Provider Press

December 2009 / Vol. 13, No. 4

Wellness initiatives for federal employees

Beginning January 1, 2010, federal employees who are members of the BlueCross and BlueShield Service Benefit Plan will receive an award certificate when they complete a Blue Health Assessment or have their child's Body Mass Index (BMI) assessed.

Upon completion of the Blue Health Assessment, adults will have the copayment for their next annual physical examination or preventive counseling visit waived. Children who are five through 17 years old who have their BMI assessed and are determined to be in the 85th percentile or higher will have copayments for up to four nutritional counseling visits waived.

Federal employees presenting a MyBlue Wellness Certificate should not have a copay collected at the time of the visit. Reimbursement from Blue Cross for eligible visits will include the member's copay.

Blue Cross and Blue Shield of Minnesota administers the BlueCross and BlueShield Service Benefit Plan, the largest privately underwritten health insurance contract under the Federal Employee Health Benefits (FEHB) Program. Sixty percent of all federal employees and retirees who receive their health care benefits through the government's FEHB Program are members of the Service Benefit Plan. Any questions regarding benefit changes for 2010 and these new programs should be directed to the federal employee program at Blue Cross and Blue Shield of Minnesota by calling **(651) 662-5044** or **1-800-859-2128**.

We appreciate your support of the wellness initiative programs that encourage good health practices for our Service Benefit Plan members. For additional information, contact the Service Center at the phone number on the back of the member's ID card.

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 service	(651) 662-5000 or 1-800-262-0820
Please verify these numbers are correctly programmed into your office phones.	

Provider Press

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

Inside preview

Pharmacy Corner

Calcium & Vitamin D supplementation

The Calcium and Vitamin D Supplementation (Ca/VitD) Performance Improvement Project was implemented in early 2007. Six health organizations who serve the Minnesota Senior Health Options/Minnesota Senior Care Plus (MSHO/MSC+) populations are working together to increase the number of MSHO/MSC+ members taking calcium and vitamin D supplementation as a means to further prevent the onset of osteoporosis within individuals of this population over the age of 65 years. This collaborative has entered the third year of project implementation with the continued promotion of guideline awareness, member over-the-counter benefits and provider/pharmacist educational efforts.

Members are encouraged to discuss Ca/VitD supplementation with their primary care provider or pharmacist to obtain their over-the-counter prescription which will enable them to get their supplements at little or no cost. The Minnesota Board of Pharmacy has continued to endorse the participation of licensed pharmacists in writing over-the-counter prescriptions for Ca/VitD supplements for eligible seniors in accordance with Minnesota Statute 256B.0625, subd.13(c).

MSHO/MSC+ care coordinators received additional materials from each health plan on how to educate members about the benefits of Ca/VitD supplementation. Care coordinators were encouraged to obtain further information on falls prevention at the Minnesota Falls Prevention website (**www.mnfallsprevention.org**). Resources for this performance improvement project can be found at **http://www.stratishealth.org/providers/healthplanpips.html**.

Results from the second year of implementation show a significant improvement in the percentage of members regularly taking Ca/Vit D supplements. Aggregated data from the collaborative showed a 13.8% increase above the baseline with a rate of 20.7% for year two measurement period. The collaborative will continue to strive for this level of success in the coming years through 2010.

Collaborating health plans are Blue Plus, FirstPlan, HealthPartners, Medica, Metropolitan Health Plan, and UCare, with support from Stratis Health.

Thank you for your ongoing support to improve our members/your patients' health. For additional questions, please contact Linda Jax at **(651)- 662-0763** or linda_a_jax@bluecrossmn.com.

Pharmacy Corner

Aspirin therapy in ischemic heart disease and diabetes mellitus

The Aspirin Therapy Performance Improvement Project began in 2008 and has already demonstrated a positive impact on members, thanks to the efforts of care coordinators, providers, and other health plan staff. Nine health plans* are partnering on this project, directed toward enrollees in the Minnesota Senior Health Options and Minnesota Senior Care Plus programs. This project aims to promote awareness of the benefits of low-dose aspirin therapy for seniors ages 65 to 84, who have a diagnosis of ischemic heart disease (IHD) and/or diabetes mellitus, and increase the use of low-dose aspirin when providers determine it is appropriate for these eligible members. Program interventions include guideline awareness for providers, encouraging awareness and use of the Medicaid Over-the-Counter (OTC) prescription drug benefit, and improving health care team communication.

Health plan members identified with IHD or diabetes mellitus are encouraged to discuss aspirin therapy with their primary healthcare provider and take aspirin only under the direction of their provider. Providers are asked to write a prescription for aspirin, which allows eligible members to receive it for little to no cost through their health plans. OTC aspirin prescriptions also result in documented aspirin use at both the clinic and pharmacy, thus benefiting patient safety. Prescriptions are tracked at the health plans through pharmacy claims which document the participation rate and allow monitoring of the project.

Recent analysis of pharmacy claims data shows the aggregated health plan rate of nearly 9% improvement for the first measurement year has already exceeded the project's goal of increasing aspirin use in the target population by 5% over the baseline usage rate of 25.9%—a significant improvement. In order for the project to meet its long-term goals, this improvement must be sustained for each of the next two project years, therefore continued efforts are needed. The Aspirin Therapy PIP will carry on into 2011, or longer if necessary to achieve desired utilization rates. Measurement data will be analyzed annually.

The aspirin project collaborative would like to congratulate care coordinators and providers for their hard work identifying and educating members who can benefit from aspirin therapy, and for providing OTC prescriptions. Thank you for your continued work on this important initiative!

More information can be found on the Stratis Health website at **http://www.stratishealth.org/providers/healthplanpips.html**. This site includes a care coordinator "toolkit", materials from previous trainings, sample educational materials for health plan members, and

continued on page 4

FYI

Aspirin therapy continued from page 3

professional guidelines for prescribing OTC aspirin.

For additional questions, please contact Linda Jax at **(651) 662-0763** or linda_a_jax@bluecrossmn.com.

**Collaborating health plans include Blue Plus, FirstPlan, HealthPartners, Itasca Medical Care, Medica, Metropolitan Health Plan, PrimeWest Health, South Country Health Alliance, and UCare, with support from Stratis Health.*

Publications available online

The following is a list of Quick Points and Bulletins published from September 2009 to November 2009 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 only available on our website unless noted otherwise in the bottom left corner of the publication.

Quick Points	Title
QP22-09	Coding H1N1 administration fees with other vaccine administration fees
QP23-09	Information on submitting appeals, replacement claims and valid/cancel claims
QP24-09	Information on electronic 835 remittances and provider portal remittance access
Bulletins	**Title**
P20R1-09	Revision to providers required to support coding changes with documentation as a result of adjustment audit bulletin
P23-09	Coding and reimbursement changes related to EIBI services for Autism Spectrum Disorder
P23R1-09	Revision to coding and reimbursement changes related to EIBI service for Autism Spectrum Disorder
P24-09	October 2009 HCPCS and ICD-9-CM code updates
P25-09	Mental and/or chemical health court-ordered evaluations
P26-09	Network participation insurance requirements
P27-09	Blue Plus Minnesota Health Care Programs in Northeast Minnesota
P28-09	Blue Cross medical policy regarding respiratory syncytial virus prophylaxis
P29-09	HIPAA compliance requirements

FYI

Provider manual updates

The following is a list of Blue Cross and Blue Shield of Minnesota provider manuals that have been updated from September 2009 to November 2009. 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
2009 Provider Policy and Procedure Manual	Chapter 5 – Health Care Options	Changed VantageBlue verbiage to Platinum Blue and multiple changes throughout
2009 Provider Policy and Procedure Manual	Chapter 10 – Appeals	Multiple changes throughout
2009 Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Behavioral Health	Added guidelines for court ordered evaluation topic: • Submitting mental and/or chemical health court ordered evaluations
2009 Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Medical Services	Added info under Immunization topic: • Supplies used in conjuction with immunization administrations
2009 Blue Plus Manual	Chapter 1 – Introduction to Blue Plus	Introduction to Blue Plus • General Overview • Member Rights and Responsibilities
2009 Blue Plus Manual	Chapter 2 – Blue Plus Members	Added new content to the following topics: • Quality-of-Care Complaints Reviewed by the Plan • Member Benefits – General Benefits – Continuity of Care After Facility Discharge

FYI

Verifying member ID cards

With the New Year around the corner, many of your patients may receive new member ID cards. To help ensure prompt and accurate claims processing, please make sure you have a copy of the patient's current ID card and use that information when submitting claims.

As a provider servicing out-of-area members, you may find the following tips helpful:

- Ask the member for the most current ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure that you have the most up-to-date information in your patient's file.
- Make copies of the front and back of the member's ID card and pass this key information to your billing staff.
- Blue Plan members' ID cards include a three-digit alpha prefix in the first three positions of the member's ID number. This alpha prefix identifies the member's Blue Plan and is critical for eligibility/benefits verification and claims processing. This may be followed by up to fourteen additional characters, any combination of letters and numbers. When filing the claim, always enter the identification number exactly as it appears on the member's card, inclusive of the alpha prefix.

Examples of ID numbers:

ABC1234567	ABC1234H567	ABC12345678901234
Alpha Prefix	Alpha Prefix	Alpha Prefix

Remember: member ID numbers must be reported exactly as shown on the ID card. Do not add, omit or alter any characters from the member ID number.

Special note about your Walmart patients and their ID cards:

New ID cards, effective January 1, 2010, will be issued before the first of the year to Walmart associates. Some ID cards will include a new alpha prefix as part of the member's ID number. To ensure that claims are processed correctly:

- Verify the ID card at every visit and make sure you have the correct one on file.
- File the claims to Blue Cross and Blue Shield of Minnesota using the exact ID card number, inclusive of alpha prefix. Do not add, omit or alter any characters from the member ID number.
- Continue to contact Blue Cross and Blue Shield of Minnesota for assistance.
- To check eligibility, benefits and pre-certification requirements, send an electronic eligibility inquiry to Blue Cross and Blue Shield of Minnesota or call **1-800-676-BLUE (2583)** and provide the three letter alpha prefix.

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

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** in the Blue Cross and Blue Shield of Minnesota Provider Policy and Procedure Manual under the Health Care Improvement Chapter.

Recently updated ICSI guidelines include:

- Diagnosis and Management of Type II Diabetes Mellitus in Adults
- Stable Coronary Artery Disease
- Major Depression in Adults in Primary Care
- Management of Labor
- Lipid Management
- Acute Coronary Syndrome

Patient and family guidelines

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

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

Coding Corner

Supplies used in conjunction with injection administrations

Syringes, needles or other supplies (A4206-A4209) used in conjunction with administering any injection, including immunization, therapeutic or diagnostic, are considered integral to that administration and will be denied as incidental to the administration.

The new codes are coming, the new codes are coming!

They have not been published yet, but we know they are coming – the January 2010 HCPCS changes! Because the January update is the largest of the quarterly HCPCS code updates, we will not publish the codes via bulletin as we do with other quarterly updates. But HCPCS codes (CPT and Level II HCPCS) are a HIPAA medical code set and must be valid for the date of service submitted. So it is very important to get your new CPT and HCPCS manuals. We will accept all new and revised HCPCS codes with a date of service of January 1, 2010 or after. Likewise, we will reject all discontinued codes with a date of service of January 1, 2010 or after.

Clear Claim Connection™ reminder

Clear Claim Connection discloses edits defined by McKesson Corporation as well as edits that are based on the medical and/or payment policies of payer organizations. Blue Cross offers this application as an opportunity for providers to review claim audit results and edit clarifications before submitting your claims to us. However, the results obtained through Clear Claim Connection are general disclosures of our edits and never a guarantee of payment. Additionally, we would like to remind you that unless a member is Medicare eligible, CCI edits do not apply.

96110-96111 included in preventive

Developmental testing, 96110 or 96111, is considered part of an age appropriate preventive medicine evaluation and management examination and as such, will deny if billed in addition to the exam (such as 99392). Exceptions are made only for our Public Program members (PMAP and MNCare).

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 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 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 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 service at **(651) 662-5200** or **1-800-262-0820** for assistance.

Medical and behavioral health policy activity

Policies Effective: 12/28/09 Notification Posted: 09/24/09

Policies developed

Hematopoietic Stem Cell Transplantation for Non-Hodgkin Lymphomas

- For patients with non-Hodgkin's lymphoma (NHL) subtypes considered aggressive, either allogeneic stem-cell transplant (SCT) using a myeloablative conditioning regimen or autologous SCT may be considered medically necessary:
  - As salvage therapy for patients who do not achieve a complete remission (CR) after first-line treatment (induction) with a full course of standard-dose chemotherapy;
  - To achieve or consolidate a CR for those in a chemosensitive first or subsequent relapse; or
  - To consolidate a first CR in patients with diffuse large B-cell lymphoma, with an age-adjusted International Prognostic Index score that predicts a high- or high-intermediate risk of relapse
- For patients with NHL subtypes considered indolent, either allogeneic SCT using a myeloablative conditioning regimen or autologous SCT may be considered medically necessary:
  - As salvage therapy for patients who do not achieve CR after first-line treatment (induction) with a full course of standard-dose chemotherapy; or
  - To achieve or consolidate CR for those in a first or subsequent chemosensitive relapse, whether or not their lymphoma has undergone transformation to a higher grade.

Medical and Behavioral Health Policy Update

- For patients with mantle cell lymphoma, autologous SCT may be considered medically necessary to consolidate a first remission.
- Reduced-intensity conditioning allogeneic SCT may be considered medically necessary as a treatment of NHL in patients who meet criteria above for an allogeneic SCT but who do not qualify for a myeloablative allogeneic SCT.
- Autologous SCT or allogeneic SCT are considered investigative:
  - As initial therapy (i.e., without a full course of standard-dose induction chemotherapy) for any NHL;
  - To consolidate a first CR for patients with diffuse large B-cell lymphoma and an International Prognostic Index score that predicts a low- or low-intermediate risk of relapse;
  - To consolidate a first CR for those with indolent NHL subtypes; and
  - For peripheral T-cell lymphoma at any stage of disease.
- Tandem transplants are considered investigative to treat patients with any stage, grade or subtype of NHL.
- Allogeneic SCT is considered investigative to treat NHL that progresses or relapses relatively soon after a prior course of high-dose chemotherapy with *autologous* SCT. (Note: This policy statement is based on a strict evidence-based analysis on outcomes of allotransplants after a failed autotransplant).
- Note: Small lymphocytic lymphoma may be considered a node-based variant of chronic lymphocytic leukemia (CLL). Therefore, SLL is considered along with CLL in a separate policy. Lymphoplasmacytic lymphoma / Waldenstrom macroglobulinemia is also considered in a separate policy.
- Prior authorization: Yes.

Non-Cancer BRCA Breast Cancer Risk Assessment

- The OncoVue® Breast Cancer Risk Test is considered investigative and not medically necessary as method of estimating individual patient risk for developing breast cancer, due to a lack of evidence demonstrating its impact on improved health outcomes.
- Prior authorization: Not applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Policies revised:

Growth Factors for Treatment of Wounds and Other Conditions

- Added the following note: "Platelet-derived growth factors (PDGF) are frequently used as an adjunct to surgery, including but not limited to their use in periodontal, plastic/reconstructive, or orthopedic procedures; adjunctive use of PDGF is considered outside the scope of this policy. This policy only addresses the use of blood-derived growth factors as primary treatment of wounds or other musculoskeletal conditions, including but not limited to, treatment of diabetic ulcers, ulcers related to venous stasis, lateral epicondylitis (i.e., tennis elbow), plantar fasciitis, or Dupuytren's contracture."
- Revised the following indication to include treatment of acute wounds: "Use of autologous blood-derived preparations (i.e., platelet-rich plasma) is considered investigative and not medically necessary in the treatment of acute or chronic, non-healing wounds."
- Prior authorization: Yes.

Amino Acid-Based Elemental Formulas

- The following has been added to the policy review criteria:
- *Initial Review:*

Medical and Behavioral Health Policy Update

The use of oral amino-acid based formula (when intended for the patient's sole source of nutrition) may be considered medically necessary up to age one when the following documentation is submitted:
  - Definitive diagnosis, with supporting lab and / or diagnostic test results.
    The use of oral amino-acid based formula may be considered medically necessary up to 180 days when requested by a physician while actively seeking confirmatory diagnosis when the following documentation is submitted:
  - Presumptive diagnosis
  - Patient's symptoms
  - Minimum of three to four prior failed formula alternatives
- *Renewal Review:*
  For children under age one, the use of oral amino-acid based formula may be considered medically necessary for an additional 180 days (when intended for the patient's sole source of nutrition) when the following documentation is submitted:
  - Improvement of the patient's symptoms while on the amino acid based formula; and
  - Definitive diagnosis accompanied with supporting lab and / or diagnostic test results; OR
  - Failure of challenge test wherein the amino acid based formula was withdrawn and other liquids were introduced.
- Prior authorization: Yes.

Oral Fentanyl for Cancer-Related Pain
- Added Onsolis™ as a type of oral fentanyl which may be considered medically necessary when medical policy criteria are met.
- Prior authorization: Yes.

Radiofrequency Facet Joint Denervation
- Added the following criteria: "Diagnostic, temporary block (2 separate blocks on different days), with local anesthetic of the facet nerve (medial branch block) or injection under fluoroscopic guidance into the facet joint, has resulted in elimination or marked decrease in intensity of pain."
- Prior authorization: Yes.

Lung Cancer Screening using Computed Tomography or Chest Radiographs
- Revised policy include Chest Radiographs, as follows: Computed Tomography and Chest Radiograph screenings, with or without computer-assisted detection or diagnosis, are considered investigative and not medically necessary.
- Revised policy investigative position on computed tomography (CT) to include "with or without computer-assisted detection or diagnosis."
- Prior authorization: Not applicable.

Hyperbaric Oxygen Therapy
- Added the following criteria for treatment of wounds:
- Non-healing diabetic wounds of the lower extremities when the following criteria are met:
  - Patient has type I or type II diabetes and a lower extremity wound due to diabetes;
  - Patient has a wound classified as Wagner grade 3 or higher*; and
  - Patient has no measurable signs of healing after 30 days of an adequate course of standard wound therapy.

Medical and Behavioral Health Policy Update

* The Wagner classification system of wounds is defined as follows: grade 0 = no open lesion; grade 1 = superficial ulcer without penetration to deeper layers; grade 2 = ulcer penetrates to tendon, bone, or joint; grade 3 = lesion has penetrated deeper than grade 2 and there is abscess, osteomyelitis, pyarthrosis, plantar space abscess, or infection of the tendon and tendon sheaths; grade 4 = wet or dry gangrene in the toes or forefoot; grade 5 = gangrene involves the whole foot or such a percentage that no local procedures are possible and amputation (at least at the below the knee level) is indicated.

- Prior authorization: No.

Magnetoencephalography / Magnetic Source Imaging

- Magnetoencephalography / magnetic source imaging (MEG / MSI) may be considered medically necessary when used for the following indications:
  - Mapping of the eloquent cortex (e.g., visual, sensory, language, or motor) in patients being prepared for surgery for epilepsy, brain tumors, arteriovenous malformations, or other indications requiring brain resection; or
  - Localization of the epileptic lesion foci in patients with medically refractory epilepsy who are being considered for surgery.
- Magnetoencephalography / magnetic source imaging (MEG / MSI) is considered investigative and not medically necessary for all other indications.
- Prior authorization: No.

Medical and Surgical Treatment of Gender Identity Disorder

- Addition of the following criteria for treatment of gender identity disorder: The patient is 18 years or older.
- Revised the additional requirements for hormone therapy as follows:
- The patient must have had a real-life experience living in the desired gender role of at least three months OR a period of psychotherapy of a minimum of three months' duration with successful completion of either.
- Addition of surgical procedures that are considered cosmetic and not medically necessary include, but are not limited to:
  - Hair removal/hair transplant
  - Blepharoplasty
  - Face lift
  - Facial bone reconstruction
  - Rhinoplasty
  - Liposuction
  - Reduction Thyroid chondroplasty
  - Voice modification surgery
- Revised the minimum licensing requirements for the diagnostician and primary treating clinician from Master's Degree level to doctoral (Ph.D or M.D.) level.
- Prior authorization: Yes, for surgical procedures for reassigning biological sex.

Orthopics or Vision Therapy

- Vision therapy / orthoptics provided in the office setting may be considered medically necessary for the treatment of binocular vision disorders when the following criteria are met:
  - The initial evaluation must include quantifiable measurements to support the diagnosis(es). This will establish the baseline against which follow-up evaluations can be measured. Initial evaluation should indicate the following:

Medical and Behavioral Health Policy Update

1. What percentage, below the normal, nearpoint acuity is;
2. How long nearpoint focus can be maintained; and
3. Which physical symptoms are present, their frequency, and, subjectively, how severe these symptoms are. Each new patient must have a comprehensive plan of treatment that includes the projected period of treatment.

- New patients are expected to show a measurable improvement within the first two months. If there is no improvement, the vision therapy services will be considered not medically necessary.
- Follow-up evaluations thereafter should be conducted at least monthly and should include quantifiable measurements and the percentage of improvement from the initial evaluation. The service will be considered not medically necessary once further improvement cannot be documented. Documentation should include the following:
  - Patient's compliance with the visual therapy exercises performed between clinic visits.
  - Follow-up exams should indicate:
    1. What percentage below the normal nearpoint acuity has occurred,
    2. How long the nearpoint focus can be maintained, and
    3. The changes in symptoms by percentage of improvement.
- Generally, maximum improvement will require no more than 12 treatments and may be achieved more quickly. Requests for additional visits will be considered on a case-by-case basis.
- Program supplies intended for use in the home setting (e.g., computer software) are considered ineligible for coverage.
- Vision therapy is considered investigative and not medically necessary for all behavioral health disorders, including learning disabilities and attention-deficit/hyperactivity disorder. No evidence supporting the efficacy of vision therapy in the treatment of behavioral health disorders could be found.
- Prior authorization: Yes, ONLY after 12 office visits.

Policies inactivated *

None.

Medical and Behavioral Health Policy Activity

Policies Effective: 01/22/10 Notification Posted: 10/22/09

Policies developed:

Hematopoietic Stem Cell Transplantation for Autoimmune Diseases

- Autologous or allogeneic hematopoietic stem-cell transplantation is considered investigative as a treatment of autoimmune diseases, including, but not limited to, the following conditions:
  - Multiple sclerosis (MS);
  - Rheumatoid arthritis (RA);
  - Systemic lupus erythematosus (SLE); and
  - Systemic sclerosis / scleroderma
- 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.

Hematopoietic Stem Cell Transplantation for Miscellaneous Solid Tumors in Adults

- Autologous or allogeneic hematopoietic stem-cell transplantation is considered investigative for the following

Medical and Behavioral Health Policy Update

malignancies in adults:
- Lung cancer, any histology
- Colon cancer
- Rectal cancer
- Pancreas cancer;
- Stomach cancer
- Esophageal cancer
- Gall bladder cancer
- Cancer of the bile duct
- Renal cell cancer
- Cervical cancer
- Uterine cancer
- Cancer of the fallopian tubes
- Prostate cancer
- Nasopharyngeal cancer
- Paranasal sinus cancer
- Neuroendocrine tumors
- Soft tissue sarcomas
- Thyroid tumors
- Tumors of the thymus
- Tumors of unknown primary origin
- Malignant melanoma
- 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.

Hematopoietic Stem Cell Transplantation for Malignant Astrocytomas and Gliomas
- Autologous hematopoietic stem-cell transplantation is considered investigative as a treatment of malignant astrocytomas and gliomas. (The latter diagnosis includes both glioblastoma multiforme and oligodendroglioma).
- 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.

Hematopoietic Stem Cell Transplantation for Primary Amyloidosis and Waldenstrom Macroglobulinemia
- Autologous hematopoietic stem-cell transplantation may be considered medically necessary to treat primary systemic amyloidosis.
- Allogeneic hematopoietic stem-cell transplantation is considered investigative to treat primary systemic amyloidosis.
- Hematopoietic stem-cell transplantation is considered investigative to treat Waldenstrom macroglobulinemia.
- Prior authorization: Yes.

Hematopoietic Stem Cell Transplantation for Chronic Lymphocytic Leukemia and Small Lymphocytic Leukemia
- Autologous or allogeneic hematopoietic stem-cell transplantation is considered investigative to treat chronic lymphocytic leukemia or small lymphocytic lymphoma.
- Prior authorization: Not applicable.

Medical and Behavioral Health Policy Update

Hematopoietic Stem Cell Transplantation for Acute Lymphoblastic Leukemia

Children

- Allogeneic or autologous hematopoietic stem-cell transplantation (SCT) may be considered medically necessary to treat childhood Acute Lymphoblastic Leukemia (ALL) in first complete remission but at high risk of relapse. Risk factors for relapse include:
  - Poor response to initial therapy including poor response to prednisone prophase defined as an absolute blast count of 1000/μL or greater, or poor treatment response to induction therapy at 6 weeks with high risk having ≥1% minimal residual disease measured by flow cytometry);
  - All children with T-cell phenotype; and
  - Patients with either the t(9;22) or t(4;11) regardless of early response measures
- Autologous or allogeneic hematopoietic SCT may be considered medically necessary to treat childhood ALL in second or greater remission or refractory ALL.
- Allogeneic hematopoietic SCT is considered investigative to treat relapsing ALL after a prior *autologous* SCT.

Adults

- Allogeneic hematopoietic SCT may be considered medically necessary to treat adult ALL in first complete remission but at high risk of relapse. Risk factors for relapse include:
  - Age greater than 35 years,
  - Leukocytosis at presentation of >30,000/μL (B-cell lineage) and >100,000/μL (T-cell lineage);
  - "Poor prognosis" genetic abnormalities like the Philadelphia chromosome (t(9;22));
  - Extramedullary disease; and
  - Time to attain complete remission longer than 4 weeks
- Allogeneic hematopoietic SCT may be considered medically necessary to treat adult ALL in second or greater remissions or in patients with relapsed or refractory ALL.
- Autologous hematopoietic SCT is considered investigative to treat adult ALL in first, second, or greater remission or those with refractory disease.
- Allogeneic hematopoietic SCT is considered investigative to treat relapsing ALL after a prior autologous SCT.
- Reduced-intensity conditioning allogeneic hematopoietic SCT may be considered medically necessary as a treatment of ALL in patients who are in complete marrow and extramedullary first or second remission, and who, for the following medical reasons, would be unable to tolerate a standard myeloablative conditioning regimen:
  - Co-morbidities (e.g., liver or kidney dysfunction, generalized debilitation, prior intensive chemotherapy, low Karnofsky Performance Status).
- Prior authorization: Yes.

Vitiligo Treatment

- Treatment of vitiligo, by any method, is considered cosmetic including, but not limited to:
  - Corticosteriods;
  - Phototherapy;
  - Photochemotherapy;
  - Laser treatment;
  - Dermabrasion;
  - Topical immunomodulators (e.g., tacrolimus); or

Medical and Behavioral Health Policy Update

  - Skin grafting
- Prior authorization: Not applicable. Claims for this service are subject to retrospective review and denial of coverage, as cosmetic services are not eligible for reimbursement.

Selective Internal Radiation Therapy (SIRT)

- Selective internal radiation therapy (SIRT) using the yttrium-90 (Y-90) microsphere SIR-Sphere® may be considered medically necessary for the treatment of isolated unresectable metastatic liver tumors from primary colorectal cancer with adjuvant intra-hepatic artery chemotherapy (IHAC) of FUDR (floxuridine).
- Selective internal radiation therapy (SIRT) using the yttrium-90 (Y-90) microsphere TheraSphere® may be considered medically necessary for radiation treatment or as a neoadjuvant to surgery or transplantation in patients with unresectable hepatocellular carcinoma (HCC) who can have appropriately positioned hepatic arterial catheters.
- Selective internal radiation therapy (SIRT) using yttrium-90 (Y-90) microspheres is considered investigative and not medically necessary for all other indications due to a lack of evidence demonstrating its impact on improved health outcomes.
- Prior authorization: Yes.

Policies revised:

KRAS Mutation Analysis

- The investigative indications for KRAS mutation analysis testing has been revised to state: "Use of KRAS mutation analysis is considered investigative and not medically necessary for all other indications, including, but not limited to, its use to predict treatment response to erlotinib in non-small cell lung carcinoma."
- Prior authorization: Yes.

Rosacea Treatment

- The policy has been revised to distinguish between treatments for active rosacea and the untoward cosmetic effects associated with rosacea.
- Medical management of active rosacea (i.e., papulopustular) using the following treatments may be considered medically necessary:
  - Oral and topical antibiotics;
  - Topical retinoids;
  - Isotretinoin; and
  - Anti-inflammatory doses of doxycycline
- The following treatments for active rosacea (i.e., papulopustular) are considered investigative and not medically necessary due to a lack of evidence demonstrating improved health outcomes:
  - Laser treatment;
  - Phototherapy;
  - Dermabrasion;
  - Chemical peels;
  - Surgery debulking; and
  - Electrosurgery
- The following treatments are considered cosmetic when used to treat the untoward cosmetic effects associated with rosacea (e.g., erythema, telangiectasias, facial scarring):

Medical and Behavioral Health Policy Update

  - Laser treatment;
  - Phototherapy;
  - Dermabrasion;
  - Chemical peels;
  - Surgery debulking; and
  - Electrosurgery
- 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.

Acne Treatment / Skin Rejuvenation

- The policy has been revised to distinguish between first-line and second-line treatments for active acne. In addition, treatments considered investigative or cosmetic for active acne have been updated.
- The following treatments may be considered medically necessary for *first-line treatment* of active acne:
  - Oral contraceptive hormone therapy;
  - Topical and oral antibiotics;
  - Topical retinoids; and
  - Isotretinoin
- The following treatments may be considered medically necessary for treatment of active acne that is *resistant to first-line treatments* described above:
  - Cryotherapy;
  - Intralesional injections of corticosteroids; and
  - Chemical exfoliation, including epidermal chemical peels.
- The following treatments for active acne are considered investigative and not medically necessary:
  - Dermabrasion;
  - Photodynamic therapy;
  - Laser therapy, including pulsed dye laser therapy;
  - Light therapy, including red, blue or violet light therapy and intense pulsed light therapy; and
  - Thermal therapy devices
- Treatment for acne scarring and other untoward cosmetic effects of acne or treatment for skin rejuvenation is considered cosmetic including, but not limited to, the following treatments:
  - Retinoids;
  - Dermabrasion;
  - Laserabrasion;
  - Photodynamic therapy; and
  - Epidermal and dermal chemical peels
- 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.

Computed Tomography (CT) to Detect Coronary Artery Calcification (formerly Screening for Coronary Artery Disease)

- The policy has been revised to include both symptomatic as well as asymptomatic individuals.
- The investigative indication for computed tomography (CT) to detect coronary artery calcification has been revised to

Medical and Behavioral Health Policy Update

state: "The use of computed tomography (CT) to detect coronary artery calcification is considered investigative and not medically necessary due to a lack of evidence demonstrating an impact on improved health outcomes."
- Prior authorization: Not applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Oscillatory Devices for Treatment of Cystic Fibrosis and Other Respiratory Disorders
- The policy has been revised to include policy statements specific to the different types of oscillatory devices used to treat Cystic Fibrosis and other respiratory disorders.
- Use of vibratory positive expiratory pressure devices (i.e., Flutter or Acapella devices) may be considered medically necessary when used in conjunction with standard chest physiotherapy in patients with the following conditions who have recurrent disease exacerbations and difficulty clearing the secretions:
  - Cystic fibrosis or
  - Chronic bronchiectasis
- Other applications of vibratory positive expiratory pressure devices (i.e., Flutter or Acapella devices) including, but not limited to their use in other lung diseases, such as chronic obstructive pulmonary disease (COPD), are considered investigative and not medically necessary.
- The use of high-frequency chest wall compression devices may be considered medically necessary as an alternative to chest physical therapy for airway clearance when standard chest physiotherapy has failed or cannot be performed in patients with the following conditions:
  - Cystic fibrosis or
  - Chronic bronchiectasis
- The use of high-frequency chest wall compression devices is considered not medically necessary as an alternative to chest physical therapy in patients with cystic fibrosis or chronic bronchiectasis in any other clinical situations; there are no clinical data to show that these devices provide any additional health benefit compared to conventional chest physical therapy in these situations.
- Other applications of high-frequency chest wall compression devices, including but not limited to, their use as an adjunct to chest physical therapy or their use in other lung diseases, such as chronic obstructive pulmonary disease (COPD), are considered investigative and not medically necessary.
- The use of intrapulmonary percussive ventilation devices is considered investigative and not medically necessary in the treatment of chronic pulmonary diseases, including cystic fibrosis and bronchiectasis.
- Prior authorization: Yes.

Botulinum Toxin (formerly Botulinum Toxin(Botox, Botox Cosmetic, Myobloc))
- The policy has been updated with the recently changed FDA nomenclature for the various forms of botulinum toxin.
- Prior authorization has been changed from No to, "Yes for off-label indications ONLY".

Policies inactivated *

Autologous Bone Marrow with or without Demineralized Bone Matrix for Percutaneous Treatment of Fracture Non-Unions

Compounded Bioidentical Hormone Therapy for Menopausal Symptoms

Medical and Behavioral Health Policy Update

Medical and Behavioral Health Policy Activity

Policies Effective: 02/22/10 Notification Posted: 11/23/09

Policies developed:

Allogeneic Hematopoietic Stem-Cell Transplantation for Genetic Diseases and Acquired Anemias

- Allogeneic hematopoietic stem cell transplantation may be considered medically necessary for selected patients with the following disorders:
  - Hemoglobinopathies
    - Sickle cell anemia for children or young adults with either a history of prior stroke or at increased risk of stroke or end-organ damage.
    - Homozygous beta-thalassemia (i.e., thalassemia major)
  - Bone marrow failure syndromes
    - Hereditary (including Fanconi anemia, dyskeratosis congenita, Shwachman-Diamond, Diamond-Blackfan); or
    - Acquired (e.g., secondary to drug or toxin exposure) forms.
  - Primary immunodeficiencies
    - Lymphocyte immunodeficiencies
      1. Adenosine deaminase deficiency
      2. Artemis deficiency
      3. Calcium channel deficiency
      4. CD 40 ligand deficiency
      5. Cernunnos/X-linked lymphoproliferative disease deficiency
      6. CHARGE syndrome with immune deficiency
      7. Common gamma chain deficiency
      8. Deficiencies in CD45, CD3, CD8
      9. DiGeorge syndrome
      10. DNA ligase IV
      11. Interleuken-7 receptor alpha deficiency
      12. Janus-associated kinase 3 (JAK3) deficiency
      13. Major histocompatibility class II deficiency
      14. Omenn syndrome
      15. Purine nucleoside phosphorylase deficiency
      16. Recombinase-activating gene (RAG) 1/2 deficiency
      17. Reticular dysgenesis
      18. Winged helix deficiency
      19. Wiskott-Aldrich syndrome
      20. X-linked lymphoproliferative disease
      21. Zeta-chain-associated protein-70 (ZAP-70) deficiency
    - Phagocytic deficiencies
      1. Chediak-Higashi syndrome
      2. Chronic granulomatous disease
      3. Hemophagocytic lymphohistiocytosis

Medical and Behavioral Health Policy Update

4. Griscelli syndrome, type 2
5. Interferon-gamma receptor deficiencies
6. Leukocyte adhesion deficiency
7. Severe congenital neutropenias
8. Shwachman-Diamond syndrome

- Other immunodeficiencies
  1. Autoimmune lymphoproliferative syndrome
  2. Cartilage hair hypoplasia
  3. CD25 deficiency
  4. Hyper IgD and IgE syndromes
  5. ICF syndrome
  6. IPEX syndrome
  7. NEMO deficiency
  8. NF-κB inhibitor, alpha (IκB-alpha) deficiency
  9. Nijmegen breakage syndrome

– Genetic disorders affecting skeletal tissue
  - Infantile malignant osteopetrosis (Albers-Schonberg disease or marble bone disease).

– Inherited metabolic disease
  - Lysosomal and peroxisomal storage disorders
  - Hurler syndrome:
  - Maroteaux-Lamy syndrome;
  - Sly syndrome;
  - Globoid-cell leukodystrophy;
  - Childhood-onset cerebral X-linked adrenoleukodystrophy;
  - Metachromatic leukodystrophy;
  - Alpha-mannosidosis;
  - Aspartylglucosaminuria.

- Allogeneic hematopoietic stem cell transplantation is considered investigative for treatment of Hunter, Sanfilippo and Morquio syndromes due to a lack of evidence demonstrating an impact on improved health outcomes.
- Prior Authorization: Yes.

Actigraphy

- Actigraphy is considered investigative and not medically necessary as a technique to record and analyze body movement, including, but not limited to, its use to evaluate sleep disorders.
- 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:

Sleep Studies / Polysomnograms in Children and Adolescents (formerly titled Pediatric Sleep Studies / Polysomnograms)

- The following has been added to the list of indications for supervised polysomnography performed in a sleep laboratory as a diagnostic test in children and adolescents for the following situations when habitual snoring is present:

Medical and Behavioral Health Policy Update

  - Adenotonsillar hypertrophy, when the only indication for performing the tonsillectomy and adenoidectomy is the presence of obstructive sleep apnea.
- The following three conditions have been added to the list of indications for supervised polysomnography performed in a sleep laboratory as a diagnostic test in children and adolescents for the following situations:
  - Suspected narcolepsy;
  - Suspected idiopathic hypersomnia;
  - Suspected restless leg syndrome or period limb movement disorder, when iron deficiency has been ruled out and the use of dopaminergic agents is being considered;
- The following statement has been added to the policy:
  - Use of supervised polysomnography performed in a sleep laboratory is considered investigative and not medically necessary for all other indications.
- 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.

Progesterone Therapy to Reduce Preterm Birth in High-Risk Pregnancies

- Title changed by replacing "preterm delivery" with "preterm birth"
- All policy statements have been revised to state:
- Weekly injections of 17 alpha-hydroxyprogesterone caproate (17P) administered between 16 and 36 weeks' gestation may be considered medically necessary for women *with a singleton pregnancy* with a prior history of *spontaneous preterm birth* before 37 weeks' gestation.
- Daily vaginal progesterone administered between 24 and 34 weeks' gestation may be considered medically necessary for women *with a singleton pregnancy* with a prior history of *spontaneous preterm birth* before 37 weeks' gestation.
- In the absence of a prior history of spontaneous preterm birth, progesterone therapy as a technique to prevent preterm delivery is considered investigative and not medically necessary in pregnant women with other risk factors for preterm delivery, including but not limited to, the following:
  - Multiple gestations;
  - Short cervical length;
  - Positive tests for cervicovaginal fetal fibronectin;
  - Cervical cerclage; OR
  - Uterine anomaly
- 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.

Meniscal Allografts and Collagen Meniscus Implants (formerly included in Complex Knee Surgeries: Allografts and Autografts)

- Separate policy created with the following criteria:
- Meniscal allograft transplantation may be considered medically necessary in patients who have had a prior meniscectomy and have symptoms related to the affected side, when all of the following criteria are met:
  - Adolescent patients should be skeletally mature with documented closure of growth plates (e.g., 15 years or older). Adult patients should be too young to be considered an appropriate candidate for total knee arthroplasty or other reconstructive knee surgery (e.g., younger than 55 years);

Medical and Behavioral Health Policy Update

  - Disabling knee pain with activity that is refractory to conservative treatment;
  - Absence or near absence (more than 50%) of the meniscus, established by imaging or prior surgery;
  - Documented minimal-to-absent degenerative changes in the surrounding articular cartilage (Outerbridge grade II or less);
  - Presence of stable ligaments (if ligaments are unstable, documentation should be provided as to how this condition will be addressed);
  - No malalignment present (if malalignment is present, documentation should indicate planned concurrent correction of alignment).
- Meniscal allograft transplantation or is considered investigative and not medically necessary when performed in combination, either concurrently or sequentially, with autologous chondrocyte implantation or osteochondral allografting.
- The use of collagen meniscus implants is considered investigative and not medically necessary due to a lack of evidence demonstrating an impact on improved health outcomes.
- 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.

Autologous Chondrocyte Implantation (formerly included in Complex Knee Surgeries: Allografts and Autografts)

- Separate policy created with the following criteria:
- Autologous chondrocyte implantation may be considered medically necessary for the treatment of disabling full-thickness articular cartilage defects of the knee caused by acute or repetitive trauma, in patients who have had an inadequate response to a prior surgical procedure, when all of the following criteria are met:
  - Adolescent patients should be skeletally mature with documented closure of growth plates (e.g., 15 years or older). Adult patients should be too young to be considered an appropriate candidate for total knee arthroplasty or other reconstructive knee surgery (e.g., younger than 55 years);
  - Size of the cartilage lesion is greater than 1.5 cm^2;
  - Focal, full-thickness (grade III or IV) unipolar lesions on the weight bearing surface of the femoral condyles or trochlea;
  - Documented minimal to absent degenerative changes in the surrounding articular cartilage (Outerbridge Grade II or less), and normal-appearing hyaline cartilage surrounding the border of the defect;
  - Presence of persistent symptoms (e.g., pain, swelling and catching/locking) that significantly limit activities of daily living;
  - Presence of stable ligaments (if ligaments are unstable, documentation should be provided as to how this condition will be addressed);
  - No malalignment present (if malalignment is present, documentation should indicate planned concurrent correction of alignment);
  - Absence of meniscal pathology.
- Autologous chondrocyte implantation for all other joints, including patellar and talar, and any indications other than those listed above is considered investigative and not medically necessary due to a lack of evidence demonstrating an impact on improved health outcomes.
- Matrix-induced autologous chondrocyte implantation is considered investigative and not medically necessary due to lack of appropriate regulatory approval for the type of implant used in this procedure.
- Prior authorization: No. However, services with specific coverage criteria may be reviewed retrospectively to determine

Medical and Behavioral Health Policy Update

if criteria are being met. Retrospective denial may result if criteria are not met.

Osteochondral Allografts and Autografts in the Treatment of Focal Articular Cartilage Lesions (formerly included in Complex Knee Surgeries: Allografts and Autografts)

- Separate policy created with the following criteria:
- Osteochondral allograft transplantation may be considered medically necessary for the treatment of symptomatic full-thickness cartilage defects caused by acute or repetitive trauma, in patients who have had an inadequate response to a prior surgical procedure, when all the following criteria are met:
  - Adolescent patients should be skeletally mature with documented closure of growth plates (e.g., 15 years or older). Adult patients should be too young to be considered an appropriate candidate for total knee arthroplasty or other reconstructive knee surgery (e.g., younger than 55 years);
  - Size of the cartilage lesion is *greater than* 1.5 cm^2;
  - Focal full-thickness (grade III or IV) cartilage lesions on the weight-bearing surface of the femoral condyles (medial or lateral) or trochlea;
  - Documented minimal to absent degenerative changes in the surrounding articular cartilage (Outerbridge grade II or less) and normal-appearing hyaline cartilage surrounding the border of the defect;
  - Presence of persistent symptoms (e.g., pain, swelling and catching/locking) that significantly limit activities of daily living;
  - Presence of stable ligaments (if ligaments are unstable, documentation should be provided as to how this condition will be addressed);
  - No malalignment present (if malalignment is present, documentation should indicate planned concurrent correction of alignment);
  - Absence of meniscal pathology.
- Osteochondral autograft transplantation (OATS or autologous mosaicplasty), using one or more cores of osteochondral tissue may be considered medically necessary for the treatment of symptomatic full-thickness cartilage defects caused by acute or repetitive trauma, in patients who have had an inadequate response to a prior surgical procedure, when all the following criteria are met:
  - Adolescent patients should be skeletally mature with documented closure of growth plates (e.g., 15 years or older). Adult patients should be too young to be considered an appropriate candidate for total knee arthroplasty or other reconstructive knee surgery (e.g., younger than 55 years);
  - Size of the cartilage lesion is 1.0 - 2.0 cm^2;
  - Focal full-thickness (grade III or IV) cartilage lesions on the weight-bearing surface of the femoral condyles (medial or lateral) or trochlea;
  - Documented minimal to absent degenerative changes in the surrounding articular cartilage (Outerbridge grade II or less) and normal-appearing hyaline cartilage surrounding the border of the defect;
  - Presence of persistent symptoms (e.g., pain, swelling and catching/locking) that significantly limit activities of daily living;
  - Presence of stable ligaments (if ligaments are unstable, documentation should be provided as to how this condition will be addressed);
  - No malalignment present;
  - Absence of meniscal pathology

Medical and Behavioral Health Policy Update

- Osteochondral allografting or autografting for all other joints, including patellar and talar, and any indications other than those listed above, is considered investigative and not medically necessary due to a lack of evidence demonstrating an impact on improved health outcomes.
- 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.

CT Colonography (Virtual Colonoscopy)

- Title changed by removing reference to "screening test for colorectal cancer" to reflect a broader policy which encompases both screening as well as non-screening applications.
- Added the use of CT colonography (virtual colonoscopy) may be considered medically necessary for the following indications:
- Failed or incomplete fiberoptic colonoscopy of the entire colon, due to inability to pass the colonoscope proximally. Failure to advance the colonoscope may be secondary to:
  - Obstructing neoplasm
  - Spasm
  - Redundant colon
  - Altered anatomy or scarring from previous surgery
  - Stricture
  - Extrinsic compression
- Coagulopathy;
- The remainder of the policy is unchanged.
- Prior authorization: Yes.

Percutaneous Vertebroplasty, Kyphoplasty, and Sacroplasty

- Title updated to include sacroplasty
- Added percutaneous sacroplasty is considered investigative and not medically necessary due to a lack of evidence demonstrating an impact on improved health outcomes.
- The remainder of the policy is unchanged.
- Prior authorization: No. However, services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial may result if criteria are not met.

Subtalar Arthroereisis (formerly titled Subtalar Arthroereisis for Treatment of Flexible Flatfoot)

- The policy no longer has coverage criteria for children.
- Subtalar arthroereisis is considered investigative and not medically necessary for treatment of all flatfoot conditions in children and adults due to the lack of evidence demonstrating an impact on improved health outcomes.
- Prior authorization: No applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Policies inactivated*

Pediatric Sleep Studies / Polysomnograms (policy replaced with the Sleep Studies / Polysomnograms in Children and Adolescents)

Medical and Behavioral Health Policy Update

Complex Knee Surgeries: Allografts and Autografts (policy replaced with three policies: Meniscal Allografts and Collagen Meniscus Implants, Autologous Chondrocyte Implantation, and Osteochondral Allografts and Autografts in the Treatment of Focal Articular Cartilage Lesions)

Treatment for Impotence

* *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 September 2009 through November 2009

- Acupuncture
- Ambulatory Blood Pressure Monitoring
- Anesthesia Services for Gastrointestinal Endoscopic Procedures
- Automated External Defibrillator for Home Use
- Balloon Catheter Therapy for Chronic Sinusitis
- Biofeedback for Disorders Listed in the DSM-IV TR
- Bipolar Radiofrequency Stimulation and Ablation (TOPAZ) as Treatment for Chronic Tendinosis
- Blepharoplasty and Brow Ptosis Repair
- Bone Morphogenetic Protein (BMP)
- Breast Implants
- Carotid Angioplasty/Stenting
- Communication Assist Devices
- Computed Tomography Angiography (CTA) for the Evaluation of Coronary Arteries
- Deep Brain Stimulation
- Durable Medical Equipment
- Electrotherapy/Electrotherapeutic Devices
- Factor Products for Treatment of Bleeding Disorders
- Fetal Fibronectin Enzyme Immunoassay
- Gene Expression Profiling for the Management Breast Cancer Treatment
- Genetic Testing and Counseling
- Genetic Testing for Breast and Ovarian Cancer
- Genetic Testing for Long QT Syndrome
- Growth Hormone
- Hematopoietic Stem Cell Transplantation, Allogeneic
- Hematopoietic Stem Cell Transplantation, Autologous
- Hypnotherapy
- Implantable Cardioverter-Defibrillator
- Influenza Virus Vaccine Live, Intranasal (FluMist)
- Left Atrial Appendage Occluder Devices

Medical and Behavioral Health Policy Update

- Lung Volume Reduction Surgery
- Metal-on-Metal Total Hip Resurfacing
- Methadone Maintenance for Chronic Opioid Dependence
- Mobile Outpatient Cardiac Telemetry
- Monoclonal Antibody Therapy for Allergic Asthma
- Noninvasive Measurement of Left Ventricular End Diastolic Pressure
- Nutritional Support
- Orthognathic Surgery
- Otoplasty
- Percutaneous Transluminal Angioplasty of Intracranial Artherosclerotic Stenoses
- Peripheral Arterial Tonometry
- Photodynamic Therapy for Oncologic Applications, Including Barrett's Esophagus
- Photodynamic Therapy for Skin Conditions
- Phototherapy with Utraviolet Light
- Pneumatic Compression Devices for Lymphedema
- Prophylactic Mastectomy
- PUVA (Psoralen Photochemotherapy)
- Ranibizumab (Lucentis) for the Treatment of Neovascular Age-Related Macular Degeneration
- Refractive Eye Surgery
- Retinal Telescreening Systems for Diabetic Retinopathy
- Rituximab for Off-Label Indications
- Sacral Nerve Stimulation
- Scanning Laser Technologies for Glaucoma
- Sclerotherapy
- Secretin Infusion Therapy for Autism
- Serum Holo-Transcobalamin as a Marker for Vitamin B12 Status
- Targeted Phototherapy for Psoriasis
- Treatment for Pathological Gambling
- Treatment for Psoriasis
- Treatment for Severe Primary Insulin-Like Growth Factor-1 (IGF-) Deficiency
- Treatment for Temporomandibular Disorder (TMD)
- Treatment of Meniere's Disease
- Treatment of Twin-Twin Transfusion Syndrome with Amnioreduction and/or Fetoscopic Laser Therapy
- Treatment of Urinary Dysfunction
- Tumors Markers, Urinary
- T-Wave Alternans
- Uterine Contraction Monitoring (Home Ambulatory)
- Vagus Nerve Stimulation
- Ventricular Assist Devices and Total Hearts
- Ventricular Reduction Surgery

Medical and Behavioral Health Policy Update

- Wearable Cardioverter-Defibrillators as a Bridge to Implantable Cardioverter-Defibrillator Placement
- Wheelchairs
- Wound Healing: Electrostimulation and Electromagnetic Therapy
- Wound Healing: Non-Contact Radiant Heat Bandage
- Wound Healing: Non-Contact Ultrasound Treatment
- Wound Healing: Vacuum-Assisted Wound Therapy in the Outpatient Setting

FYI

Medicare Cost plan VantageBlue renamed Platinum Blue

Blue Cross and Blue Shield of Minnesota announces changes to its Medicare Cost plan for groups and individuals. The Cost plan has been renamed Platinum Blue℠ (Cost) effective January 1, 2010. It will have three individual plan options – Core, Choice, Complete – and offer great value to our members. The Cost plan is also being offered to employer groups for 2010. It will be called Group Platinum Blue (Cost) and has three options-Plan A, Plan B, and Plan C. The individual and employer group plans include coverage for preventive services, a travel benefit, and a special fitness program designed for seniors. Some plan options also offer members benefits for hearing aids and eyewear. All of our plan options come with the quality, experience and stability of Blue Cross and Blue Shield.

As with VantageBlue, providers will generally bill professional services to Blue Cross. Hospital and other institutional claims will generally be paid directly by Medicare. Specific billing information is available in our online Provider Policy and Procedure Manual. Providers who are currently participating with Blue Cross Medicare programs can serve Platinum Blue (Cost) and Group Platinum Blue (Cost) members under their existing contract arrangements. For more information on Platinum Blue, please go to **providers.bluecrossmn.com**.

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:

Network Management S117
Editor: Holly Batchelder
P.O. Box 64560
St. Paul, MN 55164-0560
(651) 662-2014
toll free: 1-800-382-2000, ext. 22014

Advisors/Faith Bauer, CPC, CPC-H; Kathy Sijan, CPC, CPC-H; Janine Utecht, CPC, CPC-H, CPC-P, CPMA; and Brenda Wieber, RN, BSN

12/09

BlueCross BlueShield BluePlus of Minnesota
Independent licensees of the Blue Cross and Blue Shield Association

Network Management S117
P.O. Box 64560
St. Paul, MN 55164-0560