Provider Press

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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 at 1-800-382-2000, option 2, ext. 28516.

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, license UM staff and any other personnel who make UM decisions of this philosophy and practice.

Medical policy

As you know, updates to medical and behavioral health policies are included in each issue of Provider Press. Additionally, all medical and behavioral health policies are available online at **providers.bluecrossmn.com**. Select "Medical policy" under the Tools & Resources section. The "What's New" section identifies new or revised policies that are in effect and are posted on our website. The "Upcoming Policies" section lists policies that have been reviewed by the Medical and Behavioral Health Policy Committee and will be effective 90 days from the date these policies are posted on **providers.bluecrossmn.com.**

Quality improvement (QI) program

The Blue Cross and Blue Shield of Minnesota and Blue Plus QI program annually carries out many projects to improve members' health. The QI core documents describe our QI program description, new and current projects in 2009 and finally an evaluation of projects carried out in 2008. The QI program has projects that attempt to improve the rates of preventive health services, such as immunizations and mammograms; reduce the occurrence of acute diseases like flu; or improve the outcomes of chronic diseases such as diabetes or heart disease. It includes quality of clinical care, quality of service, patient safety and collaborative initiatives. If you'd like to learn more about the quality improvement program or to request copies of QI core documents, please call Lynda Flinck at (651) 662-9634 or toll free at 1-800-382-2000, ext. 29634.

Provider Press

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

Inside preview

FYI

Publications available online

The following is a list of Quick Points and Bulletins published from March 2009 to May 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
QP6-09	Provider section of **bluecrossmn.com** enhanced
QP7-09	New Minnesota law for standardized electronic claims submission
QP8-09	Verifying patient eligibility
QP9-09	SelectAccount℠ Pay-the-Provider, payment capability direct to provider
QP10-09	Formulary exception process update for Minnesota Health Care Programs
QP11-09	Correct billing of code Q1003 for Medicare Advantage products
QP12-09	Frequently asked questions for residential substance abuse facility admission process change
Bulletins	
P4-09	April 2009 HCPCS code update
P5-09	Residential substance abuse admission and concurrent review process change
P6-09	Blue Plus Minnesota Health Care Program (MHCP) changes in chiropractic authorization process
P7-09	Services to restricted recipients
P8-09	Injection and infusion services restrictions
P9-09	Liposuction edit change
P10-09	National Provider Identifier update
P11-09	Addition of mental health-targeted case management services to Minnesota Health Care Programs
P12R1-09	Access Management program for fully insured members
P13-09	Update: Claims submission requirements for Intensive Residential Treatment Services and Residential Crisis Stabilization
P14-09	Procedural changes related to autism spectrum disorder
P15-09	Blue Cross adopts use of AUC appeal form
P16-09	Providers need to verify member identity
P17-09	Blue Cross medical policy regarding intra-articular hyaluronan injections for osteoarthritis
P18-09	Blue Plus Minnesota Health Care Program (MHCP) changes in prior authorization

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
P.O. Box 64560
Route S116
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 2009 to May 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 1 - At Your Service	Added "Address Changes and Other Demographic Information" topic
2009 Provider Policy and Procedure Manual	Chapter 4 – Care Management	Added Content to Overview topic. Removed PMAP and MinnesotaCare, GAMC and MSHO (SecureBlue) and MN Senior Care Members topic.
2009 Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines, Behavioral Health	Multiple changes throughout
2009 Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Laboratory	Updated Papanicolaou Smears topic
2009 Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Medical Services	Added the following topics: · CHF/COPD Telemonitoring Services for CareBlue and SecureBlue · Ear Wax Removal · Billing Options for Medicare Part D Vaccines · Injection and Infusion Services Restrictions · Dispensing Fees · Unusual Travel
2009 Provider Policy and Procedure Manual	Chapter 11– Coding Policies and Guidelines, Pharmacy Services	Added new topic- Pharmacies Submitting Claims for DME
2009 Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Public Programs	Added the following topics: · Hearing Aid fee schedule Update · GenRx Formulary · Hib Shortage Billing · PCA Billing · Chiropractic Authorization · Services to Restricted Recipients
2009 Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Radiology Services	Updated High Technology Diagnostic imaging Procedures topic
2009 Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Rehabilitative Services	Added the following topics: · TMJ Orthotic Adjustments · Massage and Manual Therapy Exclusion
2009 Provider Policy and Procedure Manual	Chapter 11 – Coding Policies and Guidelines, Surgical Services	Added the following topics: · Acne Treatment/Skin Rejuvenation and Rosacea Treatment · Anesthetic Agent Injections · Liposuction Edit Change Additional changes made throughout
2009 Blue Plus Manual	Chapter 3 – Government Programs	Multiple changes throughout

FYI

Clinical practice guidelines

Blue Cross promotes the implementation of clinical practice guidelines and has adopted a number of guidelines from different expert sources including Institute for Clinical Systems Improvement (ICSI). Information about the guidelines adopted by Blue Cross is being made available in our online provider manuals with links to specific guidelines by the end of June 2009.

For more information about the guidelines, please refer to our provider letter which is being mailed to your office by the end of June 2009.

Provider section of Blue Cross website enhanced

Blue Cross has made changes to the **providers.bluecrossmn.com** website to make it more user-friendly. For new providers, the "join our network" section was revised to add more information about the contracting and credentialing process. For providers already in our network, a "make updates" section was created with answers to the most commonly asked questions, as well as direct links to any necessary forms.

Identity theft is on the rise

Blue Cross and Blue Shield of Minnesota is experiencing an influx of identity theft on claims being submitted for reimbursement. To help curb this trend, please ask for a member's ID card as well as another form of ID at ALL visits.

Red flags to watch for:

- A patient, especially a new patient, does not have a member ID card or an additional form of identification
- The patient says he or she has a different address than what is showing on provider web self-service

What you can do:

- If possible, validate phone numbers
- When using provider web self-service, make sure you don't pull information based on a person's first and last name only. Verify address, telephone number and birth date.
- If a person is a self-pay, verify the member's identity on provider web self-service AND ask for an additional form of ID

If you have suspicions, please call our fraud hotline at (651) 662-8363 or 1-800-382-2000, ext. 28363.

FYI

Requesting fee schedule allowances

Participating providers may request a fee schedule from Blue Cross by:

- E-mail: Fee_Schedule_Allowance_Request@bluecrossmn.com
- Fax: (651) 662-2313 (Attention: Fee Schedule Allowance Request)

All requests must include your clinic name and NPI or provider ID. Fee Schedule Allowance Request is a contact for fee schedule allowances only; please contact provider service for all other questions at (651) 662-5200 or toll free at 1-800-262-0820. Blue Cross is only obligated to respond to two fee schedule requests per year; this includes individual code allowances, rate sheets and complete fee schedules.

Member rights and responsibilities statements

Blue Cross, Blue Plus and BlueAdvantage/MinnesotaCare (Prepaid Medical Assistance Program/MNCare) member rights and responsibilities can be found online at **providers.bluecrossmn.com**. Click on "Our Company," "Values," then "Learn More" under Rights and Responsibilities.

If you would like a copy of the statements mailed to you, contact Pam Dempsey at pamela_m_dempsey@bluecrossmn.com or call (651) 662-7271 or toll free at 1-800-382-2000, ext. 27271. Please specify which statement(s) you would like, along with your name and mailing address.

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-name 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-name 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 R418
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.

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.

Pharmacy Corner

Changes to the formulary and the prior authorization process for growth hormone

On April 1, 2009, the Blue Cross and Blue Shield of Minnesota FlexRX formulary was updated with the following changes:

Products removed:

- Nutropin
- Nutropin AQ
- Genotropin

Product added:

- Omnitrope

Omnitrope is already on the Blue Cross GenRx formulary.

In conjunction with the formulary change, Blue Cross implemented changes in the prior authorization review for growth hormones (somatropins). As previously communicated, as of April 1, 2009, prior authorization requests for growth hormones are evaluated based on medical necessity for growth hormone replacement. Coverage for requests meeting medical necessity criteria may be subject to the member's specific benefits, including a product-specific formulary, specialty drug program or other requirements and will not be based on specified brand products. For questions related to specific contract benefits, please call provider service at (651) 662-5200 or toll free at 1-800-262-0820. Our medical necessity criteria can be viewed by clicking on the following link:

GROWTH HORMONE TREATMENT

Members currently taking growth hormone will receive notification of the formulary changes and the impact of these changes on their out-of-pocket costs, should they decide to continue use of a non-formulary product. After June 30, 2009, members with an open benefit may continue to receive a non-formulary agent but possibly at a higher out-of-pocket cost. For members with a closed benefit, non-formulary agents will be non-covered after June 30, 2009, without an approved formulary exception.

Claims Tips

Verifying patient eligibility

The Minnesota Administrative Uniformity Committee (AUC) has published a best practice related to checking eligibility and benefits for patients. The best practice covers 4 major areas:

- When and how to verify
- Preferred methods of eligibility inquiry
- Sharing eligibility information
- Data elements that should be used to update information systems

The AUC recommends that eligibility be checked for each patient once per calendar month since most eligibility changes occur at the beginning of a month.

Please refer to the best practice at the following link for other helpful tips: **www.health.state.mn.us/auc/bstprac01.pdf**

Claims submission

Minnesota Statute 62J.536 requires health care providers and group purchasers (payers, health plans) to exchange claims electronically using a standard format beginning July 15, 2009. Blue Cross, along with several other Minnesota health plans, have contracted with Infotech Global, Inc. (IGI) to offer providers a web-based tool at no cost to meet the July 15 electronic claims submission deadline. For more details on this, go to providers.bluecrossmn.com and enter "qp7-09" in the search window on the top right corner.

Coding Corner

Coding edit decisions

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

Codes and Edits	Decision/Actions
36591 denied incidental to several procedures including 77371, 96416, 85055, and E/Ms	No change, edits will be upheld
96523 denied incidental to several procedures including 12001, 77300, 85025, and E/Ms	No change, edits will be upheld

Documentation reminder

Just a reminder that documentation not only needs to support the CPT/HCPCS code(s) submitted, but also the ICD-9-CM codes.

Modifier -99

Modifier -99 indicates that multiple modifiers may apply to a particular service. Because Blue Cross can accept up to four modifiers, -99 should only be used if there are five or more modifiers applicable to a particular service line. In that circumstance, if -99 is submitted, the additional modifiers must be entered on the narrative record.

July HCPCS update

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

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: **providers.bluecrossmn.com**. Information on policies is updated following the Medical and Behavioral Health Policy Committee meeting.

The "What's New" section identifies new or revised policies that are in effect and are posted on our website. The "Upcoming Policies" section lists policies that have been reviewed by the Medical and Behavioral Health Policy Committee and will be effective 90 days from the date these policies are posted **providers.bluecrossmn.com**.

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: 06/29/09 Notification Posted: 03/31/09

Policies Developed

Biventricular Pacemakers for Congestive Heart Failure

- The use of biventricular pacemakers with or without an accompanying implantable cardiac defibrillator (i.e., a combined biventricular pacemaker/ICD) is considered accepted medical practice as a treatment of congestive heart failure in patients who meet all of the following criteria:
  - NYHA Class III or IV;
  - Left ventricular ejection fraction =35%;
  - QRS duration of =120–130* msec;
  - Patients treated with a stable pharmacological medical regimen prior to implant, such as an ACE inhibitor (or an angiotensin receptor blocker) and a beta blocker (or angiotensin receptor blocker), digoxin, and/or diuretics

  * The FDA-labeled indication for the InSync device is limited to patients with a QRS duration of >130 msec, while the FDA-labeled indication for the CONTAK CD CRT-D System is limited to patients with a QRS >120 msec.
- An intrathoracic fluid monitoring sensor is considered investigative and not medically necessary as a component of a biventricular pacemaker.
- 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.

Anti-CCP Testing for Rheumatoid Arthritis

- Accepted medical practice when used as part of the diagnostic workup for rheumatoid arthritis.
- Investigative and not medically necessary when used to monitor disease activity and/or treatment response.
- 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.

Intravitreal Implant: Fluocinolone Acetonide (Retisert)

- Accepted medical practice to treat chronic (duration of one year or more) non-infectious uveitis affecting the posterior segment of the eye.
- Investigative and not medically necessary for other uses including, but not limited to, the treatment of diabetic macular edema.

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- Prior authorization: Yes.

Intravitreal Implant: Ganciclovir (Vitrasert)

- Accepted medical practice for treatment of cytomegalovirus (CMV) retinitis in patients with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS):
  - who have sight-threatening lesions (lesions <1500 microns from the fovea or adjacent to the optic nerve head); OR
  - who have relapse of CMV retinitis while on systemic therapy; or who are at risk of non-compliance with oral valganciclovir regimens.
- In patients who have sustained CD4 counts >100 cells for six months or longer after initiation of antiretroviral therapy discontinuation of ganciclovir implant should be considered.
- Ganciclovir intravitreal implant is considered investigative and not medically necessary for all other uses.
- Prior authorization: Yes.

Policies Revised

Immune Globulin Therapy

- Investigative and not medically necessary for treatment of relapsing-remitting multiple sclerosis.
- Investigative and not medically necessary for the following new indications:
  - Asthma
  - POEMS syndrome (Polyneuropathy, Organeomegaly, Endocrinopathy, Monoclonal Gammopathy, and Skin Changes)
  - Autism Spectrum Disorder
  - PANDAS (Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal Infections)
- Remainder of the policy is unchanged.
- Prior authorization: Yes.
  Renewal of prior authorization should include documentation supporting sustained treatment-related response, such as substantial improvement in disease condition or a reduction in disease progression.

Cytochrome P450 Genotyping

- Investigative and not medically necessary for the purpose of aiding in the choice of drug or dose to increase efficacy and/or avoid toxicity.
- The following specific investigative indications have been added to the policy:
  - Selection or dose of selective serotonin reuptake inhibitor (SSRI);
  - Selection or dose of antipsychotics;
  - Deciding whether to prescribe codeine for nursing mothers;
  - Determining risk of atherothrombotic events in patients treated with clopidogrel after an acute coronary syndrome or a percutaneous coronary intervention;
  - Determining dose of atomoxetine HCl (approved for treatment of attention-deficit/hyperactivity disorder);
  - Determining dose of efavirenz (common component of highly active antiretroviral therapy for HIV infection);
  - Determining dose of immunosuppressant for organ transplantation.
- 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.

Medical and Behavioral Health Policy Update

Radiofrequency Ablation of Solid Tumors, Excluding Liver Tumors

- Criteria for coverage of renal cell tumors have been revised to state:
  - Treatment of localized renal cell carcinoma is considered accepted medical practice when tumor size is = 4 cm and either of the following criteria are met:
    - Preservation of kidney function is necessary (i.e., the patient has one kidney or renal insufficiency, defined as a glomerular filtration rate [GFR] of < 60 mL/min/m2) and standard surgical approaches would compromise kidney function; OR
    - Patient is not considered a surgical candidate due to co-morbid disease.
- Remainder of the policy is unchanged.
- Prior authorization: Yes, *only* for renal tumors. 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.

Cryosurgery for Solid Tumors

- Criteria for coverage of renal cell tumors have been added:
  - Treatment of localized renal cell carcinoma is considered accepted medical practice when tumor size is = 4 cm and either of the following criteria are met:
    - Preservation of kidney function is necessary (i.e., the patient has one kidney or renal insufficiency, defined as a glomerular filtration rate [GFR] of < 60 mL/min/m2) and standard surgical approaches would compromise kidney function; OR
    - Patient is not considered a surgical candidate due to co-morbid disease.
- Investigative and not medically necessary for the following new indications:
  - Renal cell carcinoma in patients who are surgical candidates;
  - Pancreatic cancer.
- Remainder of the policy is unchanged.
- Prior authorization: Yes, *only* for renal tumors. 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.

Dermatoscopy

- Considered incidental to the services provided during a dermatology evaluation and management service.
- Prior authorization: Not applicable.

Tobacco Cessation Treatments

- Addition of varenicline as a medically necessary treatment for tobacco dependence.
- No additional changes to coverage.
- 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.
- Coverage is subject to the member's contract benefits.
- Coverage of medications referred to in this policy, including nicotine replacement therapies, is subject to a product-specific formulary, specialty drug program or other requirements.

Allergy Testing and Treatment

- Addition of the following statements to the policy:

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  - Routine testing for allergies is considered investigative and not medically necessary for all behavioral health disorders in patients who have no symptoms of allergies. This includes, but is not limited to, the following:
    - Autistic spectrum disorders
    - Obsessive-compulsive disorders.
  - Treatment for allergies is considered investigative and not medically necessary for all behavioral health disorders in patients who have not been diagnosed with allergies by a physician. This includes, but is not limited to, the following:
    - Autistic spectrum disorders
    - Obsessive-compulsive disorders.
- Remainder of the policy is unchanged.
- Prior authorization: No. However, services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial may result if criteria are not met.

Policies Inactivated*

None.

Medical and Behavioral Health Policy Activity

Policies Effective: 07/20/09 Notification Posted: 04/21/09

Policies Developed

Cinryze (C1 Inhibitor)

- May be considered medically necessary under the following circumstances for patients with a diagnosis of hereditary angioedema (HAE):
  - 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.
  - Routine 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).

  *Diagnosis of HAE must meet the following criteria:

    1. Patient has at least one of the following clinical manifestations:
       - Recurrent self-limiting, non-inflammatory subcutaneous angioedema without urticaria lasting more than 12 hours; OR
       - Recurrent, self-remitting abdominal pain without clear organic etiology lasting more than six hours; OR
       - Recurrent laryngeal edema.

       AND

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2. Laboratory values on two separate occasions demonstrating one of the following:
   - Low C1 Inhibitor level and low C1 inhibitor function (HAE Type I); OR
   - Normal C1 Inhibitor level and low C1 inhibitor function (HAE Type II).

- Cinryze (C1 Inhibitor) is considered investigative and not medically necessaryfor 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.
- Prior authorization: Yes

Axial (Percutaneous) Interbody Lumbar Fusion

- Investigative and not medically necessary.
- 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.

Transanal Radiofrequency Treatment for Fecal Incontinence

- Investigative and not medically necessary.
- 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.

Surgical Interruption of Pelvic Nerve Pathways for Primary and Secondary Dysmenorrhea

- Investigative and not medically necessary.
- 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.

Laser-Assisted Tonsillectomy

- Investigative and not medically necessary when performed in either a single sitting or by serial surgery.
- A subtotal or partial tonsillectomy (cryptolysis) is also considered investigative and not medically necessary.
- 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.

Low-Density Lipid (LDL) Apheresis

- May be considered medically necessary in patients with homozygous familial hypercholesterolemia as an alternative to plasmapheresis.
- May be considered medically necessary in patients with heterozygous familial hypercholesterolemia who have failed a 6-month trial of diet therapy and maximum tolerated combination drug therapy* AND who meet the following FDA-approved indications: (All LDL levels represent the best achievable LDL level after a program of diet and drug therapy.)
  – Functional hypercholesterolemic heterozygotes with LDL =300 mg/dL
  – Functional hypercholesterolemic heterozygotes with LDL =200 mg/dL AND documented coronary artery disease.
  *Maximum tolerated drug therapy is defined as a trial of drugs from at least 2 separate classes of hypolipidemic agents such as bile acid sequestrants, HMG-CoA reductase inhibitors, fibric acid derivatives, or Niacin/Nicotinic acids.
- LDL apheresis is considered investigative and not medically necessary for all other uses, including use in preeclampsia.
- Prior authorization: No. However, services with specific coverage criteria may be reviewed retrospectively to determine if criteria are being met. Retrospective denial may result if criteria are not met.

Medical and Behavioral Health Policy Update

Radiofrequency Facet Joint Denervation

- May be considered medically necessary when all the following criteria are met:
  - No prior spinal fusion surgery in the vertebral level being treated;
  - Non-radicular low back (lumbosacral) or neck (cervical) pain, suggestive of facet joint origin as evidenced by absence of nerve root compression as documented in the medical record on history, physical and radiographic evaluations;
  - Pain has failed to respond to three (3) months of conservative management which may consist of therapies such as nonsteroidal anti-inflammatory medications, acetaminophen, manipulation, physical therapy and a home exercise program;
  - A trial of controlled diagnostic medial branch blocks (3 positive separate blocks or placebo controlled series of blocks) under fluoroscopic guidance has resulted in at least a 50% reduction in pain;
  - If there has been a prior radiofrequency (RF) treatment, a minimum time of six (6) months has elapsed since prior RF treatment (per side, per anatomical level of the spine).
- Investigative and not medically necessary for the treatment of chronic spinal/back pain for all uses that do not meet the criteria listed above, including but not limited to treatment of thoracic facet or sacroiliac (SI) joint pain.
- *Pulsed* radiofrequency denervation is considered investigative and not medically necessary for the treatment of chronic spinal/back pain due to a lack of evidence supporting its impact on improved health outcomes.
- Prior authorization: Yes.

Policies Revised

Percutaneous Techniques for Disc Decompression

- The following techniques have been combined in one policy and are considered investigative and not medically necessary:
  - Percutaneous discectomy
  - Laser disectomy (e.g., LASE)
  - Nucleoplasty(i.e., DISC nucleoplasty)
- 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.

Hospital Beds

Ordinary beds which are typically sold as furniture, specialty beds (i.e., Tempur-pedic), and adjustable beds (e.g.., Craftmatic, Sleep Number beds) are considered ineligible for coverage because they do not meet the definition of Durable Medical Equipment as defined in Medical Policy VII-07.

The following hospital beds are considered medically necessary if the appropriate indications are met:

- Patient requires positioning of the body in a way not feasible with an ordinary bed due to a medical condition. Elevation of the head/upper body less than 30 degrees does not usually require the use of a hospital bed. Pillows and wedges are usually sufficient in this circumstance.
- Patient requires positioning of the body in a way not feasible with an ordinary bed in order to alleviate pain.
- Patient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration.
- Patient requires traction equipment which can only be attached to a hospital bed.

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The need for a particular bed height would rarely, by itself, justify the need for a hospital bed. However, a variable height bed is covered if, in addition to meeting one or more of the above indications, the patient requires the variable height feature to complete transfers from bed to chair, wheelchair, or to a standing position. If documentation supports medical necessity of a lower level bed but the patient does not meet any of the above criteria, coverage will be based on the allowance for the least costly bed.

- Heavy-Duty, Extra-Wide Hospital Beds (E0301, E0303)
  - Patient meets the criteria for a hospital bed; and
  - Patient's weight is more than 350 pounds, but does not exceed 600 pounds.
- Extra Heavy-Duty Hospital Beds (E0302, E0304)
  - Patient meets the criteria for a hospital bed; and
  - Patient's weight exceeds 600 pounds.
- Enclosed Beds (E0300, E0316, E0328, E0329)
  - Patient has been diagnosed with one of the following conditions: traumatic brain injury, moderate to severe cerebral palsy, seizure disorder, severe behavioral disorder, or cognitive and communication impairment; and
  - Clinical documentation states that less invasive strategies (i.e., bed rails, bed rail protectors, or environmental modifications) have been tried and have not been successful
- Prior authorization: Yes, ONLY for heavy-duty beds and enclosed beds.

Pressure-Reducing Support Surfaces

- **Group 1 Pressure Reducing Support Surfaces (A4640, E0181,E0182, E0184, E0185, E0186, E0187, E0196, E0197, E0198 and E0199**

  A group 1 mattress overlay or mattress is considered medically necessary when one of the following criteria are met:
  - Patient is completely immobile; or
  - Patient cannot independently make changes in body position significant enough to alleviate pressure and has one of the following conditions:
    1. Current pressure ulcer on the trunk or pelvis;
    2. History of pressure ulcers on the trunk or pelvis;
    3. Impaired nutritional status;
    4. Fecal or urinary incontinence;
    5. Altered sensory perception;
    6. Compromised circulatory status.

- **Group 2 Pressure Reducing Support Surfaces (E0193, E0277, E0371, E0372 and E0373)**

  A group 2 pressure reducing support surface (i.e., alternating pressure and low air loss mattress and overlay) is considered medically necessary when any one of the following criteria are met:
  - Multiple stage II pressure ulcers located on the trunk or pelvis; patient has been on a comprehensive ulcer treatment for at least one month and has used lower level support surface and ulcers have worsened;
  - Large stage III (full thickness tissue loss) or IV (deep tissue destruction) pressure ulcer(s) on the trunk or pelvis and patient cannot be positioned off the ulcer areas;
  - Recent myocutaneous flap or skin graft for a pressure ulcer on the trunk or pelvis (surgery within the past 60 days) and patient has been on a pressure reducing support surface immediately prior to discharge from a hospital or long-

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term care facility;
- The patient has been on a Group 2 or Group 3 support surface immediately prior to a recent discharge from a hospital or long-term care facility (discharge within the past 30 days).
- After 6 months on a Group 2 support surface with no improvement in the patient's condition, alternative treatments must be considered before additional monthly authorization.

  *The comprehensive ulcer treatment program described above should generally include:
  1. Education of the individual and caregiver on the prevention and/or management of pressure ulcers
  2. Regular assessment by a nurse, physician or other licensed healthcare practitioner (usually at least weekly for an individual with a stage III or IV ulcer)
  3. Appropriate turning and positioning
  4. Appropriate wound care (for a stage II, III or IV ulcer)
  5. Appropriate management of moisture/incontinence
  6. Nutritional assessment and intervention consistent with the overall plan of care
- Continued use of a group 2 support surface is considered medically necessary until the ulcer is healed or, if healing does not continue, there is documentation in the medical record to show that:
  1. other aspects of the care plan are being modified to promote healing, or
  2. the use of the group 2 support surface is medically necessary for wound management
- When a group 2 pressure reducing support surface is prescribed following a myocutaneous flap or skin graft, continued use is considered medically necessary for up to 60 days from the date of surgery.

• Group 2 pressure reducing support surfaces are considered not medically necessary for the following indication:
- Patients without current pressure ulcers.

• **Group 3 Pressure Reducing Support Surfaces (E0194)**

A group 3 pressure reducing support surface (i.e., air-fluidized bed) is considered medically necessary when *all* of the following criteria are met:
- The patient has a stage III (full thickness tissue loss) or stage IV (deep tissue destruction) pressure ulcer on the trunk or pelvis; AND
- The patient is bedridden or chair-bound as a result of severely limited mobility; AND
- The air-fluidized bed is ordered by the patient's attending physician based upon a comprehensive assessment and evaluation of the patient after conservative treatment** has been tried without success; AND

  ** The course of conservative treatment must have been at least one month in duration without progression toward wound healing. Conservative treatment must include:
  1. Frequent repositioning of patient with particular attention to relief of pressure over bony prominences (usually every 2 hours); AND
  2. Use of a Group 2 support surface to reduce pressure and sheer forces on healing ulcers and to prevent new ulcer formation; AND
  3. Necessary treatment to resolve any wound infection; AND
  4. Optimization of nutrition status to promote wound healing; AND
  5. Debridement by any means, including wet-to dry gauze dressings; AND
  6. Maintenance of a clean, moist bed of granulation tissue with appropriate moist dressings protected by an occlusive covering, while the wound heals.

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  - A trained adult caregiver is available to assist patient with activities of daily living (ADLs), fluid balance, dry skin care, repositioning, recognition and management of altered mental status, dietary needs, prescribed treatments, and management and support of the air fluidized bed system and its problems such as leakage; AND
  - A physician directs the home treatment regimen, and reevaluates and recertifies the need for the air-fluidized bed on a monthly basis;
  - All other alternative equipment has been considered and ruled out.
- The continued medical necessity of an air-fluidized bed must be renewed by the treating physician every month. Continued use of an air-fluidized bed is covered until the ulcer is healed or, if healing does not continue, there is documentation to show that:
  - Other aspects of the care plan are being modified to promote healing; or
  - Use of the bed is medically necessary for wound management.
- An air-fluidized bed is considered not medically necessary under any of the following circumstances:
  - The patient has co-existing pulmonary disease;
  - The patient requires treatment with wet soaks or moist wound dressings not protected with an impervious covering unless the patient is undergoing aggressive treatment in a wound clinic and is showing measurable improvement;
  - Patients without current pressure ulcers.
- Prior authorization: Yes, ONLY as follows:
  - Group 2 items, every 3 months.
  - Group 3 items, monthly.
- Rental vs. purchase information:
  - Group 1 items are eligible for rental or purchase.
  - Group 2 items are eligible for rental only and are considered purchased after 10 months of medically necessary rental.
  - Group 3 items are eligible for medically necessary rental only.
- In the absence of a medical policy addressing a specific DME item, the medical criteria of the regional DME Medicare Administrative Contractor (MAC) will be used in determining the medical necessity of the item. Those policies are available by accessing the List of LCDs on the CMS Coverage Database.

Policies Inactivated*

- **Percutaneous Discectomy** (combined into new policy, "Percutaneous Techniques for Disc Decompression")
- **Nucleoplasty** (combined into new policy, "Percutaneous Techniques for Disc Decompression")
- **LASE** (combined into new policy, "Percutaneous Techniques for Disc Decompression")
- **Beds as Durable Medical Equipment** (separated into two new policies, "Pressure Reducing Support Surfaces" and "Hospital Beds")

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Policies Effective: 08/17/09 Notification Posted: 05/08/09

Policies Developed

Pervasive Developmental Disorders/Autism Spectrum Disorders: Assessment

- Diagnostic assessment of ASDs may be considered medically necessary when the assessment is multidisciplinary in nature and includes the following:
  - A complete medical evaluation by a licensed physician,
  - ASD-specific diagnostic tools that incorporate measures of all of the following: intellectual functioning, language development, adaptive skills, and behavioral problems, *and*
  - A psychologist for IQ and other testing, *and*
  - A speech pathologist for a language/ communication assessment, *and*
  - An audiologist with experience in testing very young children with comprehensive hearing tests
- In addition, the developmental diagnostic and medical evaluation includes ALL of the following:
- The child's developmental history, focusing on developmental milestones and delays, *and*
  - Family history; examples of important information include whether there are other family members with an ASD, mental retardation, fragile X syndrome, or tuberous sclerosis, *and* Child's medical history such as signs of deterioration, seizure activity, brain injury, head circumference, *and*
  - Conduct or secure the results of a physical exam within the past 12 months, *and*
  - Lead screening for those children with mental retardation, *and*
  - Review of educational (school) system records, *and*
  - Other evaluations and testing as indicated (e.g., neuropsychological, occupational therapy, physical therapy, family functioning, genetic, imaging, laboratory, electrophysiologic)
- **Identification of Developmental Concern**
  The detection of ASDs is an integral component of well-child care. Providers are expected to comply with existing mandates.
- **Diagnostic Assessment**
  To ensure appropriate multidisciplinary care and use of benefits, there will be a comprehensive diagnostic assessment completed within the past 12 months on file for each individual before Health Services for Autism Spectrum Disorders are provided. This diagnostic assessment will be provided by a licensed Mental Health Care Professional.

  The diagnostic assessment must include current diagnoses on all five axes, and must be used in the development of an individual treatment plan (ITP). The diagnostic assessment must indicate that the individual has the intellectual and functional capacity to benefit from the type and intensity of services proposed in the ITP.

  There are three aspects in the diagnostic assessment of a child suspected of having ASD; categorical diagnosis, dimensional assessment, and individual patient evaluation:
  - Categorical Diagnosis
    To assist with diagnosis, the clinician makes use of informant based measures, structured diagnostic interviews, observational measures and symptom checklists
  - Dimensional Assessment

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Dimensional assessments focus on specific areas of functioning such as IQ, language testing, adaptive functioning, social interactions, and behavioral problems. These evaluations may include performance-based measures, semi-structured interviews or informant-based measures.

– Individual Patient Evaluation
A complete diagnostic evaluation must include an assessment of the parent or guardian's chief complaint. The chief complaint should be characterized simply and clearly with an estimation of the frequency, intensity, and impact of the behavior

- Prior authorization: No. Coverage is subject to the member's contract benefits.

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

- Although there is currently insufficient data available to allow for a conclusive determination as to the effectiveness of Early Intensive Behavioral Intervention (EIBI), this treatment may be considered on a provisional basis when all of the following components are included in this process:
  – Individualized treatment plan,
  – Treatment,
  – Evaluation of progress,
  – Behavioral therapist,
  – Supervision, and
  – Re-evaluation
- In addition, the components of a Diagnostic Assessment as described in the Pervasive Developmental Disorders/Autism Spectrum Disorders: Assessment, Medical Policy # X-43, must be completed.
- **Individualized Treatment Plan (ITP)**
  The ITP must be based on a diagnostic assessment completed within the preceding 12 months. The individualized treatment plan must identify objective and measurable goals for the individual, as well as family, when the family is the focus of any intervention services. The ITP and medical record must be reviewed every 90 days by the clinical supervisor to monitor and document progress of the individual. The review of the ITP by the clinical supervisor must be documented in the medical record.
  The ITP must contain the following information:
  – Detailed description of parent education and support services, and
  – Coordination of care by a licensed/eligible provider/program, and
  – A multidisciplinary treatment plan developed in cooperation with the family and based on the results of the multidisciplinary assessment, and
  – Interventions specific to the child's identified and quantified disabling symptoms and provided by trained, licensed/eligible professionals/programs with expertise in treating the targeted deficits, and
  – Goals and measures of progress for each intervention specified with adjustments in approach that match persistent symptoms, and
  – Coordination of specific therapies with school (educational system) programs
- **Treatment**
  – Behavior modification, family therapy, or other forms of psychotherapy, that are clinically appropriate in terms of type, frequency, extent, site, and duration, for management of behavioral symptoms related to ASD may be considered medically necessary when required for the medical management of behaviors.

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  - Psycho-pharmacotherapy may be considered medically necessary for management of target symptoms or co-morbidities related to ASD.
  - Speech and language interventions may be considered medically necessary to improve verbal and nonverbal communication skills in individuals with ASD.
  - Physical and occupational therapy may be considered medically necessary, for the treatment of co-morbid physical impairments, in individuals with ASD.
  - Medical therapy may be considered medically necessary as indicated, for the treatment of co-morbid medical conditions, in individuals with ASD.
  - EIBI is a term used to describe an intensive, multidisciplinary approach used to treat the symptoms of a diagnosis of ASD. This area lacks standard terminology, but does include Intensive Early Interventional Therapy (IEIBT), Applied Behavioral Analysis (ABA), Lovaas and Discrete Trial Training (DTT). The available data suggests that these intensive therapies may be most beneficial when administered early in a child's development and delivered within a supervised, well-structured, and multidisciplinary team model.
- **Behavior Therapist**
  At a minimum, the lead behavior therapist will meet the Minnesota Department of Human Services qualifications for "Mental Health Practitioner" or will hold an industry recognized certification such as that of a Board Certified Behavior Analyst or a Board Certified Associate Behavior Analyst. Provider agrees to maintain proof of current qualifications/certification and will maintain a record of autism treatment related continuing education activities completed in accordance with the practitioner's certification or status as a Mental Health Practitioner.
- **Supervision**
  Clinical supervision for unlicensed staff must be provided by a Mental Health Care Professional licensed to practice independently, credentialed and approved by The Plan. Such supervision will include approval of the individual treatment plan and bimonthly (once every two months) case review of every individual receiving clinical health services. Supervision by the licensed Health Care Professional shall include at least one hour of on-site observation during the first 12 hours of services provided to an individual. Additionally, the licensed Health Care Professional shall provide at least bi-monthly (once every two months) on-site supervision to all individuals, with ongoing on-site observation by a Clinical Supervisor or Lead Therapist for at least one total hour every forty hours of service to the individual.
- **Evaluation of Progress**
  The Plan and the Provider will work collaboratively to monitor and periodically evaluate individual progress. Provider shall have a method for objectively tracking individual progress toward completion of treatment goals identified in the ITP and for identifying areas of maximal progress. Provider shall submit a summary document to The Plan outlining individual progress towards specific treatment goals as delineated in the ITP at least every 180 days.
- **Re-Evaluation**
  If it is determined the individual has reached maximal progress toward a specific treatment goal, the individual may be re-evaluated once every 180 days following the same Diagnostic Assessment criteria to determine whether the individual's developmental status has progressed to a point that treatment goals could be implemented and achieved.
- Prior authorization: Yes, *ONLY* for Early Intensive Behavioral Intervention (EIBI). Coverage is subject to the member's contract benefits.

Policies Revised

None.

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Policies Inactivated

- **Pervasive Development Disorders: Identification, Evaluation, and Treatment** (policy replaced with new policy: Pervasive Developmental Disorders/Autism Spectrum Disorders: Assessment)

MEDICAL AND BEHAVIORAL HEALTH POLICY ACTIVITY

Policies: Effective 08/20/2009 Notification Posted 05/20/2009

Policies Developed

Grenz Ray Therapy for Skin Conditions

- Investigative and not medically necessary.
- 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.

Constraint-Induced Therapy for Motor Disorders in Children

- Investigative and not medically necessary.
- 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.

Suit Therapy for Motor Disorders

- Investigative and not medically necessary.
- 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.

Genetic-Based Tests for Screening, Detection, and Management of Prostate Cancer

- Investigative and not medically necessary.
- 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.

Cardiovascular Disease Risk Assessment and Management: Laboratory Evaluation of Lipid Subclasses

- Investigative and not medically necessary.
- 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.

Homocysteine Testing in Risk Assessment and Management of Cardiovascular Disease

- Investigative and not medically necessary.
- 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.

In Vitro Chemoresistance and Chemosensitivity Assays

- Investigative and not medically necessary.
- 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.

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Bone Growth Stimulators

Electrical Bone Growth Stimulators

- Noninvasive electrical bone growth stimulators may be considered medically necessary as a treatment of fracture nonunions or congenital pseudoarthroses in the appendicular skeleton (the appendicular skeleton includes bones of the shoulder girdle, upper extremities, pelvis, and lower extremities). The diagnosis of fracture nonunion must meet ALL the following criteria:
  - At least three (3) months have passed since the date of fracture; AND
  - Serial radiographs have confirmed that no progressive signs of healing have occurred; AND
  - The fracture gap is one (1) cm or less; AND
  - The patient can be adequately immobilized and is of an age likely to comply with non-weight bearing.
- Noninvasive electrical bone growth stimulators may be considered medically necessary as a treatment of patients with failed spinal fusion. Failed spinal fusion is defined as a spinal fusion that has not healed at a minimum of 6 months after the original surgery, as evidenced by serial x-rays over a course of 3 months.
- Invasive or noninvasive electrical bone growth stimulators may be considered medically necessary as an adjunct to spinal fusion surgery in patients at high risk for fusion failure, defined as any one of the following criteria:
  - One or more previous failed spinal fusion(s);
  - Grade III or worse spondylolisthesis;
  - Fusion to be performed at more than one level;
  - Current smoking habit;
  - Diabetes;
  - Renal disease;
  - Alcoholism.
- All other applications of electrical bone growth stimulators are considered investigative and not medically necessary including, but not limited to:
  - Noninvasive or invasive electrical bone growth stimulators for treatment of a fresh fracture (less than 7 days old);
  - Noninvasive or invasive electrical bone growth stimulators for delayed union fracture, with delayed union defined as a decelerating fracture healing process, as identified by serial x-rays;
  - Invasive bone growth stimulators for any indication other than as an adjunct to spinal fusion.

Ultrasound Bone Growth Stimulators

- Low-intensity ultrasound bone growth stimulators may be considered medically necessary when used as an adjunct to conventional management (i.e., closed reduction and case immobilization) for the treatment of fresh, closed fractures in skeletally mature individuals.
- Low-intensity ultrasound bone growth stimulators may be considered medically necessary as a treatment of fracture nonunions of bones, excluding the skull and vertebra, when the all of the following criteria are met:
  - At least three (3) months have passed since the date of fracture; AND
  - Serial radiographs have confirmed that no progressive signs of healing have occurred; AND
  - The fracture gap is one (1) cm or less; AND
  - The patient can be adequately immobilized and is of an age likely to comply with non-weight bearing.
- All other applications of low-intensity ultrasound bone growth stimulators are considered investigative and not medically necessary including, but not limited to:

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  - Treatment of delayed union fracture, with delayed union defined as a decelerating fracture healing process, as identified by serial x-rays;
  - Congenital pseudoarthroses;
  - Open fractures.
- Prior authorization: Yes.

Policies Revised

Real-Time Continuous Glucose Monitoring

- Use of an insulin pump for three (3) months or longer
- The remainder of the policy is unchanged.
- Prior authorization: Yes.

Functional Neuromuscular Electrical Stimulation Devices

- Use of lower extremity functional neuromuscular stimulation devices in the home setting is considered investigative and not medically necessary for the following indications:
  - To provide ambulation in patients with spinal cord injury; and
  - As an aid for ambulation in post-stroke patients.
- Remainder of the policy is unchanged.

Positional MRI

- Investigative and not medically necessary for all indications, *including but not limited to, its use in the evaluation of patients with cervical, thoracic, or lumbosacral pain*.
- 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.

Bariatric Surgery (formerly Surgery for Morbid Obesity)

- The following additional procedure may be considered medically necessary in the treatment of obesity when patient selection criteria have been met:
  - Open or laparoscopic biliopancreatic bypass with duodenal switch in patients with a BMI ffl 50.
- The following additional procedures are considered investigative and not medically necessary:
  - Long-limb gastric bypass procedure ((i.e., > 150 cm);
  - Endoscopic procedures (e.g., insertion of the Stomaphyx device, sclerosing endotherapy) to treat weight gain after bariatric surgery or to remedy large gastric stoma or large gastric pouches;
  - Bariatric surgery (any procedure) solely as a cure for type 2 diabetes mellitus.
- The remainder of the policy is unchanged.
- Prior authorization: Yes.

Policies Inactivated*

- **Live-In Trunk And Hip Orthotics (Theratogs)** (combined into new policy, "Suit Therapy for Motor Disorders)
- **Sonic Accelerated Fracture Healing System (SAFHS)** (combined into new policy, Bone Growth Stimulators)

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

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Policies Reviewed with No Changes in March 2009 through May 2009

- Adoptive Immunotherapy
- Artificial Intervertebral Disc: Cervical Spine
- Artificial Intervertebral Disc: Lumbar Spine
- Buprenorphine for Withdrawal & Treatment of Opioid Dependence
- Chemiluminescent Testing for Oral Cancer
- Cooling Devices Used in the Outpatient Setting
- Compassionate Use
- Correlated Audioelectric Cardiography
- Coverage of Routine Care Related to Cancer Clinical Trials
- Deep Brain Stimulation
- Extracorporeal Shock Wave Treatment for Plantar Fasciitis and Other Conditions
- Eye Movement Desensitization & Reprocessing for PSD
- Genetic Testing for Helicobactor Pylori Treatment
- Hair Analysis
- Hippotherapy
- Home Prothrombin Time Monitoring
- Humanitarian Use Devices
- Intraarticular Hyaluronan Injections for Osteoarthritis
- Intradiscal Electrothermal Annuloplasty (IDET), Percutaneous Radiofrequency Annuloplasty (PIRFT), and Intradiscal Biacuplasty
- Islet Transplantation
- Ketamine For Treatment Of All Mental Health And Substance-Related Disorders
- Lysis of Epidural Adhesions
- Measurement of Exhaled Nitric Oxide and Exhaled Breath Condensate in the Diagnosis and Management of Asthma and Other Respiratory Disorders
- Orthoptics or Vision Therapy
- Palliative Care
- PathfinderTG Molecular Testing
- Phototherapy for Seasonal Affective Disorder
- Psychoanalysis
- Rhinoplasty
- Skin Contact Monochromatic Infrared Energy Therapy
- Sonic Accelerated Fracture Healing System
- Temporary Prostatic Stents
- Thermography
- Wireless Capsule Endoscopy
- Treatment of Tinnitus

Refer to the Blue Cross and Blue Shield of Minnesota website **providers.bluecrossmn.com** to view the BCBSM Medical and Behavioral Health Policies.

BlueCard Review

New process for BlueCard® claims

Currently, when a BlueCard claim with unlisted procedure codes is received and no narrative description has been provided, the entire claim is rejected back to the provider. The provider must then resubmit a new claim, along with the missing narrative description.

Blue Cross has made a process change, effective May 14, 2009, allowing Blue Cross to deny the line(s) with unlisted procedure codes, while transmitting the entire claim to the home plan. No payment will be made for these service lines, but once the narrative is received from the provider, the claim will be adjusted to consider these service lines.

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
ClearConnect	(651) 662-5742 or 1-866-251-6742
Provider Service	(651) 662-5000 or 1-800-262-0820
Please verify these numbers are correctly programmed into your office phones.	

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

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