Provider Press

March 2009 / Vol. 12, No.2

Care Comparison® helps members make informed decisions

Blue Cross is proud to announce that our new facility-based cost and quality transparency tool Care Comparison will be available to members by the end of March. With cost containment top of mind in today's economy, use of this tool will assist members with understanding and managing health care costs and demonstrate our commitment to giving members actionable information.

"Best value" providers identified

Care Comparison provides "packaged" treatment cost estimates (doctor, facility and related services) when available for over 30 common, high-cost elective surgeries and procedures in 17 states and major markets. In addition, members can compare quality-information for over 150 procedures in any state. Because the tool provides accurate cost and quality information in one tool, it gives members a way to shop for the "best value" for their health care as they do for other purchases. The costs are based on Blue Cross claims paid and will be updated every six months.

Access to information

The tool is available to registered Blue Cross and Blue Shield of Minnesota members by signing in to myBlueCross member center at **members.bluecrossmn.com** and selecting "provider cost & quality" in the choosing care area. Care Comparison is also available to BlueLink TPA and Taft-Hartley members at their member service centers.

Please note that Care Comparison replaces the **www.healthcarefacts.org** website that has been available for Minnesota provider comparisons. For more information, contact provider service at **(651) 662-5200** or **1-800-262-0820.**

Really Simple Syndication

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

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

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

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

Provider Press

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

Inside preview

FYI

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 **bluecrossmn.com** and select "for health care providers" then enter "provider demographic change form" in the search window to obtain the form. Completed forms can be faxed to **(651) 662-6684** or mailed to:

Blue Cross and Blue Shield of Minnesota PDO, S116
P.O. Box 64560
St. Paul, MN 55164-0560

Publications available online

The following is a list of Quick Points and Bulletins published from December 2008 to February 2009 that are available online at **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
QP14-08	Minnesota Health Care Programs shortage of Hib vaccine (CPT 90648)
QP15-08	Reproduction Treatment
QP16-08	BlueCard COB Questionnaire
QP17-08	Blue Cross Whole Person Health support replaces traditional disease-focused model
QP1-09	Some lab services incorrectly paid for members with Medicare products
QP2-09	Claims processing for massage and manual therapy services
QP3-09	Changes for personal care assistant services for Minnesota Health Care Programs
QP4-09	New telephone number for behavioral health providers
QP5-09	Minnesota licensed professional counselors and licensed professional clinical counselors
Bulletins	**Title**
P23R1-08	Correction to partial psych billing change
P30-08	Change in RAP claim submission
P31-08	High-technology diagnostic imaging (HTDI) program
P32-08	Billing information for Intensive Service Days
P33-08	2009 Federal Employee Program change for mental health
P1-09	Update to Attachment B: Definition of Outpatient Health Services Categories
P2-09	Blue Cross medical policy for acne treatment/skin rejuvenation and rosacea treatment
P3-09	Eligibility broadcast searches

FYI

Provider Manual Updates

The following is a list of Blue Cross and Blue Shield of Minnesota provider manuals that have been updated from December 2008 to February 2009. As a reminder, provider manuals are available online at **bluecrossmn.com** . To view the manuals, select "for health care providers", "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
2008 Provider Policy and Procedure Manual	Chapter 1 - At Your Service	Added Remote Access Services topic
2008 Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines, Hospital Care	Replaced Revenue Code 0199 with 0230 on page 11-5.
2008 Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines, Pharmacy Services	Added a link to the Pre-Service request Form on page 11-2
2009 Provider Policy and Procedure Manual	Chapter 1 - At Your Service	Changed name of Provider Appeal Form to Provider Claim Adjustment/Status Check/Appeal Form
2009 Provider Policy and Procedure Manual	Chapter 7 - BlueCard	Changed name of Provider Appeal Form to Provider Claim Adjustment/Status Check/Appeal Form
2009 Provider Policy and Procedure Manual	Chapter 10 - Appeals	Changed name of Provider Appeal Form to Provider Claim Adjustment/Status Check/Appeal Form
2009 Blue Plus Manual	Chapter 1 – Introduction to Blue Plus	Changed name of Provider Appeal Form to Provider Claim Adjustment/Status Check/Appeal Form
2009 Provider Policy and Procedure Manual	Chapter 8 - Claims filing	Added to the TOC: 1500 HICF, Site of Service, Freestanding Ambulatory Surgery Center Billing, UB-04 Situations Requiring Electronic Submission, Present on Admission, Mid-Level Practitioners
2009 Provider Policy and Procedure Manual	Chapter 10 - Appeals	Multiple changes throughout
2009 Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines, Coding	Multiple changes to coding numbers
2009 Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines, Modifiers	Multiple changes throughout
2009 Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines, Anesthesia	Multiple changes throughout
2009 Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines, Chiropractic	Complete revision to Manual Therapy section

continued on next page

FYI

Provider Manual Updates
continued

2009 Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines, Durable Medical Equipment	Hearing Aid Section and multiple changes throughout
2009 Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines, Home Health, Home Infusion, Hospice	RAP Claim Submission section added
2009 Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines, Hospital Care	Title revised to include SNF (Hospital/ SNF Care). Intensive Service Days (ISD) revised. Blue Plus form and PMAP communication form added.
2009 Provider Policy and Procedure Manual	Chapter 11 - Coding Policies and Guidelines, Maternity	Reproduction Treatment section added

Clinical Practice Guidelines

Blue Cross promotes the implementation of clinical practice guidelines and routinely notifies practitioners in appropriate specialties of updates.

Institute for Clinical Systems Improvement (ICSI)

Clinical Practice Guidelines

Updated guidelines include:
• Acute Coronary Syndrome

Note: ICSI has set a schedule to retire a number of guidelines not adopted by Blue Cross. If you are interested in finding out which guidelines are being retired and their retire date, visit www.icsi.org.

To obtain a copy of ICSI guidelines, visit **www.icsi.org** or 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.

Patient and Family Guidelines

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

Pharmacy Corner

Changes to the Formulary and the Prior Authorization process for Growth Hormone

Effective April 1, 2009 the Blue Cross and Blue Shield of Minnesota FlexRx formulary will be 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 will implement changes in the prior authorization review for growth hormones (somatropins). Beginning on April 1, 2009 prior authorizations requests for growth hormones will be evaluated based on medical necessity for growth hormone replacement. This medical necessity decision will not be based on specified brand products. Coverage for requests meeting medical necessity criteria will be subject to the member's specific benefits, including a product-specific formulary, specialty drug program or other requirements. For questions related to specific contract benefits, please call provider service at **(651) 662-5200** or **1-800-262-0820**. Our medical necessity criteria can be viewed by clicking on the following link: **Growth Hormone Treatment**

Specialty network changes effective April 1, 2009

Starting April 1, 2009, the Blue Cross specialty pharmacy network will include just two suppliers: Triessent, an affiliate of Prime Therapeutics and Fairview Pharmacy Services (for selected drug categories). All specialty drugs must be dispensed through one or both of these suppliers as specified below:

Triessent: Will supply the complete suite of all specialty pharmacy drugs to Blue Cross members.

Fairview: Will supply specialty drugs to Blue Cross members in three categories:
- Hemophilia
- Infertility
- Growth Hormone

Contact information:
Triessent
Phone: 1-888-216-6710
Fax: 1-866-203-6010

Fairview Pharmacy Services
Phone: 1-800-595-7140
Fax: 1-612-672-5262
www.fairviewspecialtyrx.com

Fairview Pharmacy Services and Prime Therapeutics LLC, which provides Triessent, are independent companies providing pharmacy benefit management services.

Lipitor and Vytorin removed from FlexRx formulary; Crestor added to FlexRx formulary

Beginning April 1, 2009, Lipitor and Vytorin will no longer be on the FlexRx formulary.

The drugs listed below are on one or both of the Blue Cross formulary options:

- Simvastatin and pravastatin are on the FlexRx and GenRx formularies.
- All strengths of Crestor have been added to the broadest Blue Cross formulary, FlexRx. Crestor 40 mg is on the GenRx formulary.

Members currently taking Lipitor or Vytorin will need a new prescription from their doctors in order to make the change to a formulary drug.

Members currently taking these medications were notified by a personal letter about this change.

Please call provider service at **(651) 662-5200** or toll free at **1-800-262-0820** if you have questions.

Coding Corner

S0302 billing

Code S0302, completed early periodic screening diagnosis and treatment service (EPSDT) (list in addition to code for appropriate evaluation and management service), should only be submitted when a completed well child or child and teen checkup is performed for a Public Program member (i.e., PMAP or MNCare). Submission of S0302 enables Blue Cross to capture the claim information for government reporting and reimburse providers a "bump-up" amount for performing the complete C&TC. The code also alerts us that all of the services on the claim are related to a completed C&TC to assure the claim is appropriately adjudicated. Thus it is very important that all services performed on the same date of service be billed on the same claim.

Coding edit decisions

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

Codes and Edits	Decision/Actions
J7300 allowed separately from 58300	No edit will be implemented – J7300 may still allow in addition to 58300
58301 denied incidental to 58555	Edit will be upheld
76831 denying incidental to 76856	Edit removed as part of a normal update 10/6/08 No recovery
90775 does not deny to 96413	No edit will be implemented
99292 did not apply the same edits 99291	Edits for 99292 were added the same as the parent code 99291
99291 denying as preop logic to 27592 99292 denying as preop logic to 27592	Edits removed 12/10/07 Recovery for dates denied 8/1/06-12/10/07
E/M denying same day as procedure logic to 96910	Edit will be upheld regardless of submission of the -25 modifier

Waiver reminder

The GA modifier (WAIVER OF LIABILITY STATEMENT ON FILE) may be submitted when the patient has signed a waiver specifically for a service that may not be covered. If the service is denied, the payment for that service is the patient's liability in most cases. For example, casting material is generally considered part of the casting procedure and is set to deny as provider liability. However, if a patient requested special casting material be used (such as Procel), this item may be considered a convenience item so it may be appropriate to obtain a waiver. A modifier GA should be submitted on the service relating to the waiver, such as, Q4050-GA.

General rules surrounding GA:

1. GA is an acceptable modifier. Providers may submit this modifier if a waiver is signed by the patient and is on file with the provider. The waiver must be for the specific service and date only – blanket waivers are not acceptable.
2. Liability will not be changed under some circumstances: Denial waiting for additional information, duplicate billing, incidental or included in the basic service rendered denials, and denials generated from a coding software decision (such as incidental, mutually exclusive or visit logic). These denials will always remain provider liability regardless if the GA is submitted.
3. If the service denies provider liability, the provider may ask for an adjustment to change to subscriber liability, if appropriate (incidental and coding software denials will remain provider liability).

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 Web site: **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 on bluecrossmn.com.

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 03/17/09 Notification Posted 12/17/08

Policies Developed

Photodynamic Therapy for Oncologic Applications, Including Barrett's Esophagus

- Photodynamic therapy is considered accepted medical practice for the following oncologic applications:
  - Palliative treatment of obstructing esophageal cancer;
  - Palliative treatment of obstructing endobronchial lesions;
  - Treatment of early-stage non-small cell lung cancer in patients who are ineligible for surgery and radiation therapy;
  - Treatment of high-grade dysplasia in Barrett's esophagus.
- All other oncologic applications of photodynamic therapy are considered investigative and not medically necessary, including but not limited to, other malignancies and Barrett's esophagus without associated high-grade dysplasia.
- Prior authorization: Yes.

KRAS Mutation Analysis in Metastatic Colorectal Cancer

- KRAS mutation analysis is considered accepted medical practice to predict nonresponse to monoclonal antibodies cetuximab and panitumumab in the treatment of metastatic colorectal cancer.
- KRAS mutation analysis is considered investigative and not medically necessary for all other indications.
- Prior authorization: Yes.

T-wave Alternans

- T-wave alternans is considered investigative and not medically necessary as a technique of risk stratification for primary or secondary prevention* of fatal

Medical and Behavioral Health Policy Update

arrhythmias and sudden cardiac death in patients with a history of myocardial infarction, congestive heart failure, cardiomyopathy, or other cardiac disorders such as long QT syndrome (e.g., Brugada syndrome).
*Primary prevention refers to patients who have not experienced a life-threatening arrhythmia. Secondary prevention refers to patients who have experienced a life-threatening arrhythmia.

- 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.

Implantable Cardioverter-Defibrillator

- The use of an implantable cardioverter-defibrillator (ICD) is considered accepted medical practice for the treatment of ventricular tachyarrhythmias and for the prevention of sudden cardiac death when one of the following indications is present:
  - History of cardiac arrest due to ventricular fibrillation (VF) or ventricular tachycardia (VT) neither of which is due to reversible or transient causes; or
  - Spontaneous sustained VT, in patients with structural heart disease; investigative and not medically necessary; or
  - Spontaneous sustained VT, in patients without structural heart disease, that is not amenable to other treatments; or
  - Syncope of undetermined origin with clinically relevant, hemodynamically significant, sustained VT or VF induced at electrophysiological study when drug therapy is ineffective, not tolerated, or not preferred; or
  - Familial or inherited conditions with a high risk for life-threatening ventricular tachyarrhythmias such as long QT syndrome or hypertrophic cardiomyopathy; or
  - Previous myocardial infarction and coronary artery disease (CAD), at least 40 days post myocardial infarction and three months post coronary artery revascularization surgery with an ejection fraction equal to or less than 35% after maximal medical therapy; or
  - Ischemic dilated cardiomyopathy (IDCM) with NYHA Class II or III heart failure, documented prior myocardial infarction (MI), at least 40 days post MI, and measured left ventricular ejection fraction (LVEF) less than or equal to 35%; or
  - Non-ischemic dilated cardiomyopathy (NIDCM) of greater than 9 months duration along with, NYHA Class II or III heart failure, and measured LVEF less than or equal to 35%.
- The use of an implantable cardioverter-defibrillator is considered investigative and not medically necessary for any other diagnosis not listed above.
- 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.

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Wearable Cardioverter-Defibrillators As A Bridge To Implantable Cardioverter-Defibrillator Placement

- Use of wearable cardioverter-defibrillators for the prevention of sudden cardiac death is considered accepted medical practice as interim treatment for patients who meet the criteria for an implantable cardioverter-defibrillator (ICD) (see indications in Medical Policy on Implantable Cardioverter-Defibrillators); and who meet either of the following criteria:
  - Patient has a temporary contraindication to receiving an ICD, such as a systemic infection, and has been scheduled for ICD placement once the contraindication is treated; or
  - Patient has had an ICD removed and is scheduled for placement of another ICD.
- Use of wearable cardioverter-defibrillators for the prevention of sudden cardiac death is considered investigative and not medically necessary for all other indications, including use immediately (i.e., less than 40 days) following an acute myocardial infarction.
- Prior authorization: Yes.

Automatic External Defibrillator For Home Use

- Automated external defibrillators for home use are considered investigative and not medically necessary due to the lack of evidence establishing that use in the home setting improves health outcomes and survival beyond that achieved with standard emergency response.
- 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.

Treatment of Twin-Twin Transfusion Syndrome With Amnioreduction and/or Fetoscopic Laser Therapy

- Amnioreduction is considered accepted medical practice as a treatment of twin-twin transfusion syndrome.
- Laser coagulation therapy is considered accepted medical practice as a treatment of twin-twin transfusion syndrome.
- Amnioreduction in combination with laser coagulation therapy is considered accepted medical practice as a treatment of twin-twin transfusion syndrome.
- 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.

Anesthesia Services For Gastrointestinal Endoscopic Procedures

- Intravenous sedation ("conscious sedation") ordered by the attending physician and administered by the surgeon or physician performing the gastrointestinal endoscopic procedure or an independent trained practitioner is considered medically

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necessary.

- Other types of anesthesia services including general and monitored anesthesia care (MAC) may be considered medically necessary during gastrointestinal endoscopic procedures when there is documentation by the operating physician and the anesthesiologist that demonstrates any of the following situations exists:
  - Prolonged or therapeutic endoscopic procedure requiring deep sedation; or
  - A history of or anticipated intolerance to standard sedatives (e.g., patient on chronic narcotics or benzodiazepines, or has a neuropsychiatric disorder); or
  - Increased risk for complications due to severe comorbidity (American Society of Anesthesiologists [ASA] class III physical status or greater); or
  - Patients over 70 years of age; or
  - Patients less than 18 years of age; or
  - Pregnancy; or
  - History of drug or alcohol abuse; or
  - Uncooperative or acutely agitated patients (e.g., delirium, organic brain disease, senile dementia); or
  - Increased risk for airway obstruction due to anatomic variant including any of the following:
    - History of previous problems with anesthesia or sedation; or
    - History of stridor or sleep apnea; or
    - Dysmorphic facial features, such as Pierre-Robin syndrome or trisomy-21; or
    - Presence of oral abnormalities including, but not limited to, a small oral opening (less than 3 cm in an adult), high arched palate, macroglossia , tonsillar hypertrophy, or a non-visible uvula (not visible when tongue is protruded with patient in sitting position, e.g., Mallampati class greater than II); or
    - Neck abnormalities including, but not limited to, short neck, obesity involving the neck and facial structures, limited neck extension, decreased hyoidmental distance (less than 3 cm in an adult), neck mass, cervical spine disease or trauma, tracheal deviation, or advanced rheumatoid arthritis; or
    - Jaw abnormalities including, but not limited to, micrognathia, retrognathia, trismus, or significant malloclusion.
- The routine assistance of an anesthesiologist or certified registered nurse anesthesiologist (CRNA) for average risk adult patients undergoing standard upper and/or lower gastrointestinal endoscopic procedures is considered not medically necessary.
- 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.

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Bone Morphogenetic Protein (BMP)

- Use of recombinant human bone morphogenetic protein-2 (rhBMP-2), including but not limited to, InFUSE bone graft is considered accepted medical practice for the following indications:
  - As an adjunct to anterior lumbar interbody fusion procedure; or
  - As an adjunct to treatment of open fracture of the tibial shaft, which has been stabilized with intramedullary nail fixation after appropriate wound management; or
  - For repair of symptomatic, posterolateral lumbar spine pseudoarthrosis in patients for whom autologous bone and/or bone marrow harvest are not feasible or are not expected to promote fusion.
- Use of recombinant human bone morphogenetic protein-7 (rhBMP-7), including but not limited to, Osteogenic Protein-1™ (OP-1™ Implant) is considered accepted medical practice for the following indications:
  - As an alternative to autograft in recalcitrant long bone nonunions where use of an autograft is unfeasible and alternative treatments have failed; or
  - As an alternative to autograft in compromised patients requiring revision posterolateral (intertransverse) lumbar spinal fusion, for whom autologous bone and bone marrow harvest are not feasible or are not expected to promote fusion.
- Use of recombinant human bone morphogenetic protein-2 (rhBMP-2) or recombinant human bone morphogenetic protein-7 (rhBMP-7) is considered investigative or not medically necessary for all other indications, including but not limited to:
  - As an adjunct to thoracic and cervical fusion procedures;
  - As initial treatment or revision of posterolateral spinal fusion, except as indicated above;
  - As management of early stages of osteonecrosis of the vascular head or femoral shaft;
  - As an adjunct to distraction ostogenesis (Iliazarov procedure)
  - Craniofacial applications including, but not limited to, periodontal defect regeneration, cleft palate repair, cranial defect repair, restoration and maintenance of the alveolar dental ridge.
- Prior authorization: No. However, bone morphogenetic protein (BMP) is not covered when used for conditions other than spinal and long-bone conditions listed above.

Policies Revised

Surgery for Morbid Obesity

- The patient selection criterion specific to participation in a medically-supervised weight loss regimen prior to surgery has been revised to state:
  The patient has participated in at least one medically-supervised attempt to lose weight within the past two years. The medically-supervised weight loss attempt(s) must include six (6) monthly medical visits over six (6) consecutive

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months with all visits under the direction of a medical doctor (MD or DO), physician's assistant (PA), nurse practitioner (NP), clinical nurse specialist (CNS), or a registered dietitian supervised by an MD, DO, PA, NP, or CNS. The patient's participation in a structured weight loss regimen must be documented in the medical record by an attending physician who supervised the patient's progress. A physician's notation, alone, is not sufficient documentation. Documentation should include medical records indicating the patient's adherence to the current nutrition and exercise program and the provider's recommended changes to the nutrition and exercise program throughout the course of the medically-supervised weight loss regimen. Such documentation is necessary to establish the patient's ability to comply with the dietary and lifestyle changes necessary for maintaining weight loss following surgery.

- The remainder of the policy is unchanged.
- Prior authorization: Yes, for all bariatric surgery and revisions/reoperations and for panniculectomy. Submitted documentation should address the patient selection criteria described above.

Policies Inactivated*

None.

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Policies: Effective 03/18/09 Notification Posted 12/15/08

Policies Developed

None.

Policies Revised

CT Colonography (Virtual Colonoscopy) as a Screening Test for Colorectal Cancer

- Change to prior authorization statement. As of 03/18/09, Prior authorization: Yes.
- Remainder of the policy is unchanged.

MRI of the Breast

- Change to prior authorization statement. As of 03/18/09, Prior authorization: Yes.
- Remainder of the policy is unchanged.

Policies Inactivated

None.

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Policies: Effective 04/16/09 Notification Posted 01/16/09

Policies Developed

None.

Policies Revised

Ventricular Assist Devices and Total Artificial Hearts

- Change to prior authorization statement. Prior authorization: Yes, ONLY for Implantation of ventricular assist devices as a bridge to heart transplantation.
- Removed the following coverage statement: Implantation of the ventricular assist system for destination therapy is limited to the centers which participated in the REMATCH study and have heart transplantation programs.
- Remainder of the policy is unchanged.

Amino Acid-Based Elemental Formula

- Change to coverage statements.
- Coverage of amino acid based formulas is subject to the member's specific contract benefits.

Initial Review:
Coverage of amino-acid based formula (when intended for the patient's sole source of nutrition) may be provided for up to age one when the following documentation is submitted:

- Definitive diagnosis, with supporting lab and / or diagnostic test results; OR

Coverage of amino-acid based formula may be provided for 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, coverage of amino-acid based formula for an additional 180 days (when intended for the patient's sole source of nutrition), may be granted 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

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and other liquids were introduced.
- Remainder of the policy is unchanged.

Policies Inactivated

None.

Medical and Behavioral Health Policy Activity

Policies: Effective 05/19/09 Notification Posted 02/19/09

Policies Developed

Thrombopoietin Mimetic Agents for Immune Thrombocytopenic Purpura

- Accepted medical practice for treatment of thrombocytopenia in patients with chronic immune (idiopathic) thrombocytopenic purpura (ITP) who meet all the following criteria:
  - Disease duration greater than six (6) months; AND
  - Insufficient response to corticosteroids, immunoglobulins, or splenectomy. An insufficient response is defined as a platelet count of less than 30,000 per microliter OR a platelet count less than 50,000 per microliter and at increased risk of bleeds due to concomitant disease states or occupation; AND
  - Enrollment in the NEXUS (Network of Experts Understanding and Supporting Nplate and Patients) Program or the PROMACTA CARES Program.
  - Case-by-case review will be considered for the following situation:
    - Disease duration of less than six (6) months, AND
    - Platelet count less than 10,000 per microliter, despite a sufficient trial of corticosteroids or immunoglobulins or splenectomy.
- All other uses of thrombopoietin mimetic agents are considered investigative and not medically necessary, including, but not limited to:
  - Initial therapy for chronic immune thrombocytopenic purpura;
  - Acute immune thrombocytopenic purpura;
  - Thrombocytopenia due to myelodysplastic syndrome;
  - To increase platelet counts and facilitate treatment for hepatitis C virus infection in patients with thrombocytopenia associated with HCV-related cirrhosis
  - Chemotherapy-induced thrombocytopenia.
- Prior Authorization: Yes.
- Coverage of medications referred to in this policy is subject to a product-specific formulary, specialty drug program or other requirements.

Catheter Ablation of the Pulmonary Veins as Treatment for Atrial Fibrillation

- Accepted medical practice as a treatment for atrial fibrillation for the following indications:

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  - Patients with symptomatic paroxysmal or persistent atrial fibrillation, who have failed antiarrhythmic medications, as an alternative to continued medical management; or
  - Patients with class II or III congestive heart failure and symptomatic atrial fibrillation in whom heart rate is poorly controlled by standard medications, as an alternative to AV nodal ablation and pacemaker insertion.
- Investigative and not medically necessary as treatment for all other atrial fibrillation indications.
- 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.

Infliximab

- Accepted medical practice for the following FDA-approved indications:
  - Rheumatoid Arthritis
  - Crohn's disease
  - Ankylosing Spondylitis
  - Psoriatic Arthritis
  - Plaque Psoriasis
  - Ulcerative Colitis
- Investigative and not medically necessary for all other indications, including but not limited to:
  - Arthritis (other than rheumatoid arthritis and psoriatic arthritis);
  - Behcet syndrome uveitis;
  - Cancer cachexia;
  - Endometriosis;
  - Giant cell arteritis;
  - Juvenile idiopathic arthritis-associated uveitis;
  - Kawasaki syndrome;
  - Polyarteritis nodosa;
  - Polyarteritis rheumatica;
  - Renal cell carcinoma;
  - Sarcoidosis;
  - Sclerosing cholangitis;
  - Sjogren syndrome;
  - Systemic necrotizing vasculitides.
- 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.

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Microwave Thermotherapy for Treatment of Primary Breast 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.

Pulmonary Rehabilitation

- Accepted medical practice for treatment of chronic pulmonary disease for patients with moderate-to-severe disease who are experiencing disabling symptoms and significantly diminished quality of life, despite optimal medical management.
- Accepted medical practice as a preoperative conditioning component for those patients considered appropriate candidates for lung volume reduction surgery and for lung transplantation.
- Multiple courses of pulmonary rehabilitation are considered investigative and not medically necessary either as maintenance therapy in patients who initially respond or in patients who fail to respond or whose response to an initial rehabilitation program has diminished over time.
- 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.

Laparoscopic and Percutaneous Techniques for Myolysis of Uterine Fibroids

- 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.

Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure

- Computer-assisted surgery for orthopedic procedures of the pelvis and appendicular skeleton is considered incidental when performed in conjunction with another related primary surgical procedure.

Endoscopic Radiofrequency Ablation for Barrett's Esophagus

- 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.

Laboratory Tests for Heart Transplant Rejection

- 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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Policies Revised

Transcranial Magnetic Stimulation

- Investigative and not medically necessary as a treatment of depression and other psychiatric/neurologic disorders, such as schizophrenia or migraine headaches.
- 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.

KRAS Mutation Analysis for Non-Small Cell Lung Cancer

- Investigative and not medically necessary to predict treatment response to erlotinib in non-small cell lung carcinoma.
- Prior authorization: Not applicable. Claims for this service are subject to retrospective review and denial of coverage, as investigative services are not eligible for reimbursement.

Spinal Cord Stimulation

- Clarification that spinal cord stimulation is considered accepted medical practice for the treatment of severe and chronic pain of the trunk or limbs when specific criteria are met.
- Investigative and not medically necessary for the following indications:
  - Treatment of critical limb ischemia as a technique to forestall amputation;
  - Treatment for refractory angina pectoris.
- Prior authorization: Yes, for the trial stimulation and for the permanent implantation.

Endoluminal Radiofrequency or Laser Ablation for Treatment of Varicose Veins/ Venous Insufficiency

- Accepted medical practice for the treatment of varicose veins when the procedure is used as an alternative to saphenous vein ligation and stripping in patients with documented symptomatic saphenofemoral or saphenopopliteal reflux.
- Investigative and not medically necessary for treatment of any other vein, including, but not limited to, perforator and tributary veins.
- Prior authorization: Yes.

Dialectical Behavior Therapy for Borderline Personality Disorder

- Accepted medical practice when treatment includes specific core functional components and treatment modalities.
- 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.

Respiratory Syncytial Virus Prophylaxis

- Additions to the policy:

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  - Once a child qualifies for initiation of prophylaxis at the start of the RSV winter season, administration should continue throughout the season and not stop at the point a child reaches 6, 12 or 24 months of age.
  - Not medically necessary for infants and children with hemodynamically insignificant heart disease.
  - Administration of more than five (5) doses in one RSV season is considered not medically necessary without documented widespread local community RSV activity, indicating early onset of season or extending past April.
- Investigative and not medically necessary for all other indications not discussed in the policy including, but not limited to, the following:
  - Adults with any diagnosis;
  - Patients undergoing stem-cell transplantation;
  - Children 24 months or older prior to the commencement of the RSV season;
  - Cystic fibrosis patients without reduced lung reserve.
- Prior authorization: Yes, ONLY after the age of two years. 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.

*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 December 2008 through February 2009

- Gravity Lumbar Reduction
- Genetic Testing and Counseling
- Altered Auditory Feedback for Stuttering
- Anterior Eye Segment Optical Imaging
- Anesthesia-Assisted Opioid Withdrawal
- Biomarker Genes for Detection of Lymph Node Metastases in Breast Cancer
- Genetic Testing for Familial Alzheimer's Disease
- MRI-Guided Focused Ultrasound for Treatment of Uterine Fibroids and other Tumors
- Neurofeedback/EEG Biofeedback
- Occlusion of Uterine Arteries as Treatment for Uterine Fibroids

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- Percutaneous Electrical Nerve Stimulation (PENS) or Percutaneous Neuromodulation Therapy (PNT)
- Pfeiffer Treatment Center Metallothionein Protein (MT) Assessment & Treatment Protocol
- Scar Excision/Revision
- Scintimammography
- Suprachoroidal Delivery of Pharmacological Agents
- Transanal Endoscopic Microsurgery

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

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:

Corporate Learning and Development (U100)
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; Pam Dempsey; Barb Luck; Becky Marciniak; Karla Krammer; and Karen Kiemele

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Corporate Learning and Development, U100
P.O. Box 64560
St. Paul, MN 55164-0560