.-level clinical psychologist;
- Testing is supervised and interpreted by a licensed behavioral health professional who is certified or registered to administer appropriate assessment instruments;
- Results of testing will be used to facilitate the individual's treatment by helping to establish the diagnosis of, and develop or modify a treatment plan for, a psychiatric or neuropsychological disorder;
- Testing instruments and time allotted for testing are appropriate for and limited to the unique clinical presentation of the individual; and
- The most current versions of validated and reliable psychological and neuropsychological testing instruments are utilized, or if an older version is used, there is specific rationale for use of that version.

• II. Psychological Testing

Psychological testing may be considered medically necessary when testing is required for *either* of the following criteria in addition to those listed in section I:

- To aid in differential diagnosis of a mental health condition when a individual's symptoms and presentation are not readily attributable to a particular psychiatric diagnosis despite previous, comprehensive psychiatric/psychological evaluation, and the questions answered by testing will improve diagnostic clarity and efficacy of treatment planning;
- or
- To develop or modify a treatment plan when an individual who has received mental health treatment intervention is not achieving the expected results and appropriate revisions or alternatives are unclear.

• III. Neuropsychological Testing

Neuropsychological testing may be considered medically necessary when testing is required for either of the following criteria in addition to those listed in section I:

- To evaluate the extended pediatric age range (birth to 21) when there is a suspected delay or impairment in the development of cognitive skills or neurocognitive functioning; or
- To evaluate an individual who has experienced a significant change in mental status, behavior change, or memory disturbance that is felt to be secondary to congenital or acquired brain injury or disease.

• Psychological and/or neuropsychological testing is considered not medically necessary for the following:

- Solely for diagnosis or management of chronic fatigue syndrome
- Solely for diagnosis or management of attention deficit and hyperactivity disorder (ADHD) in the absence of other signs or symptoms suggestive of other mental health or neurocognitive disorders which meet medical necessity requirements for testing
- Diagnosis or management of eating disorders
- Baseline testing in the absence of signs/symptoms of injury or illness, unless a baseline assessment of psychological or neurocognitive function is needed prior to a procedure that has a high likelihood of resulting in psychological or

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neurocognitive change. Examples include, but are not limited to:

- Resection of brain tumors and arteriovenous malformations
- Surgical resection of seizure foci in epilepsy
- Solid organ transplantation
- Stem cell transplantation
- Solely for presurgical assessment unless the criterion for baseline testing prior to surgery listed above is met
- Testing is a routine part of an intake assessment
- Testing is performed while an individual is actively abusing substances, having acute withdrawal symptoms or has recently entered into recovery
- Testing results are solely for rehabilitation or vocational counseling purposes
- Testing is predominately for academic or educational purposes
- Testing is part of a disability determination
- Testing is solely the result of, or for the purpose of, litigation (e.g., custody hearing)
- Brief rating scales, screening tools and standardized questionnaires that can be done as part of a professional visit are considered incidental to the visit and should not be charged for separately. Rating scales and checklists are used to augment a clinician's evaluation of the patient. They may be completed by the patient, parents, teachers, or others, depending upon the age of the patient and the nature of the behavioral health or neurological condition being assessed. Examples of rating scales include the Beck Depression Inventory, Patient Health Questionnaire (PHQ-9), Mini-Mental State Examination, and the Connors Parent and Teacher Rating Scale.
- Prior Authorization: Yes.

Policies revised

Autism Spectrum Disorders: Assessment

- The policy title has been updated; Pervasive Developmental Disorders has been removed.
- The policy has been updated with the following statements:
- Diagnostic assessment of Autism Spectrum Disorders (ASDs) may be considered medically necessary when the assessment is multidisciplinary in nature and includes the following:
 - Diagnostic assessment by a licensed Mental Health Professional; and
 - Current diagnoses on all five (5) axes of the DSM-IV multiaxial system; and
 - A complete medical evaluation by a licensed physician; and
 - Testing, supervised and interpreted by an independent, licensed psychiatrist or Ph.D. psychologist, including standardized:
 - Intellectual testing; *and*
 - Adaptive testing; *and*
 - Communication testing; *and*
 - Autism measures (e.g., ADOS, CARS, ADI-R); *and*
 - A comprehensive hearing test by an audiologist.
- In addition, the developmental diagnostic and medical evaluation includes ALL of the following:
 - The member's developmental history, focusing on developmental milestones and delays, *and*
 - Family history; examples of important information include whether there are other family members with an ASD,

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- mental retardation, fragile X syndrome, or tuberous sclerosis, *and*
- The member's medical history such as signs of deterioration, seizure activity, brain injury, head circumference, *and*
- Conduct or secure the results of a physical exam within the past 12 months, *and*
- Lead screening for those members with mental retardation, *and*
- Review of educational (school) system records, *and*
- Other evaluations and testing as indicated or as necessary to confirm the diagnosis.
- To ensure appropriate multidisciplinary care and use of benefits, there will be a comprehensive diagnostic assessment completed within the past 12 months on file for each member before health services for Autism Spectrum Disorders are initiated. The diagnostic assessment must indicate that the individual has the intellectual and functional capacity to benefit from the type and intensity of services proposed in the ITP.
- The remainder of the policy is unchanged.
- Prior authorization: No.

Autism Spectrum Disorders: Early Intensive Behavioral Intervention (EIBI)

- The policy title has been updated; Pervasive Developmental Disorders has been removed.
- The policy has been updated with the following statements:
- Early Intensive Behavioral Intervention (EIBI) for Autism Spectrum Disorders (ASDs) may be considered when all of the following criteria are met:
 - The member has a diagnosis of an Autism Spectrum Disorder (ASD) (DSM-IV-TR 299.00, 299.10, 299.80) and the components of the Diagnostic Assessment are completed as described in Medical Policy #X-43 Autism Spectrum Disorders: Assessment); *and*
 - The member's behaviors are having an impact on his/her development, communication, or adjustment such that:
 - The member cannot adequately participate in home, school, or community activities; or
 - The member presents a safety risk to self or others

AND

Individualized Treatment Plan

A time-limited, individualized treatment plan (ITP) has been developed based on a diagnostic assessment that has occurred no more than 12 months preceding initiation of treatment. The ITP must be multidisciplinary in nature, member centered, family focused, community based, culturally competent and least intrusive. The ITP must be developed specifically for each member. Treatment plans that are templates, or generic to a particular program, are not acceptable. Content of the ITP must include *all* of the following:

- Identification and detailed description of targeted behaviors/symptoms; *and*
- Objective, baseline measurement levels for each target behavior/symptoms in terms of frequency, intensity, *and* duration, including use of standardized autism measures; *and*
- A comprehensive description of treatment interventions and techniques specific to each of the member's targeted behaviors/symptoms, including documentation of number of service hours, in terms of frequency and duration, necessary for each intervention; *and*
- Establishment of treatment goals and objective measures of progress for each intervention specified; *and*
- Strategies for generalization of learned skills; *and*
- A description of parental education methods, goals and support services; *and*
- Strategies for coordinating treatment with school-based special education programs; *and*

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- Plans for transition through a continuum of treatments, services, and settings; *and*
- Measurable discharge criteria and a discharge plan;

AND

• Evaluation of Progress

- A summary document outlining the member's progress, based on the measures of progress established in the ITP, must be submitted to the Plan at least every 6 months; *and*
- Testing, supervised and interpreted by an independent, licensed Mental Health Professional who is qualified to administer appropriate assessment instruments, must be administered every 6 months for evaluation of treatment progress. Testing must include standardized:
 - Intellectual testing; *and*
 - Adaptive testing; *and*
 - Communication testing; *and*
 - Autism measures (e.g., ADOS, CARS, ADI-R); *and*
- If the member has reached maximal progress toward a specific treatment goal, the member may be re-evaluated for establishment of new treatment goals and transition to less intensive interventions.

AND

• Provider Qualifications

- At a minimum, the lead behavioral therapist, providing treatment and clinical supervision of EIBI must:
 - Meet the Minnesota Department of Human Services qualifications for "Mental Health Professional;" *and*
 - Hold an industry-recognized certification, such as that of a Board Certified Behavior Analyst or a Board Certified Associate Behavior Analyst; *and*
 - Be licensed to practice independently; *and*
 - Be credentialed and approved by the Plan; *and*
- Clinical supervision for unlicensed staff providing EIBI services must be provided by a Mental Health Professional who is licensed to practice independently, and who is credentialed and approved by the Plan. Such supervision by the Mental Health Professional must:
 - Include approval and review of the individual treatment plan (ITP) and case review of every member receiving clinical health services bimonthly (once every 60 days); *and*
 - Include at least one hour of on-site observation during the first 12 hours of services provided to a member; *and*
 - Include at least monthly on-site supervision, with on-site observation for at least one (1) hour for every 40 hours of service to a member.
- Prior Authorization: Yes, ONLY for Early Intensive Behavioral Intervention (EIBI) in which the level of treatment provided consists of more than nine (9) hours per week for intensive therapy. A week is defined as a period of seven consecutive days.

Policies inactivated

None

**Policies may be inactivated for any of the following reasons: 1) requests for coverage are no longer received for a particular therapy or procedure, 2) a particular therapy or procedure has become accepted medical practice, or 3) a particular therapy or procedure is already addressed in the subscriber contracts.*

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Policies reviewed with no changes in January 2011

- Ambulatory Event Monitors and Mobile Outpatient Cardiac Telemetry
- Anterior Eye Segment Optical Imaging
- Cooling/Heating Devices Used in the Outpatient Setting
- Dermatoscopy
- Electromagnetic Navigation Bronchoscopy
- Endoscopic Radiofrequency Ablation or Cryoablation for Barrett's Esophagus
- Extracorporeal Shock Wave Treatment for Plantar Fasciitis and Other Conditions
- Functional Neuromuscular Electrical Stimulation Devices
- Genetic Testing for Familial Alzheimer's Disease
- Hematopoietic Stem-Cell Transplantation for Chronic Myelogenous Leukemia
- Hematopoietic Stem-Cell Transplantation for Hodgkin Lymphoma
- Hematopoietic Stem-Cell Transplantation for Myelodysplastic Syndrome and Myeloproliferative Neoplasms
- Human Papillomavirus Vaccine
- Infliximab
- Laboratory Tests for Heart Transplant Rejection
- MRI-Guided Focused Ultrasound Ablation of Uterine Fibroids and Other Tumors
- Neurofeedback/Electroencephalogram (EEG) Biofeedback
- Occlusion of Uterine Arteries as Treatment for Uterine Fibroids
- Percutaneous Electrical Nerve Stimulation (PENS) or Percutaneous Neuromodulation Therapy (PNT)
- Pneumograms
- Pulmonary Rehabilitation
- Scar Excision/Revision
- Suprachoroidal Delivery of Pharmacologic Agents
- Transanal Endoscopic Microsurgery (TEMS)
- Treatment of Psoriasis (Phototherapy and Biologics)
- Treatment of Pulmonary Arterial Hypertension with Prostacyclin Analogues, Endothelin Receptor Antagonists, or Phosphodiesterase Inhibitors

Pharmacy Corner

Step therapy program applied to growth hormone therapies

Effective April 1, 2011, step therapy edits will be applied to growth hormone therapies, in addition to medical necessity review. Pre-certification/pre-authorization requests for growth hormone are currently evaluated based on medical necessity for growth hormone replacement. With the step therapy change, coverage for requests meeting medical necessity criteria may also be subject to the pharmacy step therapy criteria as well as other member specific benefits including the specialty drug program. The preferred agent on

the FlexRx and GenRx formularies is Omnitrope.

Members impacted by the step therapy will receive notification of the change. After March 31, 2011, for members subject to the step edit, non-preferred agents will be non-covered without an approved step therapy override.

For questions related to specific contract benefits, please contact provider services at **(651) 662-5200** or toll free at **1-800-262-0820**.

Helpful phone numbers	
BLUELINE (voice response unit)	(651) 662-5200 or 1-800-262-0820
BlueCard® member benefits or eligibility	1-800-676-BLUE (2583)
FEP (voice response unit)	(651) 662-5044 or 1-800-859-2128
Provider services	(651) 662-5200 or 1-800-262-0820
Please verify these numbers are correctly programmed into your office phones.	

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

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

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