Provider Press

September 2010 / Vol. 14, No. 3

Importance of blood lead screening

Children in Minnesota Health Care Programs have a higher risk of lead poisoning. For several years, Blue Plus and its participating providers, following federal and state guidelines, have succeeded in testing a high proportion of children. Gaps still exist, however, and new sources of lead have been uncovered, so blood lead testing for children around age 1 and age 2 remains a priority. Ideally, the first test should be done at 9 to 15 months of age, and a second test done at 15 to 30 months. A child who has never been tested should have one test before age 6 years.

In 2009, elevated lead levels were found in 176 Minnesota children (DHS figure). Recognizing a continuing problem, the Environmental Protection Agency recently issued new regulations requiring special training for contractors performing renovations on any structure built before 1978. While most lead poisoning in children results from ingestion of chips from lead-based paint, other sources include:

- Eating food (some imported candies) or drinking water that contains lead. Water pipes in some older homes may contain lead solder, from which lead can leach into the water. Movement of lead from soil into groundwater will depend on the type of lead compound and the characteristics of the soil.
- Ingestion of lead-based paint on toys or other small objects with high lead content.
- Household dust, which can contain lead from paint chips or soil brought in from outside.
- Spending time in areas where lead-based paints have been used and are deteriorating. Deteriorating lead paint can contribute to lead dust.
- Contact with clothes, utensils or equipment used by adults who work in jobs where lead exposure is high.
- Contact with cosmetic products or folk remedies that contain lead.
- Playing in some inflatable Ball Pit Bouncers

Even slightly elevated lead levels can cause damage. Consequences of lead poisoning include:

- Behavior problems
- Lower IQ
- Stunted growth
- Hearing loss
- Learning & attention problems
- Kidney damage

Blue Plus recently issued Provider Bulletin P27-10 entitled, "Importance of blood lead screening for children in Minnesota Health Care Programs" with details on correct coding, as a reminder that lead screening remains a required component of a well-child visit for Minnesota Health Care Programs members. Further information on blood lead testing is available on the following websites:

http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs_id_016647.pdf

health.state.mn.us/divs/eh/lead/reports/index.html

Provider Press

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

Medical records

Information regarding medical records requirements was published in Provider Quick Points QP14-10 entitled, "Medical records requirements improvement." To view the Quick Points go to **providers.bluecrossmn.com** and enter "QP14-10" in the search field located in the upper right corner.

Inside preview

Quality Improvement

Clinical practice guidelines

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

Please note that some treatment and management options recommended in clinical practice guidelines may not be covered benefits under a Blue Cross Blue and 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 - Health Care Improvement.

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

- Diagnosis and Management of Asthma
- Diagnosis and Management of Diabetes Mellitus in Adults, Type 2
- Colorectal Cancer Screening
- Routine Prenatal Care

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 toll free **1-800-382-2000, ext. 27271** for more information.

Pharmacy Corner

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

Pursuant to Statutes the State of Minnesota has developed the Minnesota Uniform Form for Prescription Drug Prior Authorization (PA) Requests and Formulary Exceptions (Uniform Form). The statute addressing formulary exceptions states: "Upon development of the form, all health care providers must submit requests for formulary exceptions using the uniform form, and all group purchasers must accept this form from health care providers." Additionally, as of January 1, 2011, the statute requires that "the uniform formulary exception form must be accessible and submitted by health care providers, and accepted and processed by group purchasers, through secure electronic transmissions."

In order to comply with the law, providers requesting formulary exceptions should use the Uniform Form. This document was last updated in July 2010. Please discard older versions of the Uniform Form or other, Blue Cross and Blue Shield of Minnesota specific, formulary exception requests forms previously used.

The July 2010 revisions to the form included updates that allow this form to also be used when requesting drug prior authorizations.

The Uniform Form is located on the Minnesota Department of Health's website. A link to this form as well as additional instructions for completing and submitting requests is located at **providers.bluecross.com** under Forms and Publications.

Claims Tips

Use correct subscriber ID for claim submission

Providers are reminded to enter the subscriber ID, including the alpha prefix, exactly as it appears on the subscriber ID card on the claim. It is important to receive correct information on the claims in order to adjudicate your claims as quickly, accurately and efficiently as possible. Submitting valid data supports our efforts for administrative simplification. To validate you have the correct subscriber ID in your practice management system, Blue Cross also recommends that you validate the member's eligibility on a monthly basis using the electronic Eligibility and Benefits transactions (270/271) or our secure provider web self-service (PWSS) portal according to the Minnesota Administrative Uniformity Committee (AUC) Best Practice. For more information regarding eligibility requests, please visit the AUC website at **health.state.mn.us/auc/**.

Common rejection reasons for electronic claim submission

As of July 1, 2010, Minnesota providers and contracted out–of-state providers have been required to submit all claims electronically to Blue Cross. Based on reports from our partner clearinghouse, Availity, and internal reporting, the most common errors with submission are as follows:

Error reason	Action
Ambulance Transport Information is required on Ambulance claims	When submitting a claim for ambulance services, be sure to complete the ambulance transport information (CR1 segment) and the ambulance certification information (CRC segment).
Diagnosis pointer cannot be duplicate to another pointer on this service line	Each diagnosis can be pointed to only once per line. Use each pointer value only once per line.
The original claim reference number (loop 2300, segment REF*F8) is required when the claim frequency code is a cancel or replacement (7 or 8)	When sending a cancel or replacement claim, the original reference number MUST be populated with the payer's original claim number.
Claim element values being submitted are invalid (for example, claim frequency type code, HCPCS codes, ICD-9-CM codes, Claim Adjustment Reason Codes, Remittance Advice Remark Codes)	Validate that the codes you are using are valid for the date of service on the claim if the code is part of a medical code set. For all other types of codes, validate that the code you are using is valid for the date of submission of the claim.
Invalid subscriber ID or alpha prefix	Verify the subscriber ID and/or prefix by checking eligibility for the patient before services being rendered or at time of service. You may use the electronic eligibility transaction or PWSS.

For more information regarding electronic claim common errors and recommended solutions, refer to Provider Quick Points QP8-10, entitled "Understanding and correcting rejected electronic claim submissions" that was issued May 17, 2010. To view the Quick Points go to **providers.bluecrossmn.com** and select forms and publications then Quick Points.

FYI

Publications available online

The following is a list of Quick Points and Bulletins published from June 2010 to August 2010 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
QP10-10	Provider agreement amendment mailing
QP11-10	Billing requirements for Platinum Blue℠ (Cost)
QP12-10	Blue Plus® Minnesota Health Care Programs (MHCP) members changes in Critical Access Hospital (CAH) billing
QP13-10	Reimbursement for eyeglasses changes for Minnesota Health Care Programs (MHCP) recipients
QP14-10	Improvement in medical records requirements
Bulletins	**Title**
P21-10	Access management program
P22-10	Update to Attachment B: Definition of outpatient health services categories
P23-10	July 2010 HCPCS code updates
P24-10	Pre-certification and concurrent review for outpatient mental health services
P25-10	Health care home guidelines (S0280/S0281 procedure codes)
P26-10	Level of care assessments and the use of the Level of Care Utilization System (LOCUS) tool for selected adult mental health services
P27-10	Importance of blood lead screening for children in Minnesota Health Care Programs (MHCP)
P28-10	DIAMOND initiative – reimbursement update
P29-10	Pre-certification and concurrent review requirements for Public Programs Long Term Adult Care (LTAC) and Acute Rehabilitation (Rehab) providers

Patient education materials

Supplement your patient education materials by ordering Blue Cross publications on the following topics: Depression, diabetes, heart care, influenza, pediatric ear infections and preventive health. To obtain the order form, go to **bluecrosmn.com** and enter "consumer health education materials" in the search window.

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 June 2010 to August 2010. 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
2010 Provider Policy and Procedure Manual	Chapter 1- At Your Service	Care Management numbers and addresses
2010 Provider Policy and Procedure Manual	Chapter 3 – Health Care Improvement	Multiple changes throughout
2010 Provider Policy and Procedure Manual	Chapter 4 – Care Management	· Types of prior authorization · Services for which prior authorization is recommended · DME and supplies reviewed · Medical referrals to nonparticipating providers
2010 Provider Policy and Procedure Manual	Chapter 5 – Health Care Options	· Guidelines for determining submissions to Medicare or Blue Cross · PMAP, MSC+ and PGAMC/ Blue Advantage · MinnesotaCare Program
2010 Provider Policy and Procedure Manual	Chapter 6 – Blue Plus	· Referral policy · Referral required · Definitions and clarifications
2010 Provider Policy and Procedure Manual	Chapter 8 – Claims Filing	Present on Admission (POA)
2010 Provider Policy and Procedure Manual	Chapter 9 – Reimbursement/ Reconciliation	Added a topic entitled Serious Preventable Medical Errors
2010 Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Behavioral Health	Multiple changes throughout
2010 Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Home Health, Home Infusion, Hospice	Multiple changes throughout
2010 Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Pharmacy	· Prior Authorization · Drug Formulary
2010 Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Public Programs	· Newborn circumcision · Hib shortage billing
2010 Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Radiology Services	High Technology Diagnostic Imaging Procedures
2010 Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Surgical Services	Correct billing of Q1003 for Medicare Advantage Products
2010 Blue Plus Manual	Chapter 1 – Introduction to Blue Plus	Contact information updated

continued on next page

FYI

Provider manual updates *continued*

Manual name	Chapter number and title	Change
2010 Blue Plus Manual	Chapter 3 – Government Programs	Multiple changes throughout
2010 Blue Plus Manual	Chapter 4 – Referrals	Updates to behavioral health referral contact information and general referral requirements
2010 Blue Plus Manual	Chapter 5 – Health Care Improvement	Multiple changes throughout

Really simple syndication

Not all provider publications are mailed out to providers. The majority of our informational Quick Points and the quarterly Provider Press are posted to our website for providers to view. Providers frequently ask us how they can be advised when new publications are added to the website at **providers.bluecrossmn.com**.

Providers can sign up to get RSS (really simple syndication) feeds of our latest news releases and updates to provider-related forms and publications. A sample of the feeds that can be requested includes:

- News releases
- Bulletins
- Forms: credentialing
- Forms: other
- How-to guides: claims
- Manuals
- Provider Press
- Quick Points

Go to **providers.bluecrossmn.com** and enter "RSS" in the search window to learn more about RSS. Questions about RSS feeds specific to your internal systems should be directed to your IT support area.

New interactive forms

In an effort to reduce costs and make it easier for providers to submit demographic data updates, Blue Cross and Blue Shield of Minnesota and Blue Plus has converted five of the most commonly used forms (see list below) into an interactive PDF format. This change will allow providers to submit their data updates via e-mail or fax in a printed copy of the form.

Forms converted to Adobe Interactive PDFs:

- Practitioner Add/Term/Change form
- Contract Request form
- Clinic Closure form
- Provider Demographic Change form
- Tax ID Change form

The forms are located in the "Forms & publications" section and can also be accessed in the "Administrative updates" section, which contains information on the most commonly asked administrative update questions.

To use the forms, a free version of Adobe Reader is required and can be downloaded at **adobe.com**.

FYI

Preventive care: more important than ever

Blue Cross has always supported preventive care as an important part of ongoing health care. That's why most Blue Cross health plans have had comprehensive preventive care coverage for many years. We continue to communicate with our members about the changes in preventive care and encourage them to use their preventive benefit.

What's new?

As you know, the Affordable Care Act, more commonly known as health reform, requires new health plans to provide 100 percent coverage for preventive care starting on September 23, 2010. New preventive care services have been added based on input from several advisory groups. Examples of these are:

- Screening, counseling and behavioral interventions for obesity in adults
- Screening for major depressive disorders in adolescents
- Prescribing of oral fluoride for children to prevent dental caries (if water is found low in fluoride)

Coverage

Collaborating with you is key to ensure that your patients and our members receive timely, complete preventive care. Our goal is to avoid surprises to members about what's covered as preventive care under their specific health plan coverage. Please help us reinforce the message that preventive care focuses on preventing conditions or diseases, and therefore some tests or treatment provided during a preventive care office visit may be covered under their medical benefit rather than preventive care.

Due to a "grandfathered" option in the law, some members' plans if covered through their employer may not follow the guidelines set by the new law. Employers are able to continue the same coverage that they've been providing if they choose to.

Use one of the methods listed below to verify eligibility and benefits for a BlueCard member:

- Submit a 270/271 HIPAA transaction
- Access PWSS at **providerhub.com**
- Call **1-800-676-BLUE (2583)**

Please watch for the specifics of how we will cover the new preventive care services in a Provider Bulletin or in a Quick Point online in "forms & publications" at **providers.bluecrossmn.com**, or call provider services at **(651) 662-5200** or **1-800-262-0820**.

Coding Corner

Signature requirement

While Blue Cross and Blue Shield of Minnesota does not require documentation be submitted with every claim, there are situations where medical documentation must be submitted. Because documentation relating to a medical service or visit is part of the patient's permanent legal record, Blue Cross has a policy on medical record documentation found in Chapter 3, Health Care Improvement, of the online *Blue Cross Provider Policy and Procedure Manual*. To view the manual go to **providers.bluecrossmn.com**.

One of the required elements of documentation that must be completed 100 percent of the time is a valid and legible provider signature. Because we have found documentation that does not meet this requirement, Blue Cross has reviewed and will be revising this policy.

Blue Cross will start denying claims if the required documentation does not contain a valid, legible, legal provider signature. No additional review or processing will be done if the claim is denied for this reason. Additionally, claims denied for an invalid legal signature will not be appealable.

While the effective date has not yet been determined, we would like you to be aware of this future change. We also want you to be aware that Blue Cross is planning to adopt the Centers for Medicare & Medicaid Services (CMS) more stringent signature policy, including, as noted above, that claims denied because of invalid or inadequate legal signature will not have appeal rights. More information will be sent later but we encourage providers to review their practices now and assure that all medical documentation contain a legal signature.

Local anesthesia reminder

Local anesthesia/anesthetics are included in the charge for the surgical procedure code. Blue Cross and Blue Shield of Minnesota does not allow a separate charge for this service. We have found, however, that some local anesthetic drug charges have been submitted separately under a variety of codes including J0670 (Injection, mepivacaine HCl, per 10 ml), J2001 (Injection, lidocaine HCl for intravenous infusion, 10 mg), S0020 (Injection, bupivicaine HCl, 30 ml), or S2400 (Injection, chloroprocaine HCl, per 30 ml) as well as the unlisted codes 01999 (Unlisted anesthesia procedure(s)) and J3490 (Unclassified drugs). Regardless of code, if submitted separately, the charge will be denied as provider liability.

October HCPCS and ICD-9-CM update

October 1 is a busy date for medical coding. First, there are several added and deleted HCPCS codes effective on that date. Also, October 1 is shared with the effective date for the added, revised and invalid ICD-9-CM diagnoses and procedures for 2011. A bulletin will be issued before the effective date with details, along with the new and deleted HCPCS codes. ICD-9-CM codes will not be included in the bulletin.

Medical and Behavioral Health Policy Update

Blue Cross and Blue Shield of Minnesota's medical and behavioral health policies are available for your use and review on the Blue Cross website at **providers.bluecrossmn.com**. Once there, select "Medical Policy" (under the Tools and 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 Medical and Behavioral Health Policy Manual. Here, there are several selections to assist with your inquiry.

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 "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 "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."

The "Prior Authorization Recommended" sections identify procedures, services, devices and drugs, recommended for prior authorization. For your convenience, a link to "Prior Authorization Forms" has also been provided. Please note, DHS and non-DHS programs have different prior authorization recommendations.

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

Medical and Behavioral Health Policy Activity

Policies Effective: 06/22/10 Notification Posted: 06/22/10
Note: these policies were effective immediately.

Policies developed

Dalfampridine (Ampyra)

- The use of dalfampridine (Ampyra) may be considered medically necessary when the following criteria have been met:
  Initial Review *:
  - A diagnosis of multiple sclerosis;
  - Prescribed by a neurologist;
  - No history of seizure disorder or epileptiform activity on EEG;
  - Creatinine clearance of 51 mL/min or greater (that is, cannot have moderate or severe renal impairment;
  - Completion of a timed 25-foot walking test, scored between 8 and 45 seconds.

  * Initial approval will be for 12 weeks.

  Review for Continuation of Therapy:
  - Demonstration of at least a 20 percent improvement in the timed 25-foot walking test.
- The use of dalfampridine (Ampyra) is considered investigative for all other indications.
- Prior Authorization: Yes. Coverage of medications referred to in this policy is subject to a product-specific formulary,

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specialty drug program or other requirements. For questions related to specific contract benefits, please call the customer service number on the member's identification card.

Cellular Immunotherapy for Prostate Cancer

- Sipuleucel-T therapy may be considered medically necessary for the treatment of prostate cancer in patients who meet all the following criteria:
  - Asymptomatic or minimally symptomatic disease (ECOG performance status 0-1); and
  - Progression of metastases, based on rising PSA levels and bone scan or CT scan demonstration of metastases, despite hormonal therapy (for example, LHRH agonist or anti-androgens).
- Sipuleucel-T therapy is considered investigative in all other situations, including but not limited to treatment of hormone-responsive prostate cancer, treatment of those with moderate to severe symptomatic metastatic prostate cancer, and those with visceral (liver, lung or brain) metastases.
- Prior authorization: Yes.

Medical and Behavioral Health Policy Activity

Policies Effective: 09/20/10 Notification Posted: 06/22/10

Policies developed:

Testing for Common Genetic Variants to Predict Risk of Non-Familial Breast Cancer

- Testing for one or more single nucleotide polymorphisms (SNPs) to predict an individual's risk of breast cancer is considered investigative due to a lack of evidence demonstrating the impact of testing on improved health outcomes.
- Prior Authorization: Not applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Policies revised:

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

- The policy has been updated with language indicating a tongue-based suspension is considered investigative for the treatment of obstructive sleep apnea and is considered not medically necessary for the treatment of snoring.
- The remainder of the policy is unchanged.
- Prior Authorization: Yes, for surgical procedures *ONLY*.

Sacral Nerve Stimulation for Pelvic Floor Dysfunction

- The following has been added to the policy: The off-label use of 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 to conventional therapy (for example, 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 (for example, 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 percent reduction in incontinence symptoms.
- The remainder of the policy is unchanged.
- Prior Authorization: Yes, *ONLY* for placement of a permanent stimulator for chronic fecal incontinence.

Respiratory Synctial Virus Prophylaxis

- The policy has been updated with the following indication: The use of immune prophylaxis (for example, palivizumab [Synagis]) for RSV for the patient's second year of treatment (maximum of 5 monthly doses) may be considered medically necessary for infants born 28 weeks of gestation and less than one year of age at onset of RSV season.
- The policy has been revised to clarify the RSV season is from November 1 through March 31. The first dose of immune prophylaxis for RSV will be approved for administration on or after November 1.
- Prior Authorization: Yes.

Spinal Fusion: Lumbar

- ALL policy statements have been revised as follows:
- Lumbar fusion may be considered medically necessary for any of the following conditions, when confirmed by radiographic imaging studies (for example, X-ray, CT, MRI):
  - Epidural compression or vertebral destruction from a tumor;
  - Idiopathic scoliosis over 40 degrees or progressive degenerative scoliosis;
  - Instability after debridement for infection;
  - Neural compression after spinal fracture;
  - Other causes of objectively documented symptomatic instability with compression of either the nerve root or the cauda equine;
  - Pseudoarthrosis;
  - Spinal tuberculosis;
  - Pars interarticularis fracture.
- Lumbar fusion may be considered medically necessary in conjunction with decompression surgery when *post-surgical instability is anticipated* for any one of the following:
  - Associated radical discectomy;
  - Intraoperative removal of excessive facet or pars interarticularis;
  - Recurrent disc herniation after failed laminectomy at the same segment;
  - Recurrent spinal stenosis at the same segment as a previous surgical procedure;
  - Spondylolisthesis.
- Lumbar fusion may be considered medically necessary for the treatment of degenerative conditions *with spinal instability* when the following criteria are met:
  - Radiographic documentation (plain radiographs, MRI, or CT scans) of spinal instability (>3 mm of translation and / or 10 degrees or more of angulation of one vertebra compared to the adjacent vertebra in a spinal motion segment); and
  - One of the following conditions are present:
    1. Post-laminectomy instability; or
    2. Flexible or progressive degenerative scoliosis or kyphosis.

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- Lumbar fusion may be considered medically necessary for chronic (present for at least 6 to 12 months) discogenic back pain (without instability) when all the following criteria are met:
  - Documentation, from the medical record, of unremitting pain and disability that is refractory to intensive conservative therapy for at least three months. Intensive conservative therapy must include all of the following:
    1. Anti-inflammatory medication and analgesics, unless contraindicated; and
    2. Physical therapy that includes all of the following components:
       - Passive treatment modalities (for example, thermal treatments, electrical stimulation, mechanical traction); *and*
       - An active, organized and progressive therapy program that includes strengthening, flexibility, balance, coordination and posture education; *and*
       - Instruction and training in the use of dynamic activities to improve function and performance; and
    3. Therapeutic injections; *and*
  - Documentation, from the patient's primary care physician or a mental health professional (that is, psychiatrist or Ph.D psychologist), of an absence of untreated, underlying, contributory mental health conditions or psychosocial issues (including but not limited to depression, drug or alcohol abuse); *and*
  - Imaging studies (for example, MRI, CT, CT myelography, or discography) do not demonstrate a distinct, surgically correctable cause of pain.
- Lumbar fusion, alone, is considered not medically necessary for the treatment of spinal stenosis when other lesions (for example, bone spurs) are the likely cause of symptoms.
- Lumbar fusion is considered investigative for the management of the following conditions:
  - With initial primary laminectomy/discectomy for nerve root decompression without documented instability;
  - Multiple-level fusions (that is, more than 2 levels) for treatment of chronic discogenic back pain.
- Prior authorization: Yes.

Policies inactivated*

Tumor Vaccines

Medical and Behavioral Health Policy Activity

There was no policy activity for July 2010.

Medical and Behavioral Health Policy Activity

Policies Effective: 11/22/10 Notification Posted: 08/20/10

Policies developed

Injectable Clostridial Collagenase for Fibroproliferative Disorders

- The use of injectable clostridial collagenase for treatment of Dupuytren's contracture is considered investigative due to concerns regarding adverse events and a lack of evidence on long-term effectiveness.
- The off-label use of injectable clostridial collagenase is considered investigative for all indications including, but not limited to:
  - Peyronie's disease; and
  - Adhesive capsulitis.

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- 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.

Advanced Glycation Endproducts (AGEs) Measurement by Skin Autofluorescence

- Measurement of advanced glycation endproducts (AGEs) in the skin is considered investigative for all indications, including but not limited to diabetes, renal failure, cardiac disease, and solid organ transplantation due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- Prior Authorization: Not applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Bronchial Thermoplasty

- Bronchial thermoplasty is considered investigative for all indications, including but not limited to asthma, due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- Prior Authorization: Not applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Policies revised

Hematopoietic Stem Cell Transplantation for Breast Cancer

- The policy has been updated with language to indicate the use of autologous hematopoietic stem cell transplantation (single or tandem) for breast cancer is considered not medically necessary.
- The remainder of the policy is unchanged.
- 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.

Sleep Studies / Polysomnograms in Children and Adolescents

- The policy has been updated with the following criteria to define daytime sleepiness: Excessive daytime sleepiness that interferes with daily activities and is not explained by other conditions, or the patient exhibits behavior that may indicate increased efforts to stay awake such as difficulty in attentiveness, hyperactivity, aggressive or disruptive behavior.
- The policy has also been updated with the following criteria to define idiopathic hypersomnia: Suspected idiopathic hypersomnia characterized by disabling daytime sleepiness (that is, 1 to 2 hour episodes of non-REM sleep) or prolonged (for example, >10 hours) nighttime sleep, after exclusion of inadequate sleep hygiene.
- Addition of multiple sleep latency testing (MSLT) and maintenance of wakefulness testing (MWT) as investigative in the diagnosis of obstructive sleep apnea syndrome (OSA) *except* to exclude or confirm narcolepsy in the diagnostic workup of OSA syndrome.
- 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.

Cochlear Implantation

- The policy has been updated with criteria to define bilateral severe-to-profound pre- or postlingual (sensorineural) hearing loss, as a hearing threshold of 70 db (decibels) or greater.
- Addition of the following: Upgrades of an existing, functioning external system to achieve aesthetic improvement, such

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as small profile components or a switch from a body-worn, external sound processor to a behind-the-ear model, are considered not medically necessary.
- 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.

Excision of Redundant Skin or Tissue
- The policy title has been updated to include the term "Tissue."
- The policy has been updated with the following language: Tissue excision procedures to change the appearance of the labia and/or the vagina are considered cosmetic including, but not limited to, labiaplasty (reduction of labia minora and/or labia majora).
  - Note: A simple, partial vulvectomy usually includes removal of the clitoris and part or all of the labia majora and labia minora, on one side, for malignant or pre-malignant conditions. Vulvectomy submitted for all other conditions will be reviewed as a labiaplasty.
- The remainder of the policy is unchanged.
- Prior authorization: Yes, when medical criteria are met.

Thermal Capsulorrhaphy
- The policy statement has been revised as follows: The use of thermal capsulorrhaphy as a treatment of joint instability, including, but not limited to the shoulder, knee and elbow is considered not medically necessary due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- Prior Authorization: Not applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

MRI of the Breast
- The lifetime breast cancer risk criteria has been updated to include risk estimation models: Lifetime risk of breast cancer of 20 to 25 percent or greater as identified by models that are largely defined by family history (for example, the Claus, Tyrer-Cusick and BRCAPRO and modified Gail models).
- Added criteria to define the level of suspicion on mammography results:
  - Diagnosis of low suspicion findings (that is, BI-RADS* category 1-3) on conventional testing not indicated for immediate biopsy and referred for short-interval follow-up. Abnormal findings on mammography are categorized according to the level of suspicion of the findings. Patients with low-suspicion findings are often recommended to undergo short interval follow-up after 3 to 6 months for a period of up to two years instead of immediate biopsy.
  - Diagnosis of a suspicious breast lesion (that is, BI-RADS* category 4-5) in order to avoid biopsy
- Added: Screening of women with history of lobular carcinoma in situ (LCIS) in the absence of other factors that confer a higher risk of breast cancer, atypical lobular hyperplasia (ALH) or atypical ductal hyperplasia (ADH) is considered investigative.
- Coverage statement updated to include:
  - Current breast cancer screening guidelines state that for those patients who meet criteria, a mammography and MRI should be performed *annually*.
  - If applicable, the BI-RADS category should be included in documentation submitted for prior authorization.
- The remainder of the policy is unchanged.

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- Prior Authorization: Yes, EXCEPT in individuals with biopsy proven breast cancer.

Policies inactivated*

Metal-on-Metal Total Hip Resurfacing

** 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.*

Policies reviewed with no changes in June and August 2010

- Allograft for Breast Reconstructive Surgery
- Audio-Visual Entrainment
- Auditory Integration Training
- Bone Conduction and Bone-Anchored Hearing Aids
- Chelation Therapy
- Computerized Dynamic Posturography
- Constraint-Induced Movement Therapy for Motor Disorders in Children
- Cranial Electrotherapy Stimulation
- Diastasis Recti Abdominis Repair
- Dynamic Spinal Visualization
- Facet Arthroplasty
- Fetal Tissue Transplantation
- Gastric Electrical Stimulation
- Gene Therapy
- Gynecomastia
- Hematopoietic Stem-Cell Transplantation for Acute Myeloid Leukemia
- Hematopoietic Stem-Cell Transplantation for Epithelial Ovarian Cancer
- Hyperhidrosis Treatments
- Infusion of Vitamins, Minerals, and/or Nutrients
- Liposuction
- Mastopexy
- Microprocessor-Controlled Prostheses for the Lower Limb
- Natalizumab (Tysabri)
- Organ Transplantation: Heart/Lung
- Organ Transplantation: Lung and Lobar Lung
- Organ Transplantation: Small Bowel
- Organ Transplantation: Small Bowel/Liver and Multivisceral
- Organ Transplantation: Allogeneic Pancreas
- Organ Transplantation: Heart
- Organ Transplantation: Kidney

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- Organ Transplantation: Liver
- Penile Plethysmography
- Phosphodiesterase-5 Inhibitors
- Positron Emission Tomography (PET): Cardiac Applications
- Prometa
- Quantitative Electroencephalogram (QEEG) or Brain Mapping for Mental Health or Substance-Related Disorders
- Re-Birthing Therapy (Also Known as Coercive Holding Therapy or Attachment Therapy)
- Reduction Mammoplasty
- Semi-Implantable Middle Ear Hearing Aid for Moderate to Severe Sensorineural Hearing Loss
- Signal-Averaged Electrocardiography
- Single Photon Emission Computed Tomography (SPECT) for Cerebral Blood Flow in Behavioral Health Disorders
- Spinal Manipulation Under Anesthesia
- Spinal Unloading Devices: Patient-Operated
- Surgical Decompression for Treatment of Diabetic Neuropathy
- Surgical Treatment of Femoroacetabular Impingement
- Targeted Amino Acid Therapy for Mental and Substance-Related Disorders
- Thought Field Therapy
- Transesophageal Endoscopic Therapies for Gastroesophageal Reflux Disease (GERD)
- Transilluminated Powered Phlebectomy
- Wireless Gastric Motility Monitoring
- X Stop Interspinous Process Distraction System and Interspinous Process Decompression

BlueCard

2010 BlueCard® program – seeking your feedback

Your feedback is important to help us make improvements in our processes and make your interactions with Blue Cross and Blue Shield of Minnesota a smooth and simple experience.

Again this year, you will have an opportunity to tell us how we are doing via phone and/or online satisfaction survey. At any point throughout the year, you may receive a call on behalf of Blue Cross seeking input on your experience with servicing out-of-area members. Our research vendor may invite you to participate in online surveys and collect your e-mail address. If your office is contacted, we encourage you to participate in these surveys. We take your feedback seriously and incorporate into enhancements of our services to you.

If you need information about the BlueCard program, utilize the resources listed below:

- Access Chapter 7 (BlueCard) of the online Provider Policy and Procedure Manual located at **providers.bluecrossmn.com**
- Contact provider services at **(651) 662-5200** or **1-800-262-0820**.

Thank you in advance for your participation. We appreciate your feedback.

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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