Provider Press

June 2010 / Vol. 14, No. 2

Utilization management statement

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

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

Review UM criteria

Blue Cross and Blue Plus Utilization Management (UM) programs use written utilization review criteria to make medical necessity determinations. Upon request, any Blue Cross or Blue Plus practitioner may review the clinical criteria used to evaluate an individual case. To review specific UM criteria, contact Kristy Harms at **(651) 662-8516** or toll free **1-800-382-2000, option 2, ext. 28516**.

Medical necessity decisions

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

Provider Press

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

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.	

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, 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 - Health Care Improvement.

Recently updated ICSI guidelines:

- **Heart Failure in Adults**
- **Acute Coronary Syndrome**
- **Diagnosis and Management of Attention Deficit Hyperactivity Disorder in Primary Care for School-Age Children and Adolescents**

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.

New hospital accreditation

The Credentialing Committee and Quality Council have approved DNV (Det Norske Veritas) Healthcare as an accepted accreditation for hospitals by Blue Cross and Blue Shield of Minnesota. DNV's accreditation program for hospitals is called NIAHO (National Integrated Accreditation for Healthcare Organizations).

On September 26, 2008, the Centers for Medicare & Medicaid Services (CMS) approved DNV Healthcare Inc. to become the first new hospital accreditation organization in 40 years. This allowed DNV to immediately begin deeming hospitals in compliance with the Medicare Conditions of Participation. A unique feature of this accreditation is that it integrates the ISO 9001 Quality Management System with the Medicare Conditions of Participation. NIAHO has accredited 50 hospitals in 22 states.

DNV is an independent foundation established in 1864 with a purpose of safeguarding life, property and the environment. It is headquartered in Oslo, Norway. DNV Healthcare is a division of DNV headquartered in Houston, Texas, with offices in Cincinnati, Ohio. The company maintains survey staff throughout the United States.

Annual clinical practice guideline mailing

In June, Blue Cross will send out an annual mailing that includes a letter discussing information that is available to practitioners, as well as an updated Clinical Practice Guideline listing. Links to the guidelines can be found in Chapter 3 at **providers.bluecrossmn.com**, forms & publications, manuals, 2010 Provider Policy & Procedure Manual.

Quality Improvement

2010 performance improvement project (PIP)

Controlling blood pressure in members with diabetes*

Objective: The objective of this PIP is to increase the proportion of members with diabetes who have blood pressure in control as indicated by the Health Plan Employer Data and Information System (HEDIS) Comprehensive Diabetes Care (130/80 mmHg blood pressure measure in adults ages 18 through 75). Success will be defined as an increase from baseline for three consecutive calendar years (number of percentage points of improvement still to be determined). The baseline rate of blood pressure control varies by product and averages approximately 50 percent.

Members targeted: Members in public programs products, ages 18 and older. Note that interventions will reach members with diabetes who are 18 and older. However, only members with diabetes who are 18 through 75 years of age and continuously enrolled for the calendar year will be included in the project measure, per HEDIS specifications for the 130/80 mmHg blood pressure measure. (Evidence currently exists for setting a blood pressure goal of less than 130/80 for adults through age 75, but not for those 76 and older.) Communication to all members will emphasize talking with their provider about what their goal should be, keeping track of their numbers and working with their provider to reach their goal.

Planned intervention strategies

Interventions to raise awareness about the importance of blood pressure control in diabetes will target members, primary care providers, care coordinators in county agencies that contract with Blue Plus and staff in long-term care facilities. Intervention strategies have been designed to: 1) activate members to improve their self-care (particularly self-monitoring of their blood pressure and managing their medications) and 2) encourage provider use of tools and tips for system changes that can reduce clinical inertia (resistance to change). A particular provider focus will be therapeutic inertia (resistance to changing medication or dosage when targeted results are not being achieved). Specific interventions include:

- Call-to-action mailings to members that focus on blood pressure self-monitoring and medication management, including promotion of Medication Therapy Management Services (MTMS) for appropriate members
- Internet-based training modules for physicians, quality improvement staff and nurses. Go to **stratishealth.org/providers/healthplanpips.html** for 30-minute recorded presentations by Patrick O'Connor, M.D. (Managing Blood Pressure to Goal in Adults with Diabetes); Karen Margolis, M.D. (Promoting Accurate Measurement and Self Management of Blood

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Quality Improvement

Controlling blood pressure continued

Pressure); and Michael Trangle, M.D. (Special Needs Population Seriously Mentally Ill Importance of Hypertension Management). An additional presentation on Medication Therapy Management Services in the Care of Patients with Diabetes and Hypertension by Ruth Seabaugh, Pharm.D., and Amanda Brummel, Pharm.D., will be available in early summer.

- Development of a suggested quality improvement project and related toolkit that will be sent to providers, with an offer to a limited number of clinics to work more intensively with the health plans on strategies for improving blood pressure control
- Training and a toolkit for care coordinators in counties
- Development of a training module and toolkit for long-term care facilities

For more information, contact Health Improvement Project Managers Sharon Torodor, MPH, or Susan Nelsen, MSE, at **Sharon_F_Torodor@bluecrossmn.com** or **Susan_A_Nelsen@bluecrossmn.com**.

*This is a collaborative PIP being undertaken by five health plans: Blue Plus, HealthPartners, Medica, Metropolitan Health Plan and UCare.

FYI

Publications available online

The following is a list of Quick Points and Bulletins published from Marc h 2010 to May 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
QP4-10	Radiology services for chiropractors
QP5-10	Reminders for submission of claim attachments and appeals
QP6-10	Provider-submitted adjustment requests
QP7-10	Provider-submitted institutional and professional claims
QP8-10	Understanding and correcting rejected electronic claim submissions
QP9-10	Clarification on replacement claims versus appeals
Bulletins	**Title**
P11-10	Inpatient hospital concurrent review
P12-10	April 2010 HCPCS code updates
P13-10	Pre-certification and concurrent review for inpatient/residential mental health and substance use disorder services
P14-10	Pharmacy claims for Blue Cross subscribers without a Pharmacy Benefit Manager
P15-10	Update to Attachment B: Definition of outpatient health services categories
P16-10	Revision to Provider Bulletin P23R1-09 regarding EIBI Services for Autism Spectrum Disorder for the Federal Employees Program (FEP)
P17-10	Timely filing limits on claims
P18-10	Reimbursement changes for uncomplicated laparoscopic cholecystectomy procedure
P19-10	Clarification of payment for Health Services for Minnesota Health Care Programs Subscribers
P20-10	Rental limitation change for large volume air compressors

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 faxed to **(651) 662-6684** or 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 March 2010 to May 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	Multiple changes throughout
2010 Provider Policy and Procedure Manual	Chapter 5 - Health Care Options	Multiple changes throughout
2010 Provider Policy and Procedure Manual	Chapter 6 – Blue Plus	Updated content within the Member Rights and Responsibilities
2010 Provider Policy and Procedure Manual	Chapter 8 - Claims Filing	Multiple changes throughout
2010 Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Public Programs	Updated the Blue Plus Contracted Interpreter Agencies table
2010 Provider Policy and Procedure Manual	Chapter 11- Coding Policies and Guidelines, Medical Services	Updated Weight Loss Programs within the Weight Management Care Topic
2010 Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines, Anesthesia	Multiple changes throughout
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, Chiropractic	Multiple changes throughout
2010 Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines, Durable Medical Equipment	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	Multiple changes throughout
2010 Blue Plus Manual	Chapter 1 – Introduction to Blue Plus	Removed reference to First Plan
2010 Blue Plus Manual	Chapter 3 – Government Programs	Updated the Blue Plus Contracted Interpreter Agencies table Added new guidelines Updated Enrollees' Rights and Responsibilities topic

Pharmacy Corner

Blue Cross GenRx and FlexRx drug formularies

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

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

The FlexRx formulary is designed to provide members with access to safe and effective medications at a reasonable overall cost. The Flex Rx formulary includes a broad range of generic and brand drugs.

The Blue Cross Coverage Committee is responsible for final selection of drugs for these lists based on recommendations of an independent Pharmacy and Therapeutics (P&T) Committee comprised of actively practicing physicians and pharmacists. The formulary is subject to periodic review and modification by these committees. Decisions to add or remove drugs from the Blue Cross formulary are made based on the medication's safety, efficacy, uniqueness and cost.

Any participating health care provider may request the addition of a drug to the formulary. Written requests should be submitted to:

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

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

Inhaled steroid and inhaled steroid combination products formulary changes to GenRx

In order to ensure the availability of clinically appropriate and cost-effective therapies for treatment of patients with asthma and chronic obstructive pulmonary disease, Blue Cross and Blue Shield of Minnesota will make changes to the GenRx formulary effective July 1, 2010.

- QVAR (beclomethasone) will be added to the GenRx formulary. Asmanex is also on GenRx.
- Advair Diskus 250/50 will be removed from the GenRx formulary. The formulary alternative is Symbicort.
- Advair Diskus 100/50 will process as a formulary agent for covered members under the age of 12 years. For covered members 12 years of age and older, all strengths of Advair will process per benefits as a non-formulary agent.

Pharmacy Corner

Adderall XR added to GenRx formulary, quantity limits applied to ADHD drugs

As part of our continued efforts to evaluate and update our formularies, Blue Cross and Blue Shield of Minnesota recently evaluated drugs used in the treatment of Attention Deficit Hyperactivity Disorder (ADHD). This evaluation included a thorough review of clinical information, including safety information and utilization. Based on our analysis we identified the following trends:

- Overall, utilization of drugs in this class continues to increase.
- Adderall XR, despite its non-formulary status, continues to be the most utilized drug in this class on the GenRx formulary.
- Seventeen percent of utilizing members are taking doses greater than those listed in the FDA approved labeling.
- Members who are prescribed quantities above FDA labeled dosages are twice as likely to be on an atypical antipsychotic and/or non-benzodiazepine hypnotic (11.7 percent vs. 6.7 percent).

As the result of this review, Blue Cross will make the following changes effective July 1st, 2010:

- Adderall XR will be added to the GenRx formulary. Adderall XR will remain on the FlexRx formulary.
- Quantity limits will be implemented for ADHD drugs on both the GenRx and FlexRx formularies. A listing of these limits can be found on the PDF versions of both the FlexRx and GenRx formularies found at **bluecrossmn.com** and **providers.bluecrossmn.com**

Please re-evaluate the continued need for dosing above FDA-approved labeling, in particular in patients also taking medications for insomnia. Alternatives in patients with insomnia include administering stimulants earlier in the day, elimination of afternoon/evening dosing or use of a short acting rather than long-acting product when an afternoon/evening dose is needed.

If, in your clinical judgment, you believe your patient(s) should continue to receive quantities above the limits, you may submit a quantity limit override form for consideration. This form is available on **providers.bluecrossmn.com**. Click on forms & publications and select forms: drugs and supplies from the drop-down box.

Medical necessity decisions for prescription medications

All denial decisions are made by licensed, board-certified reviewers. Clinical pharmacists and physician reviewers are available by telephone to discuss prescription drug decisions based on the Blue Cross and Blue Plus formulary. To discuss a prescription drug decision with a clinical pharmacist or physician reviewer, call the telephone number provided on the notification letter.

Coding Corner

Coding edit decisions

Several edits have been reviewed. The code edits and decisions are listed below.

Coding and Edits	Decision/Actions
49568 denied incidental to 36262	No change, edit will be upheld
Add edit for insertion of vaginal cylinder (S2270)	No edit will be created at this time

April HCPCS addition

A provider bulletin was issued listing several HCPCS additions and revisions effective April 1, 2010. Since then, an additional code has been added and will be accepted by Blue Cross.

G9147	Outpatient Intravenous Insulin Treatment (OIVIT) either pulsatile or continuous, by any means, guided by the results of measurements for: respiratory quotient; and/or, urine urea nitrogen (UUN); and/or, arterial, venous or capillary glucose; and/or potassium concentration.

July HCPCS update

There will be new HCPCS codes added July 1. A provider bulletin will be issued with details and the new codes before the effective date.

Unlisted code reminder

Anytime an unlisted or not otherwise classified or specified HCPCS/CPT code is submitted on a claim, a narrative must also be included. If no narrative is present, the service will be denied.

Coding Corner

Preventive care services

The following updates will also be included in the next revision of Chapter 11, Coding section of the online Blue Cross Provider Policy and Procedure Manual.

Administration of Blue Cross' preventive care policy includes a list of defined preventive care services according to evidence-based guidelines.

Benefit eligibility and/or reimbursement is subject to the member's coverage options for preventive care and cancer screening. Variations in payment may occur based on self-insured dollar and service limits. Benefits should be verified through our provider web self-service site at **provider.hub.com** or through BLUELINE at **(651) 662-5200** or toll free **1-800-262-0820**.

Services considered preventive

If a patient presents to have these services performed for preventive purposes, claims will be adjudicated as preventive care provided the reason for the visit on the claim is listed as preventive, regardless of outcome. Blue Cross' administrative guidelines are as follows:

Service	Frequency (does not apply to Blue Plus)	Clinical Practice/ Guidelines
Abdominal aortic aneurysm (AAA) screening	1 per lifetime	Blue Cross
Vision screening: glaucoma, acuity, refraction	1 per year	ICSI
Hearing	1 per year	ICSI
Standard immunizations	Per schedules determined by clinical guidelines	CDC/ACIP
Radiology: osteoporosis screening	1 per year	ICSI
Laboratory services: cholesterol/lipid profile	As recommended by physician	ICSI
Diabetes screening	As recommended by physician	Blue Cross
STD screening: HIV, chlamydia, gonorrhea, syphilis	As recommended by physician	ICSI/Mandate
Preventive medical examination for adults including skin exam, testicular exam, prostate-digital rectal exam, breast exam, hypertension screening	As recommended by physician	Blue Cross and ICSI

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Coding Corner

Preventive care services continued

Cancer screening paid at the highest level

Service	Frequency	Clinical Practice/ Guidelines
Colon cancer screening: occult blood	1 per year	ICSI/ACS
Colon cancer screening: barium enema, sigmoidoscopy, proctosig-moidoscopy	As recommended by physician	ICSI/ACS
Colon cancer screening: colonoscopy	As recommended by physician	ICSI/ACS
Cervical cancer screening: Pap test	1 per year	ICSI/ACS
Breast cancer screening: conventional film screen mammography	1 per year	ICSI/ACS
Prostate cancer: prostate specific antigen (PSA)	1 per year	Blue Cross/Mandate
Ovarian cancer: CA125, for those at high risk, and trans-vaginal ultrasound	1 per year	Blue Cross/Mandate

Services for consideration under the illness/medical level of benefits

- Any/all services that have an increased frequency due to an effort to control or prevent abnormal condition from recurring
- Procedures not considered preventive according to evidence-based guidelines developed as clinical and industry standards; for example, chest X-rays, urinalysis, complex lab and diagnostic imaging procedures
- Non-standard immunizations
- Contraceptive management
- Eyewear including lenses, frames and contact lenses

Using the current version of the ICD-9-CM, report the patient's condition at the highest level of certainty that are related to the services provided. Both the findings (if any exist) and the reason for the visit should be reported.

Clinical practice guideline abbreviations include:

- CDC/ACIP – Centers for Disease Control/Advisory Committee on Immunization Practices
- ICSI – Institute for Clinical Systems Improvement
- ACS – American Cancer Society
- Mandate – Mandated by Minnesota statute
- Blue Cross – Blue Cross and Blue Shield of Minnesota and Blue Plus

Medical and Behavioral Health Policy Update

Blue Cross Blue Shield of Minnesota's medical and behavioral health policies are available for your use and review on the Blue Cross web site 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 BCBSMN 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 BCBSMN 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 BCBSMN's 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: 06/18/10 Notification Posted: 03/19/10

Policies developed:

Hematopoietic Stem-Cell Transplantation for Central Nervous System (CNS) Embryonal Tumors and Ependymoma

- *Embryonal tumors of the CNS*
  - Autologous hematopoietic stem-cell transplantation may be considered medically necessary as consolidation therapy for previously untreated embryonal tumors of the CNS that show partial or complete response to induction chemotherapy, or stable disease after induction therapy.
  - Autologous hematopoietic stem-cell transplantation may be considered medically necessary to treat recurrent embryonal tumors of the central nervous system (CNS) if the child has not received initial treatment with chemotherapy and radiotherapy.
  - Allogeneic hematopoietic stem-cell transplantation is considered investigative to treat embryonal tumors of the central nervous system (CNS).
- *Ependymoma*
  - Autologous, tandem autologous, and allogeneic hematopoietic stem-cell transplantation is considered investigative to treat ependymoma.
- Prior authorization: Yes.

Medical and Behavioral Health Policy Update

Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood

- Autologous hematopoietic stem-cell transplantation may be considered medically necessary for:
  - Initial treatment of high-risk neuroblastoma;
  - Recurrent or refractory neuroblastoma;
  - Initial treatment of high-risk Ewing's sarcoma; and
  - Recurrent or refractory Ewing's sarcoma.
- Autologous hematopoietic stem-cell transplantation is considered investigative as initial treatment of low- or intermediate-risk neuroblastoma, initial treatment of low- or intermediate-risk Ewing's sarcoma, and for other solid tumors of childhood including, but not limited, to the following:
  - Rhabdomyosarcoma;
  - Wilms tumor;
  - Osteosarcoma;
  - Retinoblastoma.
- Tandem or multiple hematopoietic stem-cell transplantations are considered investigative for treatment of all solid tumors of childhood.
- Salvage allogeneic hematopoietic stem-cell transplantation for neuroblastoma or other pediatric solid tumors that relapse after autologous transplantation or fail to respond is considered investigative.
- Prior authorization: Yes.

Occipital Nerve Stimulation

- The use of occipital nerve stimulation for any indication is considered investigative due to a lack of evidence demonstrating its impact on improved health outcomes.
- Prior authorization: Not applicable.

Intravenous Anesthetics for the Treatment of Chronic Neuropathic Pain

- Intravenous infusion of anesthetics (e.g., ketamine or lidocaine) for the management of chronic neuropathic pain is considered investigative due to a lack of evidence demonstrating its safety and effectiveness for this indication.
- Prior authorization: Not applicable.

Genetic Testing for Warfarin Dose

- Genotyping to determine cytochrome p450 2C9 *(CYP2C9)* and vitamin K epoxide reductase subunit C1 *(VKORC1)* genetic polymorphisms is considered investigative for the purpose of managing the administration and dosing of warfarin, including use in guiding the initial warfarin dose to decrease time to stable INR and reducing the risk of serious bleeding.
- Prior authorization: Not applicable.

Policies revised:

Intra-Articular Hyaluronan Injections for Osteoarthritis

- Addition of the following medically necessary indication:
- A single dose injection of intra-articular hyaluronan (i.e., Synvisc-One™) may be used in lieu of the course of 3-5 weekly injections when medical policy criteria, as stated above, have been met.
- The remainder of the policy is unchanged.
- Prior authorization: No.

Medical and Behavioral Health Policy Update

Immune Globulin Replacement Therapy

- Expanded the organ transplant section to include a medically necessary indication for treatment of related immunodeficiencies following stem-cell transplantation.
- The remainder of the policy is unchanged.
- Prior authorization: Yes.

Treatment of Hereditary Angioedema with CI Inhibitor or Plasma Kallikrein Inhibitor

- Expanded our policy to include two new drugs with recent FDA approvals for treatment of hereditary angioedema (Berinert and Kalbitor).
- Title changed by removing reference to "Cinryze" and adding "Plasma Kallikrein Inhibitor" to reflect a broader policy which encompasses additional types of pharmacologic therapies for treatment of hereditary angioedema.
- Policy statements have been revised as follows:
- Berinert has been added as an example of a C1 esterase inhibitor that may be considered medically necessary, for patients with a diagnosis of hereditary angioedema (HAE*), in the following circumstances:
  - Treatment of acute attacks for:
    1. Any patient with laryngeal edema; or
    2. Severe abdominal attacks
  - Short-term prophylaxis:
    1. Prior to surgery, invasive medical procedures or substantial dental procedures such as tooth extractions in patients with a history of laryngeal edema.
  - Long-term prophylaxis against angioedema attacks in adolescent and adult patients:
    1. Who experience greater than one severe attack per month or are disabled more than 5 days per month or have laryngeal attacks; AND
    2. Have a documented trial and failure or intolerance to a 17-alpha alkylated androgen (danazol, ocandrolone, methyltestosterone)
- Plasma kallikrein inhibitor (Kalbitor) has been added to the policy as medically necessary, for patients with a diagnosis of hereditary angioedema (HAE*), under the following circumstances:
  - Treatment of acute attacks for:
    1. Any patient with laryngeal edema; or
    2. Severe abdominal attacks
- Use of a C1 esterase inhibitor (i.e., Cinryze, Berinert) or plasma kallikrein inhibitor (i.e., Kalbitor) is considered investigative for all other indications including but not limited to use as a diagnostic agent to distinguish abdominal attacks of C1 inhibitor disorders from other abdominal pathologies.
- The combined use of a C1 Esterase Inhibitor (i.e., Cinryze, Berinert) and a plasma kallikrein inhibitor (i.e., Kalbitor) is considered investigative.
- Prior authorization: Yes, *ONLY* for Cinryze and Berinert when used for prophylaxis. *Emergent or acute use DOES NOT need prior authorization unless billed under the pharmacy benefit.*

Medical and Behavioral Health Policy Update

Biventricular Pacemakers for the Treatment of Congestive Heart Failure

- Addition of the following investigative policy statement:
- Biventricular pacemakers with or without an accompanying implantable cardiac defibrillator are considered investigative as a treatment of NYHA class I or II heart failure.
- The remainder of the policy is unchanged.
- Prior authorization: No.

Cytochrome P450 Genotyping

- The following has been added to the list of investigative indications:
- Selection or dose of beta blockers (e.g., metoprolol).
- The remainder of the policy is unchanged.
- Prior authorization: Not applicable.

Dialectical Behavior Therapy for Borderline Personality Disorder

- The policy has been reorganized to specifically address our criteria for dialectical behavior therapy for borderline personality disorder.
- The description section of the policy has been updated with information describing the four basic modes of treatment (individual therapy, skills training, telephone coaching, and therapist group consultation meetings)
- The policy criteria has not changed, but all policy statements have been revised as follows:
- Dialectical behavior therapy, when defined as containing the following five (5) categories of core functional components, may be considered medically necessary in the treatment of patients with borderline personality disorder:
  - Enhances behavioral capabilities;
  - Improves motivation to change
  - Assures that new capabilities generalize to the natural environment
  - Structures the treatment environment in ways to support patients' and therapists' capabilities
  - Enhances therapist capabilities and motivation to treat patients effectively
- If the four basic modes of treatment (individual therapy, skills training, telephone coaching, and therapist group consultation meetings) are not being used, the provider must explain how the modalities they are using meet the criteria of the five core functional components listed above.
- Prior authorization: No.

Pervasive Developmental Disorders / Autism Spectrum Disorders: Assessment

- Revised the multidisciplinary diagnostic assessment of ASD criteria for the hearing assessment to read as follows:
- A comprehensive hearing test by an audiologist.
- The remainder of the policy is unchanged.
- Prior authorization: No.

Pervasive Developmental Disorders / Autism Spectrum Disorders: Early Intensive Behavioral Intervention (EIBI)

- The following statement regarding prior authorization documentation has been added:
- A summary of the components of the multidisciplinary Diagnostic Assessment as described in the Pervasive Developmental Disorders/Autism Spectrum Disorders: Assessment, Medical Policy # X-43, must be included with the authorization request.

Medical and Behavioral Health Policy Update

- The remainder of the policy is unchanged.
- Prior authorization: Yes.

Policies inactivated*

None

Medical and Behavioral Health Policy Activity

Policies Effective: 07/26/10 Notification Posted: 04/26/10

Policies developed:

Charged-Particle (Proton or Helium Ion) Radiation Therapy

- Charged-particle irradiation with proton or helium ion beams may be considered medically necessary in the following clinical situations:
  - Primary therapy for melanoma of the uveal tract (iris, choroid, or ciliary body), with no evidence of metastasis or extrascleral extension, and with tumors up to 24 mm in largest diameter and 14 mm in height;
  - Postoperative therapy (with or without conventional high-energy x-rays) in patients who have undergone biopsy or partial resection of chordoma or low-grade (I or II) chondrosarcoma of the basisphenoid region (skull-base chordoma or chondrosarcoma) or cervical spine. Patients eligible for this treatment have residual localized tumor without evidence of metastasis.
- Charged-particle irradiation with proton beams may be considered medically necessary for treatment of localized prostate cancer (Stages C or D1 [without distant metastases], also classified as T3 or T4).
- All other applications of charged-particle irradiation are considered investigative due to a lack of evidence demonstrating an impact on improved health outcomes.
- Prior authorization: Yes.

Near-Infrared Imaging for Evaluation of Coronary Artery Plaques

- The use of near-infrared imaging for evaluation of coronary artery plaques is considered investigative due to a lack of evidence demonstrating its impact on improved health outcomes.
- Prior Authorization: Not applicable.

Multigene Expression Assay for Predicting Recurrence In Colon Cancer

- The 12-gene expression test (Onco*type* DX® colon cancer test) is considered investigative for all indications; including its use for predicting the likelihood of disease recurrence for patients with stage II colon cancer following surgery because evidence is lacking to show that use of the test improves health outcomes.
- Prior authorization: Not applicable.

Policies revised:

Wireless Capsule Endoscopy

- "Evaluation of the colon including, but not limited to, detection of colonic polyps or colon cancer" has been added to the list of investigative indications for wireless capsule endoscopy:
- The remainder of the policy is unchanged.
- Prior authorization: No.

Medical and Behavioral Health Policy Update

Bipolar Radiofrequency Stimulation and Ablation for Treatment of Musculoskeletal Conditions

- "Musculoskeletal conditions, including but not limited to, chronic tendinosis and plantar fasciitis" have been added as investigative uses of bipolar radiofrequency stimulation and ablation.
- The remainder of the policy is unchanged.
- Prior Authorization: Not applicable.

Bariatric Surgery

- The following statement has been added to the list of investigative indications for bariatric surgery: "Endoluminal (also called endosurgical, endoscopic, sclerosing endotherapy or natural orifice transluminal endoscopic) procedure as a primary bariatric procedure or as a revision procedure (e.g., to treat weight gain after bariatric surgery or to remedy large gastric stoma or large gastric pouches), by any method (e.g., insertion of the StomaphyX™ device)."
- The remainder of the policy is unchanged.
- Prior Authorization: Yes, for all bariatric surgery and revisions / reoperations. Submitted documentation should address the patient selection criteria described above.

Genetic Testing for Hereditary Breast and/or Ovarian Cancer

- The policy criteria for genetic testing of BRCA1 and BRCA2 genetic mutations in *cancer-affected individuals* has been updated with the following two conditions:
  - fallopian tube cancer
  - primary peritoneal cancer
- The policy has been updated with the following criteria for testing for genomic rearrangements of the BRCA1 and BRCA2 genes [BRAC®Analysis Rearrangement Test (BART)]:
- Testing for genomic rearrangements of the BRCA1 and BRCA2 genes [BRAC®Analysis Rearrangement Test (BART) may be considered medically necessary in individuals at exceptionally high risk who have tested negative for sequence mutations and the most common large DNA rearrangements in the BRCA1 and BRCA2 genes and who meet one of the following additional patient selection criteria:
  - Condition: Breast cancer before age 50
    Family history: Two or more first- or second degree relatives with breast cancer before age 50 or ovarian or fallopian tube or primary peritoneal cancer at any age
  - Condition: Ovarian or fallopian tube or primary peritoneal cancer at any age
    Family History: Two or more first- or second-degree relatives with breast cancer before age 50 or ovarian or fallopian tube or primary peritoneal cancer at any age
  - Condition: Male breast cancer at any age
    Family History: Two or more first- or second- degree relatives with breast cancer before age 50 or ovarian or fallopian tube or primary peritoneal cancer at any age
  - Condition: Breast cancer at or after age 50 and ovarian or fallopian tube or primary peritoneal cancer at any age
    Family History: One or more first- or second-degree relatives with breast cancer before age 50 or ovarian or fallopian tube or primary peritoneal cancer at any age
  - Condition: Breast cancer before age 50 and ovarian or fallopian tube or primary peritoneal cancer at any age
    Family History: No additional relatives required
  - Family History: Patients with a known large DNA rearrangement in the family.

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- Testing for CHEK2 genetic abnormalities (mutations, deletions, etc.) has been added to the policy as investigative in affected and unaffected patients with breast cancer irrespective of the family history.
- Prior authorization: Yes.

Retinal Telescreening Systems for Diabetic Retinopathy

- The policy has been update to indicate that all uses of retinal telescreening systems, other than for the detection of diabetic retinopathy, are considered not medically necessary.
- The remainder of the policy is unchanged.
- Prior authorization: No.

Policies inactivated*

- Immunochemical Fecal Occult Blood Test
- Laser Tonsillectomy
- Positional Magnetic Resonance Imaging (MRI) (Stand-Up, Seated, Upright, Weight-Bearing MRI) (The effective date of this policy inactivation is April 26, 2010)

Medical and Behavioral Health Policy Activity

Policies Effective: 08/23/10 Notification Posted: 05/21/10

Policies developed:

Orthopedic Applications of Stem Cell Therapy

- The use of mesenchymal stem cell therapy is considered investigative for all orthopedic applications, including use in repair or regeneration of musculoskeletal tissue.
- Prior authorization: Not applicable.

Systems Pathology Testing for Predicting Risk of Recurrence in Prostate Cancer

- The use of testing that employs a Systems Pathology model (e.g. Prostate Px+, Post-Op Px) is considered investigative for all indications, including but not limited to, its use in predicting risk of recurrence in patients with prostate cancer.
- Prior Authorization: Not applicable.

Epidermal Growth Factor Receptor (EGFR) Analysis for Non-Small Cell Lung Cancer

- Analysis of the gene for epidermal growth factor receptor (EGFR), by any of the following tests, is considered investigative as a technique to predict treatment response to tyrosine kinase inhibitor therapy [e.g., erlotinib (Tarceva®) or getfitinib (Iressa®)] in patients with non-small cell lung cancer (NSCLC):
  - Mutation analysis;
  - Germline analysis;
  - Gene amplification.
- Prior authorization: Not applicable.

Medical and Behavioral Health Policy Update

Policies revised:

Bone Growth Stimulators

- Chronic steroid use may be considered medically necessary for invasive or noninvasive electrical bone growth stimulators as an adjunct to *lumbar* spinal fusion surgery in patients at high risk for fusion failure.
- The use of invasive or noninvasive bone growth stimulators as an adjunct to *non-lumbar spinal fusion* (e.g., as an adjunct to cervical or thoracic fusion, or for failed cervical or thoracic spinal surgery) is considered investigative.
- The use of semi-invasive electrical bone growth stimulators is considered investigative for all applications.
- The use of low-intensity ultrasound bond growth stimulators is considered investigative for the treatment of both stress fractures and open fractures (e.g., as an adjunct to open reduction internal fixation or osteotomy).
- The remainder of the policy is unchanged.
- Prior authorization: Yes.

Hematopoietic Stem-Cell Transplantation for Chronic Lymphocytic Leukemia and Small Lymphocytic Lymphoma

- *Allogeneic* hematopoietic stem-cell transplantation may be considered medically necessary to treat chronic lymphocytic leukemia or small lymphocytic lymphoma in patients with markers of high-risk disease, as defined by one of the classification systems used to determine stage and prognosis of patients with CLL/SLL (Rai staging system or Binet classification system). Use of a myeloablative or reduced-intensity pretransplant conditioning regimen should be individualized based on factors that include patient age, the presence of comorbidities, and disease burden.
- All other uses of *allogenic* hematopoietic stem-cell transplantation to treat chronic lymphocytic leukemia or small lymphocytic lymphoma are considered investigative.
- Autologous hematopoietic stem-cell transplantation to treat chronic lymphocytic leukemia or small lymphocytic lymphoma remains investigative.
- Prior authorization: Yes.

Hematopoietic Stem-Cell Transplantation in the Treatment of Germ-Cell Tumors

- The policy has been updated with the following statements:
- *Single autologous* hematopoietic stem-cell transplantation may be considered medically necessary as salvage therapy for germ-cell tumors:
  - in patients with favorable prognostic factors* who have failed a previous course of conventional-dose salvage chemotherapy; OR
  - in patients with unfavorable prognostic factors** as initial treatment of first relapse (i.e., without a course of conventional-dose salvage chemotherapy) and in patients with platinum-refractory disease.

  *Patients with *favorable prognostic factors* include those with a testis or retroperitoneal primary site, a complete response to initial chemotherapy, low levels of serum markers and low volume disease.

  **Patients with *unfavorable prognostic factors* are those with an incomplete response to initial therapy or relapsing mediastinal nonseminomatous germ-cell tumors.
- *Tandem autologous* hematopoietic stem-cell transplantation may be considered medically necessary for the treatment of testicular tumors either as salvage therapy or with platinum-refractory disease.
- All others indications for tandem autologous hematopoietic stem-cell transplantation in the treatment of germ-cell tumors are considered investigative.
- *Autologous* stem-cell transplant is considered investigative as a component of first-line treatment for germ-cell tumors.

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- Allogeneic hematopoietic stem-cell transplantation is considered investigative to treat germ-cell tumors, including, but not limited to its use as therapy after a prior failed autologous hematopoietic stem-cell transplantation.
- Prior Authorization: Yes.

Sleep Disorder Testing in Adults

- The use of unattended (unsupervised) home sleep studies with a Type II or III device is limited to 1 night.
- The use of unattended (unsupervised) sleep studies with a Type IV device is considered investigative, including studies using a device that records four channels, but measures only one respiratory parameter (e.g. Watch-PAT™ device).
- Repeat supervised polysomnography performed in a sleep laboratory may be considered medically necessary to assess efficacy of treatment (e.g., CPAP, oral appliances, surgery).
- The use of maintenance of wakefulness testing (MWT) is considered not medically necessary in the diagnosis of obstructive sleep apnea syndrome (OSA) except to exclude or confirm narcolepsy in the diagnostic work-up of OSA syndrome.
- The remainder of the policy is unchanged.
- Prior authorization: No.

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.*

Policies Reviewed with no changes in March through May, 2010

- Anti-CCP Testing for Rheumatoid Arthritis
- Artificial Intervertebral Disc: Cervical Spine
- Artificial Intervertebral Disc: Lumbar Spine
- Axial (Percutaneous) Lumbar Interbody Fusion (ALIF)
- Cardiovascular Disease Risk Assessment and Management: Laboratory Evaluation of Lipid Subclasses
- Chemiluminescent Testing for Oral Cancer
- Compassionate Use
- Corneal Topography/Computerized Corneal Topography
- Coverage of Routine Care Related to Cancer Clinical Trials
- Cryosurgical Ablation of Solid Tumors
- Dynesys Spinal System and Lumbar Dynamic Stabilization
- Electrical/Electromagnetic Stimulation for Treatment of Arthritis
- Electrocardiographic (ECG) Body Surface Mapping
- Eye Movement Desensitization and Reprocessing for Posttraumatic Stress Disorder (PTSD)
- Full Body CT Scanning
- Genetic Testing for Helicobacter Pylori Treatment
- Genetic Testing for Tamoxifen Treatment
- Genetic-Based Tests for Screening, Detection, and/or Management of Prostate Cancer
- Hair Analysis

- Hippotherapy
- Home Prothrombin Time Monitoring
- Homocysteine Testing in Risk Assessment and Management of Cardiovascular Disease
- Hospital Beds
- Islet Transplantation
- Ketamine for Treatment of All Mental Health and Substance-Related Disorders
- Low Density Lipid (LDL) Apheresis
- Lung Cancer Screening Using Computed Tomography (CT) and Chest Radiographs
- Measurement of Exhaled Nitric Oxide and Exhaled Breath Condensate in the Diagnosis and Management of Asthma and Other Respiratory Disorders
- Measurement of Lipoprotein-Associated Phospholipase A2 (Lp-PLA2) in the Assessment of Cardiovascular Risk
- Measurement of Long Chain Omega-3 Fatty Acids as a Cardiac Risk Factor
- Methadone Maintenance Treatment for Chronic Opioid Dependence
- Nociceptive Trigeminal Inhibition-Tension Suppression System (NTI-tss) for Treatment of Headache
- Palliative Care
- Percutaneous Techniques for Disc Decompression
- Photodynamic Therapy for Oncologic Applications, including Barrett's Esophagus
- Phototherapy for Seasonal Affective Disorder
- Pressure-Reducing Support Surfaces
- Prolotherapy
- Psychoanalysis
- Quantitative Sensory Testing
- Radiofrequency Ablation of Solid Tumors, Excluding Liver Tumors
- Replacement of Amalgams
- Rhinomanometry and Acoustic/Optical Rhinometry
- Rhinoplasty
- Saliva Hormone Tests for Menopause
- Skin Contact Monochromatic Infrared Energy Therapy
- Spider Veins/Dermal Telangiectiasias
- Squeeze Machine for Autistic Spectrum Disorders
- Suit Therapy for Motor Disorders
- Surface Electromyography (SEMG)
- Surgical Interruption of Pelvic Nerve Pathways for Primary and Secondary Dysmenorrhea
- Temporary Prostatic Stents
- Thermography
- Tobacco Cessation Treatments
- Traction Decompression of the Spine (VAX-D, LORDEX, DRX9000)
- Transanal Radiofrequency Treatment of Fecal Incontinence
- Treatment of Tinnitus
- Unicondylar Interpositional Spacer (Unispacer)
- Vacuum Therapy for Female Sexual Dysfunction
- Zoster Vaccine Live (Zostavax)

FYI

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