Provider Press

Provider information

Sept 2015 / Vol. 19, No. 3

BlueCross BlueShield Minnesota

ICD-10 CODING UPDATE AND FINAL REMINDERS

Note: The information below was also published on August 5, 2015, in Provider Bulletin P30-15.
The ICD-10 federal compliance date of **October 1, 2015**, is almost here. The help you with your final preparations for the impacts of ICD-10, Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) is publishing some new information and final reminders.

New Information

- Beginning October 1, 2015, when submitting procedures for prior authorization (PA) requests you must submit the ICD-10 diagnosis code. PA requests submitted before October 1, 2015, must be submitted with the ICD-9 diagnosis code.
- Provider Policy and Procedure Manual references to ICD-9 codes will be updated to reflect the appropriate ICD-10 codes. We anticipate completing the updates no later than September 1, 2015. To access the manual go to **providers.bluecrossmn.com** and select "Forms & Publications," then "manuals."
- Reimbursement policy references to ICD-9 codes will be updated to also reflect the appropriate ICD-10 codes. The updates will be completed prior to October 1, 2015. To access reimbursement policy documents go to the "Tools and Resources" section of **providers.bluecrossmn.com**.
- Providers having difficulty with claim submission software after the compliance date may use the free of charge claim submission entry on the Availity provider portal to submit their claims. This process does require registration but is easy to use and is fully tested for ICD-10 functionality. For more information, visit **availity.com**.

Coding Reminders

Code all diagnosis and procedures to the greatest level of specificity possible. Medical record documentation must support the code selection on the claim transactions.

General Billing Reminders

Due to the impacts to our members, Blue Cross will not extend the timely filing deadlines or advance payments to any providers who fail to comply with the ICD-10 mandate. Claims must be submitted timely to Blue Cross. Any claims received after the timely filing period specified in your Participating Provider Service Agreement will be denied as provider liability. Please work with your software vendor and clearinghouse to make sure you are ready to submit ICD-10 coded claims by the compliance date.

Only one version of the code set (ICD-9 or ICD-10) is allowed per submitted claim.ICD-9 only must be used on claims with service dates and inpatient discharge dates prior to October 1, 2015. ICD-10 only must be used on claims with service dates and inpatient discharge dates October 1, 2015, and after.

Claims with service dates spanning October 1, 2015, must be submitted as two separate claims transactions with the exception of inpatient services. Please refer to CMS MLN Matters publication for more information:

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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 June 2015 to August 2015 that are available online at **providers.bluecrossmn.com**.
As a reminder, Bulletins are mailed to all participating providers affected by the information. Quick Points are available only on our website unless noted otherwise in the bottom left corner of the publication.

QUICK POINTS	TITLE
QP13-15	Provider Cost Data Update
QP14-15	Update to Buprenorphine and Buprenorphine/Naloxone (Bunavail™/Suboxone®/ Zubsolv®) Prior Authorization and Quantity Limit Criteria
QP15-15	Update to Nuvigil®/Armodafinil, Provigil®/Modafinil Prior Authorization and Quantity Limit Criteria
QP16-15	ICD-10 Provider Partner Testing Summary
QP17-15	Who is BlueLink TPA?
BULLETINS	**TITLE**
P21-15	New Claims Filing Rules for Air Ambulance Providers
P22-15	July 2015 HCPCS Code Updates
P23-15	Medical Necessity Review Criteria Update for MHCP Subscribers
P24-15	Mental Health Services Requirement for Minnesota Health Care Programs (MHCP) Subscribers
P25-15	New Drug-related Prior Authorization Criteria: Proprotein Convertase Subtilisin/Kexin Type 9 (PCSK9) Inhibitors for Familial Hypercholesterolemia PA with Quantity Limit
P26-15	Update on Knee Arthroplasty Criteria for MHCP Subscribers
P27-15	Non-Covered Medicare Services and Organization Determination Update for Platinum Blue Subscribers
P28-15	Facility Place of Service Changes
P29-15	Medicare Training and Education Requirements
P30-15	ICD-10 Coding Update and Final Reminders
P31-15	Common Carrier and Special Transportation Providers Billing Code Updates

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:

Emailed to: Provider.Data@bluecrossmn.com

Faxed to **(651) 662-6684**

Mailed to:
Blue Cross and Blue Shield of Minnesota
PDO, R316
P.O. Box 64560
St. Paul, MN 55164-0560

FYI

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**
Availity	**1-800-282-4548**
Provider services	**(651) 662-5200 or 1-800-262-0820**
Please verify these numbers are correctly programmed into your office phones.	

FYI

PROVIDER MANUAL UPDATES

The following is a list of Blue Cross and Blue Shield of Minnesota provider manuals that have been updated from June 2015 to August 2015. As a reminder, provider manuals are available online at **providers.bluecrossmn.com**. To view the manuals, select "Forms & 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
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Medical Services section	Topic of "Non-covered Tobacco Treatments" was deleted.
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Public Programs section	Content change to Transportation Services (Formerly titled Special Transportation)
Provider Policy and Procedure Manual	All chapters	References to ICD-9 codes will be updated to reflect the appropriate ICD-10 codes. Note: We anticipate completing all the updates no later than September 1, 2015.

REALLY SIMPLE SYNDICATION

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

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

- Bulletins
- Forms: admin updates and contracting
- Forms: credentialing
- Forms: pre-certification and pre-authorization
- Manuals
- Provider Press
- Quick Points

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

2015 HOLIDAY SCHEDULE

Provider services will be closed on the following days in 2015:

Monday, September 7

Thursday, November 26

Friday, November 27

Thursday, December 24

Friday, December 25

With the exception of the dates stated above, representatives answering the provider services numbers are available to assist you 8 a.m. to 5 p.m. Monday through Thursday, and 9 a.m. to 5 p.m. on Friday.

CODING CORNER

REPLACEMENT CLAIM REMINDER

When do I need a replacement claim? Well, are you making changes to a claim that was previously processed? If yes, you will need to send in a replacement claim. This includes:

- changing a date of service
- adding or changing a procedure
- adding or changing a diagnosis
- removing a modifier
- adding a modifier

Note that when adding modifiers -24, -25, -57, -59, -78 and/or 79, medical notes supporting the modifier also need to be sent with the replacement claim.

See Provider Bulletin P28-14 dated October 1, 2014 for more information.

26 OR TC USE

Not every code, in particular radiology codes, has a professional component (reported with a -26 modifier) and technical component (reported with a –TC modifier). For example, CPT code 77387 is "Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed". This code does not have a professional or technical component. Thus, if it is submitted with a component modifier (-26 or -TC) it will be denied because an invalid modifier was appended to the service.

ICD-10 CODING UPDATE AND FINAL REMINDERS continued from page 1

http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/SE1325.pdf.

Use the correct code qualifier indicating whether the code is ICD-9 or ICD-10 for the code set being reported in the HIPAA transaction.

Review your claim acknowledgement reports timely to ensure claims have been correctly submitted and accepted by Blue Cross. Claims rejected on these reports must be corrected and submitted again. Claims rejected on acknowledgment reports are not considered submitted for timely filing purposes.

Additional information is available under the ICD-10 compliance link on our website at **providers.bluecrossmn.com**.

Questions?

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

THE HCPCS ARE COMING, THE HCPCS ARE COMING

It's not just the ICD codes that will be the coding stars on October 1, 2015, HCPCS codes are updated as well on that fall date. Blue Cross will publish a Provider Bulletin closer to the October 1, 2015 effective date that provides more details.

HEALTH LITERACY

Try both aleve 2pills bid with flexeril at hs.

As a health care professional you probably understand exactly what the doctor who sent this message was saying: *Take 2 Aleve pills 2 times a day and take 1 Flexeril pill at bedtime*. But the patient who received it had no idea what the doctor was saying. Most people don't. Clear communication increases patient safety and adherence to treatment plans.

October is health literacy month. Here are some activities that your practice/clinic can incorporate to help make a healthy difference in your patient's lives:

Use the **Teach Back** method also known as the "show-me" technique to ensure that patients (or care takers) understand their treatment plan and what they need to do. Think about doing a simple teach back training at your practice during the month of October. Click here for a program ready to use from the Minnesota Health Literacy Partnership.

Promote the **Ask Me 3** program from the National Patient Safety Foundation which focuses on patient understanding of 3 simple questions:

1) What is my main problem?

2) What do I need to do?

3) Why is it important for me to do this?

You can use these questions to help guide the information you provide during visits with your patients. Make sure they know the answer to these questions before they leave your office. Consider displaying posters and brochures throughout your office during October to remind staff about the 3 questions. For more information on Ask Me 3, click here.

Review your own patient education materials. Select a few of the patient education materials that you commonly use in your practice and review them using one of the health literacy tools from the Office of Disease Prevention and Health Promotion. Perhaps form a team to review the pieces together. Click here for resources. Or, contact us if you want a copy of the tool used at Blue Cross.

To learn more about building a culture of health literacy and using plain language at your practice, please send an email to Alisha.Odhiambo@bluecrossmn.com. Additional information can also be found online at http://healthliteracymn.org/

QUALITY IMPROVEMENT

PCC QUALITY OF CARE COMPLAINT REPORT

Providers are required to complete the Blue Plus Quality of Care Complaint report for all written and verbal complaints from Blue Plus, Prepaid Medical Assistance Program and MinnesotaCare subscribers on a quarterly basis, per Minnesota Department of Health regulations. Complaints logged at the provider offices are to be investigated and resolved by the provider's office whenever possible.

These complaints are reported to Blue Plus in January, April, July and October for the preceding three months. The Primary Care Clinic (PCC) must submit a quarterly report even if the facility does not receive any complaints for the quarter. Your contract outlines the procedures required for your Quality of Care (QOC) PCC complaint reporting adherence agreement.

Complaints should no longer be directed to the attention of a single designated person. Sending your PCC QOC complaint report form to any source not listed below may delay the processing of your PCC QOC complaint report.

To access the PCC Blue Plus Quality of Care Complaint Report Form, go to **providers.bluecrossmn.com** and select "Forms & publications," then "forms - clinical operations."

Submit quarterly PCC QOC reports using one of these methods:

Email: pcc.complaint@bluecrossmn.com

Secure fax line: **(651) 662-4004**

Mail: Blue Plus
Attn: Quality Health Management Dept.
R472
P.O. Box 64179
St. Paul, MN 55164-0179

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.

QUALITY IMPROVEMENT

CLINICAL PRACTICE GUIDELINES

Blue Cross believes that the use of clinical practice guidelines is a key component of Quality Improvement. Each year, Blue Cross' Clinical Practice Quality Committee (a designee of the Quality Council) approves the adoption of select guidelines that are used to support various programs and initiatives. The guidelines do not substitute for sound clinical judgment; however, they are intended to assist clinicians in understanding key processes for improvement efforts.

Clinical Practice Guidelines with hyperlinks are available in Chapter Three of the Blue Cross Provider Policy and Procedure Manual. To access the manual, go to **providers.bluecrossmn.com** and select "Forms and Publications" then "Manuals."

Recommended sources:
Blue Cross recognizes the following sources for Clinical Practice Guidelines for a variety of areas of clinical practice.

• USPSTF: U.S. Preventive Services Task Force
http://www.uspreventiveservicestaskforce.org/browseRec/Index

• AAP: American Academy of Pediatrics, including Bright Futures
http://pediatrics.aappublications.org/search?flag=practice_guidelines&submit=yes&x=18&y=8&format=_standard&hits=30&sortspec=date&submit=Gohttp://pediatrics.aappublications.org/search?flag=_practice_guidelines&submit=yes&x=18&y=8&format=standard&hits=30&sortspec=date&submit=Go

http://brightfutures.aap.org/

• ICSI: Institute for Clinical Systems Improvement
https://www.icsi.org/guidelines__more/guidelines_a_to_z/

Specific guidelines:
Specific guidelines recommended by Blue Cross include the following:

• Behavioral Health
- ADHD - Diagnosis, Evaluation, and Treatment of Attention-Deficit/ HyperactivityDisorder in Children and Adolescents (AAP)
- Depression Screening in Adults (USPSTF)

• Non-Preventive Acute or Chronic Conditions
- Diabetes – Diagnosis and Management of Type 2 Diabetes Mellitus in Adults (ICSI)
- Asthma – Diagnosis and Management of Asthma (ICSI)

• Preventive Care Guidelines
- Preventive Services for Adults (ICSI)
- Preventive Services Children and Adolescents (ICSI and Bright Futures)
- Routine Prenatal Care (ICSI)

Questions concerning Clinical Practice Guidelines can be directed to Eileen Johnson, Director, Quality and Health Management at **(651) 662-4224**. A copy of the clinical practice guidelines with hyperlinks is also available by calling Eileen Johnson.

QUALITY IMPROVEMENT

BLUE PLUS MEDICAL RECORD DOCUMENTATION REVIEW

Advance Directives

An advance directive provides an opportunity for adults of any age to make their health care wishes known if or when a potential life-threatening event occurs and they are unable to verbalize their wishes at the time of the event.

A representative sample review of our Blue Plus members' medical records for dates of service in 2014 has been completed and the results are below. We encourage providers to discuss the benefits of completing an advance directive with all our adult members.

	TOTAL MEMBERS IN SAMPLE	ADVANCE DIRECTIVE PRESENT OR DISCUSSED	AGE RANGE FOR MEMBERS WITH DISCUSSION
Medicare/Medicaid Eligible (MSHO)	300	187 (62%)	Avg: 83, Range: 67-107
Medicaid	600	61 (10%)	Avg: 48, Range: 20-64

Body Mass Index (BMI) And Counseling For Obesity

Documentation of a member's BMI is the first step towards addressing the prevalence of obesity in our society. Blue Plus completed a review of a sample of Blue Plus members' medical records with dates of service in 2014 to evaluate documentation of BMI value and counseling for obesity. Obesity is defined as a BMI over 30. The results are shown below. One-third of Medicaid members defined as obese had documentation of a discussion with their provider concerning their weight management.

	TOTAL MEMBERS	BMI DOCUMENTED	BMI > 30 (IF DOCUMENTED)	IF BMI > 30, ADVISED ON WEIGHT MANAGEMENT	AVERAGE BMI FOR MEMBERS WITH DISCUSSION
Medicare/Medicaid Eligible (MSHO)	300	183 (61%)	70 (38%)	6 (9%)	Avg: 36.03 Range: 30.89-50.1
Medicaid	600	550 (92%)	237 (43%)	93 (39%)	Avg: 38.07 Range: 26.76-71.0
Total	900	733 (81%)	307 (42%)	99 (32%)	Avg: 37.95

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QUALITY IMPROVEMENT

BLUE PLUS MEDICAL RECORD DOCUMENTATION REVIEW

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Tobacco Use Assessment And Counseling

A sample of medical records were reviewed to determine tobacco use among our Blue Plus members and discussions promoting tobacco cessation during a provider visit in 2014. While tobacco use appears to be routinely assessed at least once during 2014, only half of our members have documentation of provider efforts in addressing this health concern.

	TOTAL MEMBERS	ASSESSED FOR TOBACCO USE	TOBACCO USE	AVERAGE AGE OF TOBACCO USERS	DISCUSSION AND/ OR RX ASSISTANCE
MSHO	300	281 (93%)	24 (8.5%)	Avg: 75 (67-87)	10 (42%)
PMAP/MNCARE	600	518 (86%)	164 (32%)	Avg: 44 (20-64)	89 (54%)
Total	900	799 (89%)	188 (24%)	Avg: 49 (20-87)	99 (53%)

These reviews were completed to encourage providers to open the door to meaningful discussions with their patients on important health issues. If you have any questions concerning this article please send an email to the Quality and Health Management department c/o Sheila.dalen@bluecrossmn.com.

Better Care Through Quality Improvement

Every year, Blue Cross and Blue Shield of Minnesota (Blue Cross) reviews the care delivered to our subscribers. This review determines the goals for the quality program. The program currently has many goals to improve health services.

Making sure our subscribers receive preventive services and health screenings; making sure people with health problems, like heart disease, receive treatment; and improving the customer service experience are just a few of the goals in the program.

More detailed information is available about Blue Cross' process and outcomes in meeting quality improvement goals related to subscriber care and service. You can see more information about our quality improvement program at **bluecrossmn.com**. Enter "quality improvement program" in the search field. If you are unable to access the website please contact Eileen Johnson, Director | Accreditation & Quality Improvement, at **(651) 662-4224** to request information about the Quality Improvement Program.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

Medical and behavioral health policies are available for your use and review on the Blue Cross and Blue Shield of Minnesota website at **providers.bluecrossmn.com**. From this site, there are two ways to access medical policy information depending on the patient's Blue Plan membership.

For out-of-area Blue Plan patients:
Select "Medical Policy PreCert/PreAuth Router" and click Go. You will be taken to the page where you select either medical policy or pre-certification/prior authorization and enter the patient's three-letter alpha prefix as found on their member identification card, and click Go. Once you accept the requirements, you will be routed to the patient's home plan where you can access medical policy or pre-certification/pre-authorization information.

For local Blue Cross and Blue Shield of Minnesota plan patients:
Select "Medical policy" (under the Tools & Resources), read and accept the Blue Cross Medical Policy Statement, and then select "View All Active Policies." You have now navigated to the Blue Cross and Blue Shield of Minnesota Medical and Behavioral Health Policy Manual, where there are several selections to assist with your inquiry.

The "What's New" section identifies our latest new or revised policies approved by Blue Cross' Medical and Behavioral Health Policy Committee at least **50** days ago. These policies are now effective, and providers should begin following these policies immediately. These policies also appear in the "Active Policy" section of the Medical and Behavioral Health Policy Manual.

The "Upcoming Policies" section lists new or revised policies approved by the Blue Cross Medical and Behavioral Health Policy Committee and are effective **50** days from the date they were posted to the "Upcoming Policies" section of the Medical and Behavioral Health Policy Manual.

The "Active Policy" section contains the entire list of policies effective at the time of your inquiry. Please note, DHS Programs (Coverage Guidelines for DHS Programs - MHCP Manual) and Medicare Contractors (Part A – National Government Services [NGS], Part B – National Government Services [NGS], Home Health and Hospice – National Government Services [NGS], Durable Medical Equipment Medicare Administrative Contractor – National Government Services [NGS], and The Centers for Medicare and Medicaid Services – CMS) have separate sections.

The "Pre-Certification/Pre-Authorization" section identifies various services, procedures, prescription drugs, and medical devices that require pre-certification/pre-authorization. The following Pre-Certification/Pre-Authorization Lists are provided for review: Commercial (including BlueLink TPA), MN Government Programs, and Medicare Plans. These lists are not exclusive to medical policy services only; they encompass other services that are subject to pre-certification/ pre-authorization requirements.

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

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

MEDICAL AND BEHAVIORAL HEALTH POLICY ACTIVITY

Policies Effective: 07/20/15 Notification Posted: 05/28/15

Policies developed

None

Policies revised

Pneumatic Compression Devices in the Outpatient or Home Setting

- The use of segmented or non-segmented pneumatic compression devices without calibrated gradient pressure (non-programmable pumps) may be considered MEDICALLY NECESSARY for the treatment of lymphedema in the outpatient or home setting when ALL of the following criteria are met:
  1. The patient has undergone a four-week trial of conservative therapy which includes:
     a. Use of an appropriate compression bandage system or compression garment,
     b. Exercise, AND
     c. Elevation of the limb;
     AND
  2. The treating physician determines that no significant improvement has occurred or significant symptoms remain following the four-week trial.
- The use of segmented pneumatic compression therapy devices with calibrated gradient pressure (programmable pumps) may be considered MEDICALLY NECESSARY in the outpatient or home setting when the patient meets criteria for a device without calibrated gradient pressure (non-programmable pumps) and either of the following criteria are met:
  1. The patient's medical condition has failed to respond to therapy using segmented or non-segmented pneumatic compression devices without calibrated gradient pressure (non-programmable pumps);
     OR
  2. The individual has unique characteristics (e.g., significant scarring) that prevent satisfactory pneumatic compression treatment using segmented or non-segmented pneumatic compression devices without calibrated gradient pressure (non-programmable pumps).
- The use of segmented or non-segmented pneumatic compression devices without calibrated gradient pressure (non-programmable pumps) may be considered MEDICALLY NECESSARY for the treatment of chronic venous insufficiency of the lower extremities in the outpatient or home setting when ALL of the following criteria are met:
  1. The patient has one or more venous stasis ulcers;
     AND
  2. The patient has undergone a trial of conservative therapy for a minimum of six months which includes ALL of the following:
     a. The use of an appropriate compression bandage system or compression garment,
     b. Appropriate dressings for the wound,
     c. Exercise, and
     d. Elevation of the limb;
     AND
  3. The treating physician determines that the venous stasis ulcer has failed to heal.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

- The use of segmented pneumatic compression therapy devices with calibrated gradient pressure (programmable pumps) may be considered MEDICALLY NECESSARY in the outpatient or home setting when the patient meets criteria for a device without calibrated gradient pressure (nonprogrammable pumps) and either of the following criteria are met:
  1. The patient's medical condition has failed to respond to therapy using segmented or non-segmented pneumatic compression devices without calibrated gradient pressure (non-programmable pumps);
     OR
  2. The individual has unique characteristics (e.g., significant scarring) that prevent satisfactory pneumatic compression treatment using segmented or non-segmented pneumatic compression devices without calibrated gradient pressure (non-programmable pumps).
- The use of pneumatic compression devices in the outpatient or home setting may be considered MEDICALLY NECESSARY in patients who have undergone a surgical procedure when BOTH 1 and 2 are met:
  1. Patient meets one or more of the following:
     a. Major surgery (e.g., total hip arthroplasty, total knee arthroplasty, hip fracture repair, open abdominal or open pelvic procedure;
        OR
     b. Patient is at moderate to severe risk of VTE. Examples include:
        i. Patient is not able to walk unassisted or is bedridden
        ii. Age greater than 60 years, anesthesia at least 2 hours and bed rest at least 4 days during current episode of care
        iii. Inpatient stay of more than 2 days during current episode of care
        iv. Central venous access during current episode of care
        v. Sepsis during current episode of care
        vi. Active cancer or cancer treatment
        vii. Significant comorbidity such as recent myocardial infarction, congestive heart failure, cerebrovascular disease, moderate to severe chronic obstructive pulmonary disease, moderate to severe liver disease, moderate to severe chronic kidney disease
        viii. Pregnancy or post-partum state (< 1 month)
        ix. Hypercoagulable state (e.g. Factor V Leiden, antithrombin III deficiency, protein C or S deficiency, antiphospholipid syndrome; dysfibrinolysis, prothrombin 20210 defect)
        x. Prior VTE

     AND
  2. The patient has a contraindication to pharmacologic anticoagulants, such as being at high-risk for bleeding. Risk factors for bleeding include:
     a. Bleeding disorder such as hemophilia
     b. Active liver disease
     c. Severe renal failure
     d. Previous major bleed (and previous bleeding risk similar to current risk)
     e. Concomitant antiplatelet agent
     f. History of or difficult-to-control surgical bleeding during the current operative procedure, extensive surgical dissection, and revision surgery.
- Outpatient or home use of pneumatic compression devices for post-surgical VTE prophylaxis is considered NOT MEDICALLY NECESSARY for patients who have undergone a surgical procedure with a low risk for VTE and who have no additional risk factors for VTE. Examples of lower risk surgical procedures include but are not limited to laparoscopic cholecystectomy, appendectomy, transurethral prostatectomy, and inguinal herniorrhaphy.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

- The use of pneumatic compression devices in the outpatient or home setting is considered INVESTIGATIVE for all other indications, including but not limited to treatment of arterial insufficiency (e, g, peripheral arterial disease) and restless legs syndrome due to the lack of clinical evidence demonstrating its impact on improved health outcomes.

Angioplasty and/or Stenting for Intracranial Aneurysms and Atherosclerosis

- Intracranial stent placement may be considered MEDICALLY NECESSARY as part of the endovascular treatment of intracranial aneurysms for patients when surgical treatment is not feasible and standard endovascular techniques do not allow for complete isolation of the aneurysm, e.g., wide-neck aneurysm (4 mm or more) or sack-to-neck ratio less than 2:1.
- Intracranial flow diverting stents with FDA approval for the treatment of intracranial aneurysms may be considered MEDICALLY NECESSARY as part of the endovascular treatment of intracranial aneurysms that are large or giant wide-necked (aneurysm size of 10 mm or more and a neck diameter of 4 mm or more) in the internal carotid artery from the petrous to the superior hypophyseal segments and which are not amenable to surgical treatment or standard endovascular therapy.
- Intracranial stent placement is considered INVESTIGATIVE in the treatment of intracranial aneurysms, except as noted above, due to the lack of clinical evidence demonstrating its impact on improved health outcomes.
- Percutaneous transluminal angioplasty with or without stenting is considered INVESTIGATIVE for the treatment of intracranial atherosclerosis due to the lack of clinical evidence demonstrating its impact on improved health outcomes.

Surgical Treatment of Femoroacetabular Impingement

- Open or arthroscopic treatment of femoroacetabular impingement may be considered MEDICALLY NECESSARY when ALL of the following conditions are met:
  A. Age:
  Patient is skeletally mature with documented closure of growth plates (e.g., 15 years or older).
  B. Symptoms:
  1. Moderate-to-severe hip pain that is worsened by flexion activities (e.g., squatting or prolonged sitting) and which significantly limits activities; AND
  2. Pain which is unresponsive, or recurs after a trial of conservative therapy lasting at least 3 months (including activity modifications, restriction of athletic pursuits and avoidance of symptomatic motion); AND
  3. Positive impingement sign is present on clinical examination (pain elicited with 90 degrees of flexion and internal rotation and adduction of the femur).
  C. Imaging:
  1. Imaging studies (e.g., x-rays, MRI) confirm the diagnosis of a cam or pincer-type FAI. Examples of morphology indicative of FAI include:
  a. pistol-grip deformity;
  b. femoral head-neck offset with an alpha angle greater than 50 degrees;
  c. a positive wall sign;
  d. acetabular retroversion (overcoverage with crossover sign);
  e. coxa profunda or protrusion;
  f. damage of the acetabular rim;
  AND
  2. No evidence of advanced osteoarthritis (defined as Tonnis grade II or III, or joint space of less than 2 mm); AND
  3. No evidence of severe (modified Outerbridge grade IV) chondral damage.
- Surgical treatment of femoroacetabular impingement (FAI) is considered INVESTIGATIVE in all other situations.

MEDICAL AND BEHAVIORAL HEALTH POLICY UPDATE

Policies inactivated

Tobacco Cessation Treatments

Policies Effective: 08/17/15 Notification Posted: 06/25/15

Policies developed

None

Policies revised

Treatment of Obstructive Sleep Apnea and Snoring in Adults

- Medical Management

A. Intraoral Appliances

Intraoral appliances (e.g., mandibular advancing/positioning devices or tongue-retaining devices) may be considered MEDICALLY NECESSARY when ALL of the following criteria are met:

1. Patient has been diagnosed with OSA defined by:
   a. An AHI or RDI of 15 or greater events per hour;
      OR
   b. An AHI or RDI between 5 and 14 events per hour with any of the following associated symptoms:
      i. Excessive daytime sleepiness
      ii. Documented hypertension
      iii. Ischemic heart disease
      iv. History of stroke

   AND
2. There is absence of temporomandibular dysfunction or periodontal disease;
   AND
3. The device is prescribed after a diagnosis of OSA has been established by a physician who is either a diplomate of the American Board of Sleep Medicine, a recognized subspecialty of the American Board of Medical Specialties (ABMS), or an active staff member of a sleep center or laboratory accredited by the American Academy of Sleep Medicine (AASM) or The Joint Commission;
   AND
4. The device is custom-fitted by qualified dental personnel under the direction of a Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD).

B. Continuous Positive Airway Pressure (CPAP)

Continuous positive airway pressure (CPAP) may be considered MEDICALLY NECESSARY in patients with confirmed OSA with:

1. An AHI or RDI of 15 events per hour or greater;
   OR
2. An AHI or RDI between 5 and 14 events per hour with any of the following associated symptoms:
   a. Excessive daytime sleepiness
   b. Documented hypertension
   c. Ischemic heart disease
   d. History of stroke

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C. Bi-level Positive Airway Pressure (BiPAP)
BiPAP may be considered MEDICALLY NECESSARY in patients who:
1. Meet the criteria for CPAP; AND
2. Have failed a prior trial of CPAP; OR
3. For whom BiPAP is found to be more effective than CPAP in the sleep laboratory.

D. Auto-Adjusting PAP (APAP)
APAP may be considered MEDICALLY NECESSARY in patients who:
1. Meet the criteria for CPAP above; AND
2. Have a contraindication to CPAP, have failed a prior trial of CPAP OR are undergoing a trial of APAP to titrate CPAP;
AND
3. Have no evidence by history or physical examination of the following conditions:
   a. Central sleep apnea
   b. Congestive heart failure
   c. Chronic pulmonary disease such as chronic obstructive pulmonary disease
   d. Pulmonary hypertension
   e. Obesity hypoventilation syndrome or other condition which may cause nocturnal arterial oxyhemoglobin desaturation

- Surgical Management

A. Uvulopalatopharyngoplasty (UPPP)
UPPP may be considered MEDICALLY NECESSARY when all the following criteria are met:
1. Presence of significant, unexplained cor pulmonale or cardiac arrhythmia resulting from documented OSA;
OR
2. An AHI or RDI of 15 events per hour or greater; or an AHI or RDI between 5 and 14 with documented hypertension, ischemic heart disease, or history of stroke;
AND
   a. BMI less than 40;
   AND
   b. A trial of oral appliance therapy has failed or the patient is not a candidate for an oral appliance;
   AND
   c. Patient has not responded to or does not tolerate CPAP, BiPAP, or APAP following a minimum of 4 hours per night for three (3) months of PAP usage.

B. Maxillofacial Procedures
Maxillofacial surgical procedures, such as inferior sagittal mandibular osteotomy and genioglossal advancement with or without hyoid myotomy and suspension or mandibular-maxillary advancement (MMA) may be considered MEDICALLY NECESSARY when the following criteria are met:
1. Presence of significant, unexplained cor pulmonale or cardiac arrhythmia resulting from documented OSA;
OR
2. An AHI or RDI of 15 events per hour or greater; or an AHI or RDI between 5 and 14 with documented hypertension, ischemic heart disease, or history of stroke;
AND
   a. Objective evidence of hypopharyngeal obstruction documented by either fiberoptic examination or cephalometric radiographs;
   AND

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b. Patient has not responded to or does not tolerate CPAP, BiPAP, or APAP following a minimum of 4 hours per night for three (3) months of PAP usage.

- Treatment of Snoring

  Treatment of snoring is considered NOT MEDICALLY NECESSARY because simple snoring in the absence of documented obstructive sleep apnea is not considered a medical condition. Therefore, all procedures for the sole or adjunctive treatment of snoring are considered NOT MEDICALLY NECESSARY, including but not limited to:

  A. Uvulopalatopharyngoplasty (UPPP)
  B. Uvulectomy
  C. Laser-assisted uvulopalatoplasty (LAUP)
  D. Radiofrequency volumetric reduction of the palatal tissues
  E. Radiofrequency volumetric tissue reduction of the tongue, with or without radiofrequency reduction of the palatal tissues
  F. Palatal stiffening procedures, including but not limited to, cautery-assisted palatal stiffening operation, and the implantation of palatal implants
  G. Tongue base suspension

- Investigative Indications

  The following treatments are considered INVESTIGATIVE due to a lack of evidence demonstrating improved health outcomes.

  A. UPPP for any condition other than obstructive sleep apnea or snoring
  B. Expiratory Positive Airway Pressure (EPAP) including the Provent® device
  C. Oral pressure therapy devices, including but not limited to the WinxTM system
  D. Atrial pacing
  E. All other surgical procedures for the sole or adjunctive treatment of obstructive sleep apnea/upper airway resistance syndrome, including, but not limited to:
     1. Uvulectomy
     2. Laser-assisted uvulopalatoplasty (LAUP)
     3. Radiofrequency volumetric reduction of the palatal tissues
     4. Radiofrequency volumetric tissue reduction of the tongue, with or without radiofrequency reduction of the palatal tissues
     5. Palatal stiffening procedures, including but not limited to, cautery-assisted palatal stiffening operation and the implantation of palatal implants
     6. Tongue base suspension
     7. Implantable hypoglossal nerve stimulators

Respiratory Syncytial Virus (RSV) Prophylaxis

- INITIAL RSV SEASON

  The use of immune prophylaxis (e.g., palivizumab [Synagis]) for RSV for the initial RSV season may be considered MEDICALLY NECESSARY when the following criteria are met:

  A. Chronic Lung Disease (CLD) of Prematurity
     1. Infant was born at < 32 weeks, 0 days gestation; AND
     2. Infant is ≤ 12 months of age at the onset of RSV season; AND
     3. Infant requires > 21% oxygen for at least the first 28 days after birth.
  B. Congenital Heart Disease (CHD)
     1. Infant is ≤ 12 months of age at the onset of RSV season AND meets ONE of the following:

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a. Acyanotic CHD, when the infant is receiving medication to control congestive heart failure and will require a cardiac surgical procedure; OR
b. Cyanotic CHD, when palivizumab is recommended after consultation with a pediatric cardiologist; OR
c. Diagnosis of moderate to severe pulmonary hypertension.

OR

2. Child is < 24 months of age at the onset of RSV season AND meets ONE of the following:
   a. Child undergoes cardiac transplantation during the RSV season; OR
   b. Child is receiving RSV prophylaxis and continues to require prophylaxis after a surgical procedure involving cardiac bypass or at the conclusion of extracorporeal membrane oxygenation.

C. Anatomic Pulmonary Abnormalities OR Neuromuscular Disorder (e.g., cerebral palsy, muscular dystrophy)
   1. Infant is ≤ 12 months of age at the onset of RSV season; AND
   2. Infant has impaired ability to clear secretions from the upper airway.

D. Cystic Fibrosis
   1. Infant is ≤ 12 months of age at the onset of RSV season, with evidence of CLD and/or malnutrition.

E. Immunocompromised Status
   1. Child is < 24 months of age at the onset of RSV season; AND
   2. Child is profoundly immunocompromised (e.g., due to solid organ transplantation, hematopoietic stem-cell transplantation, or chemotherapy).

F. Prematurity without CLD or CHD
   1. Infant was born at < 29 weeks, 0 days gestation (i.e., 28 weeks, 6 days, or less); AND
   2. Infant is < 12 months of age at the onset of RSV season.

- <u>SECOND RSV SEASON</u>

The use of immune prophylaxis (e.g., palivizumab [Synagis]) for RSV for the patient's second year of treatment may be considered MEDICALLY NECESSARY when the following criteria are met:

A. CLD of Prematurity
   1. Child was born at < 32 weeks, 0 days gestation; AND
   2. Child is 12 months to < 24 months of age at the onset of the second RSV season; AND
   3. Child continues to require at least ONE of the following within six (6) months of the start of the second RSV season:
      a. Supplemental oxygen; OR
      b. Chronic systemic corticosteroid therapy; OR
      c. Diuretic therapy; OR
      d. Bronchodilator therapy.

B. Cystic Fibrosis
   1. Child is 12 months to < 24 months of age at the onset of the second RSV season, with evidence of CLD and/or malnutrition.

- Administration of RSV Prophylaxis

A. When the appropriate criteria above are met, a maximum of five (5) monthly doses of palivizumab (Synagis®) will be covered per RSV season (defined as November 1st through March 31st).
B. The first monthly dose of palivizumab (Synagis®) will be approved for coverage of administration on or after November 1st.
C. A post-operative dose of palivizumab (Synagis®) will be covered for children < 24 months who are receiving RSV prophylaxis and continue to require prophylaxis after a surgical procedure involving cardiac bypass or at the conclusion of extracorporeal membrane oxygenation.

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Chromosomal Microarray Analysis and Next Generation Sequencing to Evaluate Patients with Developmental Delay/Intellectual Disability or Autism Spectrum Disorders

- Chromosomal microarray analysis may be considered MEDICALLY NECESSARY for diagnosing a genetic abnormality in children with apparent nonsyndromic cognitive developmental delay/intellectual disability (DD/ID) or autism spectrum disorder (ASD) according to accepted Diagnostic and Statistical Manual of Mental Disorders (DSM) criteria when ALL of the following conditions are met:
  A. Any indicated biochemical tests for metabolic disease have been performed, and results are non-diagnostic; AND
  B. FMR1 gene analysis (for Fragile X), when clinically indicated, is negative; AND
  C. ASD or apparent non-syndromic DD/ID in a child with multiple anomalies not specific to a well-delineated genetic syndrome as defined above; AND
  D. The results of the genetic testing have the potential to impact the clinical management of the patient; AND
  E. Testing is requested after the parent(s) and/or legal guardian(s) have been engaged in face-to-face genetic counseling with a healthcare professional who has the appropriate genetics training and experience and is independent of the laboratory performing the test.
- Chromosomal microarray analysis is considered INVESTIGATIVE for the following due to a lack of clinical evidence demonstrating its impact on improved health outcomes:
  A. All other cases of suspected genetic abnormality in children with developmental delay/intellectual disability or autism spectrum disorder
  B. To confirm the diagnosis of a disorder or syndrome that is routinely diagnosed based on clinical evaluation alone. These include but are not limited to attention deficit hyperactivity disorder (ADHD), learning disability, growth retardation, or speech delay.
  C. Population screening
- Panel testing using next-generation sequencing is considered INVESTIGATIVE in all cases of suspected genetic abnormality in children with DD/ID or ASD.

Spinal Fusion: Lumbar

- Lumbar spinal fusion may be considered MEDICALLY NECESSARY for any of the following indications when a correlative abnormality is confirmed by imaging studies (e.g., x-ray, CT, MRI):
  A. Epidural compression or vertebral destruction from a tumor;
  B. Neural compression after spinal fracture;
  C. Instability after debridement for infection;
  D. Spinal infections (e.g., osteomyelitis, spinal tuberculosis);
  E. Severe or rapidly progressive neurological deficit (e.g., motor loss, sensory loss, neurogenic claudication or cauda equina syndrome);
  F. Idiopathic scoliosis when EITHER of the following criteria are met:
     1. Scoliotic curve with a Cobb angle > 45 degrees in children who are skeletally immature; OR
     2. Scoliotic curve with a Cobb angle > 50 degrees resulting in functional impairment in skeletally mature individuals;
  G. Symptomatic pseudarthrosis.
- Lumbar spinal fusion, alone or in conjunction with a primary decompression surgery, may be considered MEDICALLY NECESSARY for treatment of degenerative conditions with spinal instability when ALL the following criteria are met:
  A. ONE of the following conditions are present:
     1. Post-laminectomy instability; OR
     2. Degenerative scoliosis or kyphosis; OR
     3. Spondylolisthesis, OR

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4. Spinal stenosis with spondylolisthesis;
AND

B. Documented unremitting pain and disability refractory to intensive conservative therapy for 3 months. Intensive conservative therapy must have occurred within the previous 12 months AND must include ALL of the following:
1. An active, organized, and progressive strength and flexibility program;
NOTE: If a patient is unable to complete physical therapy (PT) due to progressively worsening pain and disability, the case will be reviewed on an individual basis by an internal physician reviewer (See Documentation Submission section); AND
2. A minimum of two sessions per week over the 3-month period; AND
3. Functional assessment, as measured by the Oswestry Disability Index (ODI), demonstrating ONE of the following:
a. Less than 30% improvement in the ODI score between the first and last physical therapy session; OR
b. Continued ODI score of greater than or equal to 40% at the conclusion of physical therapy
AND
4. An educational component that deals with patient expectations and perceptions, as well as the anatomic sources of back pain
AND

C. Diagnostic imaging (e.g., x-ray, CT, MRI), obtained within the previous 12 months, demonstrates spinal instability (> 3mm of translation and/or 10 degrees or more of angulation of one vertebra compared to the adjacent vertebra in a spinal motion segment).

- Lumbar spinal fusion in conjunction with a decompression surgery may be considered MEDICALLY NECESSARY in the treatment of certain degenerative conditions without existing instability when ALL the following criteria are met:

A. ONE of the following conditions are present:
1. Spinal stenosis; OR
2. Recurrent spinal stenosis at the same segment; OR
3. Recurrent disc herniation with failed laminectomy
AND

B. Documented unremitting pain and disability refractory to intensive conservative therapy for 3 months. Intensive conservative therapy must have occurred within the previous 12 months AND must include ALL of the following:
1. An active, organized, and progressive strength and flexibility program;
NOTE: If a patient is unable to complete physical therapy (PT) due to progressively worsening pain and disability, the case will be reviewed on an individual basis by an internal physician reviewer (See Documentation Submission section);
AND
2. A minimum of two sessions per week over the 3-month period; AND
3. Functional assessment, as measured by the Oswestry Disability Index (ODI), demonstrating ONE of the following:
a. Less than 30% improvement in the ODI score between the first and last physical therapy session; OR
b. Continued ODI score of greater than or equal to 40% at the conclusion of physical therapy
AND
4. An educational component that deals with patient expectations and perceptions, as well as the anatomic sources of back pain
AND

C. Diagnostic imaging (e.g., CT, MRI), obtained within the previous 12 months demonstrates spinal cord or nerve root compression.

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- Lumbar spinal fusion may be considered MEDICALLY NECESSARY for chronic (present for at least 6 – 12 months) discogenic back pain without instability when ALL the following criteria are met:
  A. Documented unremitting pain and disability refractory to intensive conservative therapy for at least 3 months. Intensive conservative therapy must have occurred within the previous 12 months AND must include ALL of the following:
     1. Anti-inflammatory medication and analgesics, unless contraindicated; AND
     2. Therapeutic injections; AND
     3. An active, organized, and progressive strength and flexibility program
        NOTE: If a patient is unable to complete physical therapy (PT) due to progressively, worsening pain and disability, the case will be reviewed on an individual basis by an internal physician reviewer (See Documentation Submission section);
        AND
     4. A minimum of two sessions per week over the 3-month period; AND
     5. Functional assessment, as measured by the Oswestry Disability Index (ODI), demonstrating ONE of the following:
        a. Less than 30% improvement in the ODI score between the first and last physical therapy session; OR
        b. Continued ODI score of greater than or equal to 40% at the conclusion of physical therapy
     6. An educational component that deals with patient expectations and perceptions, as well as the anatomic sources of back pain

     AND
  B. Absence of untreated, underlying, contributory mental health conditions or psychosocial issues including, but not limited to, depression or drug or alcohol abuse;
     AND
  C. Diagnostic imaging (e.g. MRI, CT), obtained within the previous 12 months, demonstrates degenerative disc disease limited to 1 – 2 disc levels.
- Documentation supporting the medical necessity criteria described in the policy must be included in the prior authorization. In addition, the following documentation must also be submitted:
  1. Written report, from a radiologist, describing findings from spinal diagnostic imaging studies.
  2. Intensive conservative therapy:
     - Documentation from the physical therapist must include Oswestry Disability Index (ODI) scores
     - If a patient is unable to complete physical therapy (PT) due to progressively, worsening symptoms of pain and disability, the case will be reviewed on an individual basis by an internal physician reviewer. Documentation must be submitted from the physical therapist describing the patient's inability to complete PT.
  3. For patients with chronic discogenic back pain without instability (policy section IV), documentation regarding the absence of untreated, underlying, contributory mental health conditions or psychosocial issues including, but not limited to, depression or drug or alcohol abuse must be submitted by the patient's primary care physician or a Mental Health Professional. The Mental Health Professional must meet the Minnesota Department of Human Services qualifications, as set forth in Minn.Stat. §245.462, subd. 18 (2013) and Minn.Stat. §245.4871, subd 27 (2013).

Policies inactivated

None

There was no Medical and Behavioral Health Policy Activity for July 2015

Policies reviewed with no changes in May 2015 and June 2015:

Acupuncture

Artificial Intervertebral Disc: Cervical Spine

Belimumab

Cardiovascular Disease Risk Assessment and Management: Laboratory Evaluation of Non-Traditional Lipid and Nonlipid Biomarkers

Cellular Immunotherapy for Prostate Cancer

Chelation Therapy

Computerized Dynamic Posturography

Continuous and Intermittent Glucose Monitoring of Interstitial Fluid

Cytochrome P450 Genotyping

Digital Breast Tomosynthesis

Electrocardiographic (ECG) Body Surface Mapping

Endoscopic Radiofrequency Ablation or Cryoablation for Barrett's Esophagus

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

H.P. Acthar Gel (Repository Corticotropin)

Hematopoietic Stem-Cell Transplantation for Non-Hodgkin Lymphomas

Hematopoietic Stem-Cell Transplantation for Primary Amyloidosis

Hematopoietic Stem-Cell Transplantation for Waldenstrom Macroglobulinemia

Image-Guided Minimally Invasive Lumbar Decompression for Spinal Stenosis

Liposuction

Lung Cancer Screening Using Computed Tomography (CT)

Mastopexy

Microprocessor-Controlled Prosthesis for the Lower Limb

Myoelectric Prosthesis for the Upper Limb

Organ Transplantation

Percutaneous and Endoscopic Techniques for Disc Decompression

Peripheral Nerve Stimulation of the Trunk or Limbs for Treatment of Pain

Rhinomanometry and Acoustic/Optical Rhinometry

Sleep Studies / Polysomnograms in Children and Adolescents

Spinal Unloading Devices: Patient-Operated

Stem-Cell Therapy for Peripheral Arterial Disease

Subcutaneous Hormone Pellets

Surgical Interruption of Pelvic Nerve Pathways for Primary and Secondary Dysmenorrhea

Systems Pathology Testing for Predicting Risk of Recurrence in Prostate Cancer

Urine Drug Testing for Substance Abuse Treatment and Chronic Pain Management

Wireless Gastric Motility Monitoring

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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