Provider Press

Provider information

December 2015 / Vol. 19, No. 4

BlueCross BlueShield Minnesota

BLUE CROSS AND BLUE SHIELD OF MINNESOTA'S NEW OPERATING SYSTEM

Blue Cross and Blue Shield of Minnesota (Blue Cross) determined a number of years ago that our current operating system was not sustainable into the future and embarked on identifying and implementing a new operating system.

After a significant amount of work, Blue Cross began migrating a small group of subscribers to the new operating system on November 1, 2015. On January 1, 2016, a larger group of subscribers, which includes subscribers with an Individual Commercial Plan, as well as Blue Cross employees, will migrate to the new operating system. Subscriber migration will continue over the next few years, with a goal of having all subscribers migrated to the new operating system by the end of 2018.

While the change to the new operating system results in large changes to Blue Cross's internal processes, Blue Cross intends to make the change as seamless as possible for providers. Some differences have been identified and communicated in Bulletins and Quick Points. As any other impacts to providers are identified, these will be communicated in a manner appropriate to the impact. Blue Cross is committed to open, frequent, and transparent communication during this multiyear transformation of our operating system.

A webpage has been created to consolidate the information about our Operating System Transition to one location on our website and will be updated as the need for new or additional communication is identified. A link to the webpage can be found in the Tools and Resources section of **providers.bluecrossmn.com**. All communication, including Bulletins and Quick Points, related to the transition can be found on this webpage.

FYI

MEMBER RIGHTS AND RESPONSIBILITIES

Blue Cross and Blue Shield of Minnesota and Blue Plus member rights and responsibilities can be found online at **bluecrossmn.com** by entering 'member rights' in the search field.

A paper copy of members' rights and responsibilities is available upon request. Call Jessica Titus, Sr. Project Manager, Quality and Health Management at **(651) 662-2038** to request a paper copy.

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 September 2015 to November 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
QP17-15	Who is BlueLink TPA?
QP18-15	New Operating System – Sample Identification Card
QP19-15	Emdeon Coding Advisor
QP20-15	Quality Improvement Information Available in Provider Press Publication
QP21-15	Reorganized Medical Policy and Utilization Management Website Landing Pages
QP22-15	New Operating System Provider Transaction Differences
QP23-15	Retirement of Clear Claim Connection
QP24-15	Blue Cross Is Offering Two New Networks In 2016
QP25-15	Prior Authorization, Appeals and Medical Record Requests for Platinum Blue and SecureBlue Subscribers
QP26-15	XE, XP, XS, XU Modifier Update
QP27-15	New Medicare Star Ratings Program Provider Website
QP28-15	Free Webinar November 12, 2015: Shared Decision-Making & Depression Treatment in Primary Care
QP29-15	New Operating System- Anesthesia Related Procedure Submission
QP30-15	New Operating System-Institutional Claim Submissions
QP31-15	New Operating System - MNCare Tax on Remits
QP32-15	New Operating System - Submitting a Subscriber ID
BULLETINS	**TITLE**
P30R1-15	Revised: ICD-10 Coding Update and Final Reminders
P31R1-15	Revised: Common Carrier and Special Transportation Providers Billing Code Updates
P32-15	Medical Policies on the New Operating System Effective November 1, 2015
P33-15	Operating System Grouper Update Timing Differences
P34-15	New Operating System – Code Edit Changes Notification
P35-15	New Operating System - Allowed Code Based on Higher Charge Rather than Higher RVU in Incidental or Mutually Exclusive Edits
P36-15	Providers will see a Change in our Prior Authorization Process for Commercial Products
P37-15	Billing DME Upgrades for Platinum Blue Subscribers
P38-15	New Drug-related Prior Authorization Criteria: Insulin Prior Authorization with Quantity Limit
P39-15	Elimination of Prior Authorization Requirements for Two Medical Policies
P40-15	October 2015 HCPCS Code Updates

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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

PUBLICATIONS AVAILABLE ONLINE - continued from previous page

BULLETINS	TITLE
P41-15	Medicare Requirements for Reporting Provider Demographic Changes
P42-15	Addition of Drugs to the Self-Administered Oncology Prior Authorization with Quantity Limit Program
P43-15	Addition of Hepatitis C Drugs to Existing Drug-related Prior Authorization Programs
P44-15	Medical Necessity Review Criteria Change for Residential Stays for Chemical Dependency

PROVIDER MANUAL UPDATES

The following is a list of Blue Cross provider manuals that have been updated from September 2015 to November 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	SUMMARY OF CHANGES
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Public Programs sub-section	Transportation Services (Special Transportation Services and Common Carrier)
Blue Plus Manual	Chapter 3, Government Programs	• Family Health Protocols Transportation, • Special Transportation Services and Common Carrier
Blue Plus Manual	Chapter 5, Health Care Improvement	Clinical Practice Guidelines
Provider Policy and Procedure Manual	Chapter 4, Integrated Health Management	Medical Policy and Behavioral Health Policy Manual Pre-Certification Requirements for Local Blue Cross Plan Patients
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Maternity sub-section	Reproduction Treatment
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Pharmacy sub-section	Prior Authorization Compound Prescriptions and Specialty Drugs

2016 HOLIDAY SCHEDULE

Provider services will be closed on the following days in 2016:

Friday, January 1

Monday, May 30

Monday, July 4

Monday, September 5

Thursday, November 24

Friday, November 25

Monday, December 26

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

HOME INFUSION "PER DIEM" BILLING REMINDER

The complete policy is found in Chapter 11 of the Blue Cross Provider Policy and Procedure Manual, but here is a reminder of one of the types of items that can be billed – the "per diem" codes. The HCPCS "S" codes for home infusion services are based on a "per diem" reimbursement methodology. The per diem includes all supplies, care coordination and professional pharmacy services. The per diem is billed for each day that a patient is receiving the home infusion services from date of admission through date of discharge. Only **one** per diem code is allowed regardless of the number of drugs or other services rendered.

READ THOSE CPT NOTES

In addition to the code and narrative, CPT includes many parenthetical notes following the code entry. Take advantage of this information to help identify correct coding submission and avoid denials. For example, the parenthetical note following teletherapy isodose plan code 77307 includes "Do not report 77306-77307 in conjunction with 77300". Another example is the parenthetical note following code 88431 which indicates "(Do not use more than one unit of 878341, 88342, 88344 for each separately identifiable antibody per specimen)".

YES, WE STILL ACCEPT THE CPT CONSULTATION CODES

CMS does not allow submission of inpatient and outpatient consultation codes for Medicare claims. This coding and submission will be followed only for our Medicare business. There is **no** change for all other lines of business. Blue Cross accepts all valid HIPAA medical codes. The consultation codes **99241-99245** and **99251-99255** are still valid CPT codes and as such will be accepted. We expect that the documentation will support any code submitted.

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.	

HEALTH LITERACY

PROMOTING HEALTH LITERACY AND CULTURAL COMPETENCY IN YOUR PRACTICE

Your practice office staff is your front line of communication. Patients most likely interact with your office staff at a much higher frequency than the physicians at your practice. Patients call your staff to not only schedule appointments but to ask a wide array of health care questions. At Blue Cross our customer service representatives are our front line. To ensure our representatives are prepared to address the needs of our members effectively we emphasize the importance of member understanding through health literacy and cultural competency training.

If a patient's first experience is speaking with a staff member who recognizes that understanding health and insurance information is challenging and uses plain language to address questions, they are more likely to have a better experience. Better yet, if office staff are bilingual or represent cultures served by your clinic, interactions with these staff can lead to a more positive interaction with the physician during their visit because the patient's literacy and cultural needs have already been recognized. Successful medical encounters require effective communication between everyone in the clinic and the patient.

Awareness is the first step to incorporate a continuous process of integrating health literacy and cultural competency in your practice. Communicating to patients in a more relatable fashion will promote higher compliance with actions needed to reach health care goals. The Agency for Healthcare Research and Quality recommends training all staff, from front office staff to the medical director, in better understanding the impacts of health literacy and to consistently work on making health care easier.

Nutrition Facts

Serving Size	½ cup
Servings per container	4
Amount per serving	
Calories 250	Fat Cal 120
	%DV
Total Fat 13g	20%
Sat Fat 9g	40%
Cholesterol 28mg	12%
Sodium 55mg	2%
Total Carbohydrate 30g	12%
Dietary Fiber 2g	
Sugars 23g	
Protein 4g	8%

*Percentage Daily Values (DV) are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.

Ingredients: Cream, Skim Milk, Liquid Sugar, Water, Egg Yolks, Brown Sugar, Milkfat, Peanut Oil, Sugar, Butter, Salt, Carrageenan, Vanilla Extract.

The nutrition label shown is from the Newest Vital Sign (Ann Fam Med. 2005; 3(6):514-22)

Try this exercise at your next staff meeting:

Use the nutrition label on the right to answer this question - "Your doctor advises you to reduce the amount of saturated fat in your diet. You usually have 42g of saturated fat each day, which includes one serving of ice cream. If you stop eating ice cream, how many grams of saturated fat would you be consuming each day?"

Staff discussion questions

- What did it feel like to be asked to answer that question?
- Did you experience any anxiety related to having to do a mathematical calculation?
- What examples of health literacy barriers have you encountered when working with our patients?

Additional recommendations to educating staff

Like with blood safety, experts recommend a universal precautions approach be taken to address health literacy because we can't know which patients are challenged by health care information and tasks at any given time.

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HEALTH LITERACY

PROMOTING HEALTH LITERACY AND CULTURAL COMPETENCY IN YOUR PRACTICE - continued from previous page

Raise awareness in your staff by:

- Showing the video American College of Physician's Health Literacy Video (6 minutes).
- Showing the American Medical Association video Health Literacy and Patient Safety: Help Patients Understand (23 minutes).
- Play a plain language game. Ask teams of staff members to come up with plain language alternatives and descriptions for common medical terms.
- Have staff and clinicians role play good and bad health literacy practices.

Make sure to have a plan for revisiting the topic of health literacy periodically and training new staff. If you have fellows or residents, be sure to emphasize during their training that they're learning communication skills that will be valuable regardless of their chosen specialty.

CODING CORNER

CHECK OUT THE AUC

The Minnesota Administrative Uniformity Committee (AUC) is a voluntary, broad-based group representing Minnesota health care public and private payers, hospitals, health care providers and state agencies, working to standardize, streamline, and simplify health care administrative processes. Blue Cross is an active member of the AUC and several Technical Action Groups (TAG).

As part of the of the Health Care Administrative Simplification Act (ASA) of 1994, the Minnesota Department of Health's (MDH) Center for Health Care Purchasing Improvement (CHCPI) develops and implements rules (i.e., Minnesota uniform companion guides) for the standard, electronic exchange of health care administrative transactions pursuant to Minnesota Statutes Section 62J.536 and related rules. This work is undertaken in consultation with the AUC.

Check out the AUC at http://www.health.state.mn.us/auc/index.html for MN claims and coding companion guides, best practices and forms.

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

REVIEW UM CRITERIA

Blue Cross and Blue Plus utilization management (UM) programs use written utilization review criteria to make medical necessity determinations. Upon request, any Blue Cross or Blue Plus practitioner may review the clinical criteria used to evaluate an individual case. Medical and behavioral health policies are available for your use and review on the Blue Cross website at **providers.bluecrossmn.com**.

QUALITY IMPROVEMENT

INTRODUCING THE BLUE CROSS STAR RATINGS WEBSITE

Announcing the 2016 Star Ratings
Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) achieved a 4.5 Star rating for our Platinum Blue℠ Cost plan and a 4 Star rating on the SecureBlue℠ (HMO SNP) Minnesota Senior Health Option (MSHO) plan. We are pleased with the results which reflect our shared dedication to the delivery of high quality care that results in optimal health outcomes for the Medicare beneficiaries we jointly serve.

As part of our ongoing commitment to quality improvement, Blue Cross is pleased to introduce the Medicare Star Ratings Program website designed specifically for providers. The website successfully launched on October 16, 2015.

The website includes information about the Star Ratings Program as well as best practices and resources designed to help improve the quality of care delivered to your patients. You can also access educational information, Star ratings updates, and programs/services offered to our members to help them take charge of their health. We look forward to working together with you to continue to provide our members and your patients with the highest quality care available. We hope you find this information useful. We welcome your feedback which will help us to improve the website functionality and content to better meet your needs.

How to access the website
https://www.bluecrossmn.com/healthy/public/personal/home/providers/

Click on Star Ratings Program under "Tools and Resources" or Click on Tools & Resources under "What's Inside."

FYI

PHARMACY INFORMATION

Did you know that information regarding pharmacy or prescription drugs can be found in our Provider Policy and Procedure Manual? Below are a few examples of some of the topics that providers are able to learn more about:

- Claims Processing
- Prior Authorizations
- Drug Formulary
- Step Therapy Program

Please refer to the Pharmacy Services section of the Provider Policy and Procedure Manual. To access the manual go to **providers.bluecrossmn.com** and select "Forms and Publications" then "Manuals."

There are additional tools and resources online related to Pharmacy on our website as well. To access these materials go to **providers.bluecrossmn.com** and select "Prescription drugs" under the "Tools and Resources" section.

FYI

THE CHLAMYDIA EPIDEMIC AND PRIVACY CHALLENGES

The American Academy of Family Physicians and the American Academy of Pediatrics fully support the recommendation to screen all sexually active females 25 years of age and younger for chlamydia. And yet, chlamydia screening percentage rates, based on Blue Cross and Blue Shield of Minnesota (Blue Cross) HEDIS data, continue to fall below the national Medicaid 25th percentile. So what's the problem?

Barriers still surround STI testing. Teens cite fear, shame and the simple lack of symptoms, as reasons they don't get tested. But what about our side of the table. The more we explore the lack of teen screening, the more is revealed regarding a system failing to ensure privacy. In both the urban and rural areas, challenges include the parents' desire for information as well as physicians and clinics dealing with an electronic medical record or paper chart that doesn't effectively manage sensitive sexual health screening information. The lack of automated confidentiality measures clearly discourages adolescents.

Blue Cross has explored our own internal processes and discovered similar challenges. The Explanation of Benefits (EOB), which is typically sent after a visit, may be just enough to "blow someone's cover." Although a chlamydia screening will be coded as "lab test," it still identifies that an office visit has taken place. The complexity of when and who receives an EOB adds to the puzzle. A Medicaid member will never get an EOB, so this population will never have a paper trail following a visit. However, an EOB in the commercial population has many more exceptions. Is the visit coded as a preventive visit? Did the employer group opt to have all EOBs sent to the member? Was the visit with a non-participating provider? Reflecting on our current practices, Blue Cross continues to work towards enhanced member communication and looks forward to implementing electronic EOB delivery. Regardless of technology, our providers should be aware that patients can request confidential communication. Any member, 12+ years of age, can call our customer service department and request their EOB be sent to an alternate mailing address.

The lesson learned? Minnesota healthcare has a keen awareness around teen privacy, but we still have miles to go. EMRs are getting more sophisticated, clinics have refined policies and guidelines, and physicians, health plans and community networks continue to educate our teen population. Blue Cross remains a participant in the Minnesota Chlamydia Partnership. This endeavor allows for ongoing development of resources to improve chlamydia screening rates and to support our providers.

If your clinic would like support, including quarterly member lists for screening follow up, please contact Linda Bohlig in the Health Management Quality Department at: linda.bohlig@bcbsmn.com.

ADDITIONAL RESOURCES:	
Minnesota Chlamydia Partnership website:	**http://www.mnchlamydiapartnership.org/**
Collaborative Health Plan Provider Toolkit:	**http://www.stratishealth.org/pip/documents/Chlamydia_Toolkit.pdf**

REALLY SIMPLE SYNDICATION

Not all provider publications are mailed out to providers. All 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
- Quick Points
- Manuals
- Provider Press
- Forms: admin updates and contracting
- Forms: credentialing
- Forms: pre-certification and pre-authorization

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.

FYI

COORDINATING CARE FOR PATIENTS – FOCUS GROUP FEEDBACK FROM EMERGENCY DEPARTMENTS AND PRIMARY CARE PHYSICIANS

A successful continuity of care program must address all parties: patients, physicians and health plans. Helping patients understand the health care network and how to get the right care, at the right time, from the right place is key. Effective coordination of care is important to ensure a consistent and reliable patient experience and improvement in health outcomes. Health plans can facilitate discussions between physician groups to forge connections to create a more consistent communication bridge without adding to the workload.

Blue Cross conducted a focus group research study on care coordination between Emergency Departments (EDs) and Primary Care Physicians (PCPs) to better understand gaps and opportunities related to continuity and coordination of care for patients who visit the ED. Four focus groups with medical professionals from emergency departments and ambulatory clinics were conducted in August 2015 along with a discussion session with the Blue Cross Physician Quality Advisory Group. Our research objectives were to:

- Better understand the degree to which care is coordinated between EDs and PCPs
- Learn what barriers EDs and PCPs face in both receiving and providing pertinent information with each other
- Gather recommendations on improving communication and coordination of care between PCPs and EDs

Key Takeaways

Patients show up in the ED for a variety of reasons and with very different health status levels. ED physicians enjoy the challenge of working in the ED and can be frustrated by the lack of history they are able to obtain about patients and their conditions. PCPs enjoy the long-term relationships they build with patients and yet they too struggle to obtain timely and useful information about patients who have visited EDs, especially when patients are referred to them after an ED visit for the first time. Both avenues of care commented that they do receive information, but that it is often not timely and doesn't include the information they really want. Both also report issues with trying to connect and share information, even when they want to. For instance, inability to reach the ED physician who will actually see the patient or difficulty getting to speak with a physician who is overbooked in the primary care setting.

This may sound bleak, but the good news here is that both groups want to share information and want to make this information meaningful and useful for their colleagues and their patients.

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FYI

COORDINATING CARE FOR PATIENTS – continued from previous page

Primary Barriers

Primary care physicians often don't know why patients were in the ED, if they know they were there at all.

- The lag time for notes to be dictated, transcribed and sent may be longer than anticipated
- Physician schedule may simply say "ED follow-up" but provide little additional information

"I had three come in today, three ER follow-ups. I had no records on any of them except for what the patient brought me and I didn't know they were there. My schedule at 2 o'clock is so and so from the ER, and I don't know why." – PCP Participant

Information is not in a format that is easily stored or used by physicians in both EDs and primary care.

- Current discharge instructions are overly long, complex, confusing and don't serve to effectively communicate issues and follow up needs
- Discharge plans have to be written for two audiences – for the patient and for their PCP

"You spend 5 minutes trying to search the document for what you need…because the format is really unusual or there's so much extraneous information" - PCP Participant

Process and schedules make it difficult to connect in person with other physicians to consult on shared cases.

- Phone call contacting often means the answering ED team may be different than those who originally saw the patient
- It can be difficult to identify the right personnel and ensure that the messages are recorded and filed appropriately

"One barrier is that a primary physician may call into our ER needing information but at any given time we may have five providers working, and so you never know where the patient will land" – ED Participant

Recommendation Highlights

- ED and PCP participants both agreed patient education on authorizations to share information could greatly benefit communication abilities between EDs and PCPs. ED physicians felt that patients may not be aware of the limits of physician communication when an authorization to disclosure is not in place.
- Standardize discharge summaries and develop critical patient information sheets that show the most important information about a patient. Participants suggested creating a brief "face page" that PCPs could use to convey critical patient information in an easy to understand, digestible and current state overview.

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FYI

COORDINATING CARE FOR PATIENTS – continued from previous page

Recommendation Highlights

- Create pathways for additional funding for care coordination activities and resources.
- Advocate for uniform standards for medical records, release of information forms, and sharing of information between different care systems/providers.

PCPs and EDs Value Continuity of Patient Care

"I honestly love that longitudinal care and helping keep people active and healthy. In Minnesota, we do a really good job of that and I love having that responsibility for people." - PCP Participant

"What I find rewarding about it is seeing a lot of different variety of patients, kind of all age groups and different stages of health and trying to figure out what they're in for and what we can do to help them." – ED participant

CHOLESTEROL SCREENING IN DIABETICS TO REDUCE CARDIOVASCULAR RISK UPDATE 2015

One of the goals of our Chronic Care Improvement Program for members with diabetes is to reduce and/or manage risk factors for cardiovascular disease. In 2012, CMS directed all Medicare Advantage plans to leverage information from the American Heart Association's One Million Hearts campaign and implement a quality project aimed at improving at least one of the ABCs of Cardiovascular Care for members with Diabetes. Blue Plus chose to address cholesterol management and improve annual LDL-screening rates by eight percentage points based on the 2012 Healthcare Effectiveness and Information Set® (HEDIS) technical specifications and rate. This is a five year project and the following table illustrates year-to-year comparison of administrative rates.

Year-to-Year Data Results

LDL SCREENING FOR SECUREBLUE (MSHO) MEMBERS WITH DIABETES - CCIP PROJECT				
	HEDIS 2012	HEDIS 2013	HEDIS 2014	HEDIS 2015
Measurement Year	2011 (Baseline)	2012	2013	2014
Administrative Rates (Member Ages up to 75 Years per 2012 HEDIS Specifications)	80.23%	82.12%	84.74%	81.75%

While we are seeing slight improvements in our rates from baseline, we have a long way to go to reach our stated goal. This year, in addition to annual Care Coordinator training, an intervention was added to assist the Care Coordinator's efforts in completing an annual Health Risk Assessment (HRA). A quarterly member-specific data report has been provided to the Care Coordinator identifying any potential "gaps in care" based on claims not received for a select number of quality measurements, including LDL screening. Throughout the year at touchpoints with the member, and/or especially in these last few months of 2015, the Care Coordinator will address individual health care needs, educate, and assist members in getting in to see their provider.

Thank you for your partnership in meeting the healthcare needs of this vulnerable population to support living healthy and enhancing quality of life. Direct any questions concerning this project to Sheila Dalen, RN, Sr. Project Manager, Quality and Health Management at **(651) 662-1170** or **sheila.dalen@bluecrossmn.com**.

FYI

DISEASE MANAGEMENT PROGRAM

Medical Management includes a process for Disease Management (DM). This program is intended to increase advocacy, support and education for our subscribers.

Disease management is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations who have or are at risk for, chronic medical and behavioral health conditions. Disease management supports the practitioner-patient relationship and plan of care, emphasizes the prevention of exacerbation and complications using cost-effective, evidence-based practice guidelines and patient empowerment strategies such as education and self-management.

The process of disease management evaluates clinical, social/humanistic and economic outcomes with the goal of improving overall health of the whole person. Subscribers who receive disease management services receive support from a dedicated clinician, who assists in facilitating the health of the whole person, not just their individual condition.

Disease Management clinicians may call the provider when the subscriber triggers for DM and meets our provider call criteria. Provider call criteria may include:

- Concerns about subscriber's compliance with the treatment plan
- Lack of clarity about subscriber's treatment plan

Providers may also receive a letter including the subscriber's goals and/or gaps in care to inform the provider on what Blue Cross is working on with the subscriber to advance their health care needs. Blue Cross looks forward to working with its Subscriber's Health Care Practitioners to make a healthy difference in the health of its Subscribers.

Additional information regarding our Disease Management program can be found in Chapter 4 of the Provider Policy and Procedure Manual. To access the manual, go to **providers.bluecrossmn.com** and select "Forms and Publications" then "Manuals."

For questions about Disease Management or if would like to determine program eligibility for one of your patients, please contact provider services at **(651) 662-5200** or **1-800-262-0820**.

Please note: Services are offered to subscribers, however, participation is optional. Subscriber eligibility for disease management is determined by their Benefit Plan.

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:
Under "Medical Policy and Pre-Certification/Authorization Router," 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 Tools & Resources), and then read and accept the Blue Cross Medical Policy Statement. You have now navigated to the Blue Cross and Blue Shield of Minnesota Medical Policy web page.

Click on the "+" (plus) sign next to "Medical and Behavioral Health Policies."

- The "Upcoming Medical Policy Notifications" 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.
- The "Medical and Behavioral Health Policies" section lists all policies effective at the time of your inquiry.
    - Note: On November 1, 2015, Blue Cross and Blue Shield of Minnesota began migrating subscribers from our legacy operating system to our new operating system. Subscriber migration will continue over the next few years with the goal of having all subscribers migrated to the new operating system by the end of 2018. During the migration, there will be two sets of medical policies: one for migrated subscribers (new operating system) and one for non-migrated subscribers (legacy operating system). Please follow the instructions on the web page to select the applicable medical policy based upon the member's migration status. This change was previously communicated in the Provider Bulletin entitled "Medical Policies on the New Operating System Effective November 1, 2015" (P-32-15), which published September 9, 2015.

Click on the "+" (plus) sign next to "Utilization Management."

- The Pre-Certification/Pre-Authorization lists identify various services, procedures, prescription drugs, and medical devices that require pre-certification/pre-authorization. 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: 10/19/15 Notification Posted: 09/01/15

Policies developed

Whole Body Dual X-Ray Absorptiometry (DXA) to Determine Body Composition

- Whole body dual x-ray absorptiometry to determine body composition is considered INVESTIGATIVE for all indications due to the lack of clinical evidence demonstrating its impact on improved health outcomes.

Policies revised

Genetic Testing for Hereditary Breast and/or Ovarian Cancer Syndrome (BRCA1 and BRCA2 Genes)

- Genetic testing of *BRCA1* and *BRCA2* may be considered MEDICALLY NECESSARY for an individual with a close blood relative who has a known deleterious mutation in *BRCA1* and/or *BRCA2*. Individuals who meet this criterion are candidates for *BRCA* single-site (known family variant) analysis.
- Genetic testing of *BRCA1* and/or *BRCA2* may be considered MEDICALLY NECESSARY for an individual with **a personal history** of one or more of the following:
  - A. Breast cancer
  - B. Ovarian cancer
  - C. Fallopian tube cancer
  - D. Primary peritoneal cancer
  - E. Pancreatic cancer at any age meeting either 1 or 2 below:
    1. One or more close blood relative(s) with one of the following:
       a. Breast cancer at age 50 or younger; and/or
       b. Ovarian, fallopian tube, or primary peritoneal cancer at any age; and/or
       c. Pancreatic cancer at any age.

    OR

    2. Ashkenazi Jewish ancestry.
  - F. Prostate cancer (Gleason score of 7 or greater) at any age with one or more close blood relative(s) meeting either 1, 2, or 3 below:
    1. Breast cancer at age 50 or younger, and/or
    2. Ovarian, fallopian tube, or primary peritoneal cancer at any age; and/or
    3. Pancreatic cancer or prostate cancer (Gleason score of 7 or greater) at any age.
- Genetic testing of *BRCA1* and/or *BRCA2* may be considered MEDICALLY NECESSARY for an individual 18 years of age or older with no personal history of cancers listed in section I or II of this policy who:
  - A. Has received pre-test genetic counseling by a healthcare professional who has the appropriate genetics training and experience and is independent of the laboratory performing the test;
    AND
  - B. Has a reasonable likelihood of a mutation based on pre-test genetic counseling AND an appropriate affected family member is unavailable for testing (e.g., affected relative refuses testing or relative is deceased);
    AND
  - C. Meets 1 or 2 below:
    1. A first-or second-degree blood relative meets any of the criteria in section II of this policy;
       OR
    2. A third-degree blood relative with breast cancer and/or ovarian, fallopian tube or primary peritoneal cancer; AND

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who has **either** of the following:

a. Two or more close blood relatives from the same side of the family have with breast cancer (at least one with breast cancer diagnosed at age 50 or younger); AND/OR
b. Two or more close blood relatives from the same side of the family have with ovarian, fallopian tube or primary peritoneal cancer.

- Testing for rearrangements of the *BRCA1* and *BRCA2* genes may be considered MEDICALLY NECESSARY for an individual who:
  A. Meets criteria in sections I, II, or III of this policy;
  AND
  B. Has tested negative for mutations in *BRCA1* and/or *BRCA2* sequencing.
- *BRCA1* and/or *BRCA2* testing is considered INVESTIGATIVE for all other indications, including but not limited to the following due to a lack of clinical evidence demonstrating its impact on improved health outcomes:
  A. Testing in individuals younger than age 18 without a personal history of cancers addressed in this policy
  B. Laboratory testing for mutations in *BRCA1* and/or *BRCA2* in the general population
- Genetic testing for hereditary breast and/or ovarian cancer syndrome using multi-gene next generation sequencing panels is considered INVESTIGATIVE.
  Note: This medical policy describes medically necessary indications for the distinct *BRCA1* and *BRCA2* CPT® codes listed in the Coding Section of the policy. *BRCA1* and *BRCA2* components of a multi-gene panel will be eligible for coverage when the member meets medical necessity criteria. Codes for other genetic tests included in the panel will be denied.
- Documentation from the ordering clinician supporting the medical necessity criteria described in the policy must be included in the prior authorization. In addition, the following documentation must be submitted:
  1. Documentation of a known deleterious *BRCA1* and/or *BRCA2* mutation in a close blood relative (policy section I);
     OR
  2. Diagnosis of individual with personal history of cancer (policy section II);
     OR
  3. For a patient without a personal history of cancer (policy section III) verification of pre-test genetic counseling, as defined above, by a healthcare professional who has the appropriate genetics training and experience and is independent of the laboratory performing the test.

Policies inactivated

Multianalyte Assays with Algorithmic Analyses for Assessing Risk of Type 2 Diabetes
Digital Breast Tomosynthesis
Advanced Glycation Endproducts (AGEs) Measurement by Skin Autofluorescence
Electrotherapy/Electrotherapeutic Devices
KRAS Mutation Analysis

Policies Effective: 10/29/15 Notification Posted: 09/08/15

Policies developed

None

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Policies revised

Anesthesia Services for Routine Upper and/or Lower Gastrointestinal Endoscopic Procedures

- Intravenous sedation ("conscious sedation") ordered by the attending physician and administered by the surgeon or physician performing the gastrointestinal endoscopic procedure may be considered MEDICALLY NECESSARY.
- Other types of anesthesia services including general and monitored anesthesia care (MAC) may be considered MEDICALLY NECESSARY during routine upper and/or lower gastrointestinal endoscopic procedures when there is documentation by the operating physician and/or the anesthesiologist that ANY of the following situations exist:
  - A. Prolonged or therapeutic endoscopic procedure requiring deep sedation; OR
  - B. A history of or anticipated intolerance to standard sedatives (e.g., patient is on chronic narcotics or benzodiazepines, or patient has a neuropsychiatric disorder, history of idiosyncratic reaction to sedatives, or a neurodevelopmental impairment); OR
  - C. Increased risk for complications due to mild to severe comorbidity (American Society of Anesthesiologists [ASA] Physical Status 2 or greater); OR
  - D. Patients over 70 years of age; OR
  - E. Patients less than 18 years of age; OR
  - F. Pregnancy; OR
  - G. Patients with active medical problems related to drug or alcohol abuse; OR
  - H. Uncooperative or acutely agitated patients (e.g., delirium, organic brain disease, senile dementia); OR
  - I. Morbid obesity (body mass index [BMI] > 40); OR
  - J. Spasticity or movement disorder complicating the procedure; OR
  - K. Increased risk for airway obstruction due to anatomic variant including ANY of the following:
    1. History of previous problems with anesthesia or sedation; OR
    2. History of stridor or sleep apnea; OR
    3. Dysmorphic facial features, such as Pierre-Robin syndrome or trisomy-21; OR
    4. 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
    5. Neck abnormalities including, but not limited to, short neck, obesity involving the neck and facial structures, limited neck extension, decreased hyoid-mental distance (less than 3 cm in an adult), neck mass, cervical spine disease or trauma, tracheal deviation, or advanced rheumatoid arthritis; OR
    6. Jaw abnormalities including, but not limited to, micrognathia, retrognathia, trismus, or significant malocclusion; OR
  - L. Increased risk of aspiration.
- The routine assistance of an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) for patients not meeting the above criteria (section II) who are undergoing standard upper and/or lower gastrointestinal endoscopic procedures is considered NOT MEDICALLY NECESSARY.

Policies inactivated

None

Policies Effective: 11/16/15 Notification Posted: 09/24/15

Policies developed

None

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Policies revised

Rituximab

- Rituximab may be considered MEDICALLY NECESSARY for the following:
  - A. Oncologic Indications
    1. Acute lymphoblastic/lymphocytic leukemia (ALL)
    2. Central nervous system (CNS) lymphoma (e.g., primary CNS lymphoma, leptomeningeal metastases from lymphomas)
    3. Chronic lymphocytic leukemia (CLL)
    4. Hairy cell leukemia
    5. Hodgkin's lymphoma (e.g., nodular lymphocyte-predominant Hodgkin lymphoma)
    6. Non-Hodgkin's lymphoma (NHL) (e.g. AIDS-related B-cell lymphoma, B-cell lymphoma, Burkitt's lymphoma, chronic lymphocytic leukemia/small lymphocytic lymphoma, diffuse large B-cell lymphoma, follicular lymphoma, gastric mucosa-associated lymphoid tissue (MALT) lymphoma, lymphoblastic lymphoma, mantle cell lymphoma, nodal marginal zone lymphoma, non-gastric MALT lymphoma, primary cutaneous B-cell lymphoma, and splenic marginal zone lymphoma)
    7. Waldenström's macroglobulinemia/lymphoplasmacytic lymphoma
  - B. Non-Oncologic Indications
    1. Autoimmune hemolytic anemia (AIHA)
    2. Autoimmune mucocutaneous blistering diseases (e.g., pemphigus vulgaris, pemphigus foliaceus, paraneoplastic pemphigus, bullous pemphigoid, mucous membrane pemphigoid, epidermolysis bullosa acquisita), refractory to glucocorticoids
    3. Castleman's disease/angiofollicular lymph node hyperplasia
    4. Chronic graft versus host disease, refractory to glucocorticoids and immunosuppressants
    5. Granulomatosis with polyangiitis (GPA or Wegener's granulomatosis) and microscopic polyangiitis (MPA), in combination with glucocorticoids
    6. Idiopathic or immune thrombocytopenic purpura (ITP)
    7. Moderately-to-severely-active rheumatoid arthritis, in combination with methotrexate following an inadequate response to one or more tumor necrosis factor (TNF) antagonist therapies
    8. Neuromyelitis optica
    9. Post-transplant lymphoproliferative disorder (PTLD)
    10. Thrombotic thrombocytopenic purpura (TTP), in combination with glucocorticoids and plasma exchange
- The use of rituximab is considered INVESTIGATIVE for all other indications due to the lack of clinical evidence demonstrating an impact on improved health outcomes.

Panniculectomy/Excision of Redundant Skin or Tissue

- The following change has been made to policy. Other policy criteria have not been substantively revised:
  - Suction-assisted protein lipectomy (SAPL) of the lower extremities is considered INVESTIGATIVE due to a lack of evidence demonstrating its impact on improved health outcomes.

Sublingual Immunotherapy Drops for Allergy Treatment

- Sublingual immunotherapy drops are considered INVESTIGATIVE for allergy treatment due to the lack of clinical evidence demonstrating an impact on improved health outcomes.

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Policies inactivated
None

Policies Effective: 12/21/15 Notification Posted: 10/30/15

Policies developed
None

Policies revised

Intravitreal Angiogenesis Inhibitors for Treatment of Retinal and Choroidal Vascular Conditions

- Pegaptanib (Macugen)
  - A. Intravitreal injections of pegaptanib may be considered MEDICALLY NECESSARY as a treatment of neovascular (wet) age-related macular degeneration.
  - B. The use of pegaptanib for treatment of all other conditions is considered INVESTIGATIVE.
- Aflibercept (Eylea)
  - A. Intravitreal injections of aflibercept may be considered MEDICALLY NECESSARY for treatment of the following conditions:
    1. Neovascular (wet) age-related macular degeneration;
    2. Macular edema following retinal vein occlusion;
    3. Diabetic macular edema, including diabetic retinopathy in patients with diabetic macular edema.
  - B. The use of aflibercept for treatment of all other non-neoplastic conditions is considered INVESTIGATIVE.
- Ranibizumab (Lucentis)
  - A. Intravitreal injections of ranibizumab may be considered MEDICALLY NECESSARY for treatment of the following conditions:
    1. Neovascular (wet) age-related macular degeneration;
    2. Macular edema following retinal vein occlusion;
    3. Diabetic macular edema, including diabetic retinopathy in patients with diabetic macular edema;
    4. Proliferative diabetic retinopathy as an adjunctive treatment to vitrectomy or photocoagulation;
    5. Choroidal neovascularization due to angioid streaks, central serous chorioretinopathy, choroidal rupture or trauma, idiopathic choroidal neovascularization, multifocal choroiditis, pathologic myopia, presumed ocular histoplasmosis syndrome or uveitis.
  - B. The use of ranibizumab for treatment of all other conditions is considered INVESTIGATIVE.
- Bevacizumab (Avastin)
  - A. Intravitreal injections of bevacizumab may be considered MEDICALLY NECESSARY for treatment of the following conditions:
    1. Neovascular (wet) age-related macular degeneration;
    2. Macular edema following retinal vein occlusion;
    3. Diabetic macular edema;
    4. Proliferative diabetic retinopathy as an adjunctive treatment to vitrectomy or photocoagulation;
    5. Choroidal neovascularization due to angioid streaks, central serous chorioretinopathy, choroidal rupture or trauma, idiopathic choroidal neovascularization, multifocal choroiditis, pathologic myopia, presumed ocular histoplasmosis syndrome, or uveitis;
    6. Neovascular glaucoma;

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7. Rubeosis (i.e., neovascularization of the iris);
8. Retinopathy of prematurity.

B. The use of bevacizumab for treatment of all other non-neoplastic conditions is considered INVESTIGATIVE.

Vagus Nerve Stimulation and Blocking Therapy

- Implantable vagus nerve stimulation may be considered MEDICALLY NECESSARY for the treatment of medically refractory or intractable epileptic seizures, defined as failure of at least two antiepileptic drugs.
- Implantable vagus nerve stimulation is considered INVESTIGATIVE for all other indications, due to a lack of evidence demonstrating an impact on improved health outcomes. Those indications include, but are not limited to, the following:
  A. Major depressive disorder;
  B. Essential tremor;
  C. Headache;
  D. Obesity;
  E. Fibromyalgia;
  F. Congestive heart failure;
  G. Tinnitus;
  H. Traumatic brain injury (TBI);
  I. Post-traumatic stress disorder (PTSD).
- Non-implantable transcutaneous vagus nerve stimulation is considered INVESTIGATIVE for all indications due to the lack of clinical evidence demonstrating an impact on improved health outcomes.
- Intra-abdominal vagus nerve blocking therapy is considered INVESTIGATIVE for all indications, including but not limited to the treatment of obesity due to the lack of clinical evidence demonstrating an impact on improved health outcomes.

Osteochondral Allografts and Autografts in the Treatment of Focal Articular Cartilage Lesions

- Osteochondral Allografting
  A. Osteochondral allografting may be considered MEDICALLY NECESSARY for the treatment of symptomatic full-thickness articular cartilage defects of the knee caused by acute or repetitive trauma, in patients who have had an inadequate response to a prior surgical procedure (e.g., debridement, subchondral drilling, abrasion arthroscopy, microfracture) or are not candidates for such procedures, when all the following criteria are met:
     1. Patient is an adult OR a skeletally mature adolescent with documented closure of growth plates (e.g., 15 years or older);
     2. Total area of the cartilage lesion (i.e. length x width, in centimeters or cm) is greater than 1.5 cm2 (centimeters squared);
     3. Focal full-thickness (modified Outerbridge grade III or IV) cartilage lesions on the weight-bearing surface of the femoral condyles (medial or lateral) or trochlea;
     4. Documented minimal to absent degenerative changes in the surrounding articular cartilage (modified Outerbridge grade II or less) and normal-appearing hyaline cartilage surrounding the border of the defect;
     5. Presence of persistent symptoms (e.g., pain, swelling and catching/locking) that significantly limit activities of daily living;
     6. Presence of stable ligaments (if ligaments are unstable, documentation should be provided as to how this condition will be addressed);
     7. No malalignment present (if malalignment is present, documentation should indicate planned concurrent correction of alignment).
  B. Osteochondral allografting for treatment of all other articular cartilage defects of the knee (i.e., defects that do not meet the criteria outlined under A) is considered INVESTIGATIVE, due to a lack of evidence demonstrating an impact on improved health outcomes.

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C. Osteochondral allografting for all other indications and in all other joints is considered INVESTIGATIVE due to a lack of evidence demonstrating an impact on improved health outcomes. Those investigative indications include, but are not limited to:
   1. Lesions in joints other than the knee (e.g., talus);
   2. Lesions of the patella or tibia.

D. Allograft minced cartilage procedures are considered INVESTIGATIVE for all indications and in all joints, due to a lack of evidence demonstrating an impact on improved health outcomes.

- Osteochondral Autografting

A. Osteochondral autografting (OATS or autologous mosaicplasty), using one or more cores of osteochondral tissue may be considered MEDICALLY NECESSARY for the treatment of symptomatic full-thickness cartilage defects of the knee caused by acute or repetitive trauma, in patients who have had an inadequate response to a prior surgical procedure (e.g., debridement, subchondral drilling, abrasion arthroscopy, microfracture) or are not candidates for such procedures, when all the following criteria are met:
   1. Patient is an adult OR a skeletally mature adolescent with documented closure of growth plates (e.g., 15 years or older);
   2. Total area of the cartilage lesion (i.e. length x width, in centimeters or cm) is ≥ 1.0 cm2 (centimeters squared) and ≤ 4.0 cm2;
   3. Focal full-thickness (modified Outerbridge grade III or IV) cartilage lesions on the weight-bearing surface of the femoral condyles (medial or lateral) or trochlea;
   4. Documented minimal to absent degenerative changes in the surrounding articular cartilage (modified Outerbridge grade II or less) and normal-appearing hyaline cartilage surrounding the border of the defect;
   5. Presence of persistent symptoms (e.g., pain, swelling and catching/locking) that significantly limit activities of daily living;
   6. Presence of stable ligaments (if ligaments are unstable, documentation should be provided as to how this condition will be addressed);
   7. No malalignment present (if malalignment is present, documentation should indicate planned concurrent correction of alignment).

B. Osteochondral autografting for treatment of all other articular cartilage defects of the knee (i.e., defects that do not meet the criteria outlined under A) is considered INVESTIGATIVE due to a lack of evidence demonstrating an impact on improved health outcomes.

C. Osteochondral autografting for all other indications and in all other joints is considered INVESTIGATIVE due to a lack of evidence demonstrating an impact on improved health outcomes. Those investigative indications include, but are not limited to:
   1. Lesions in joints other than the knee (e.g., talus);
   2. Lesions of the patella or tibia.

D. Autograft minced cartilage procedures are considered INVESTIGATIVE for all indications and in all joints, due to a lack of evidence demonstrating an impact on improved health outcomes.

Policies inactivated

Ophthalmologic Techniques for Evaluating Glaucoma

Policies reviewed with no changes in August 2015 – October 2015:

Air Ambulance

Amino Acid-Based Elemental Formulas

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Autologous Chondrocyte Implantation of Focal Articular Cartilage Lesions

Autologous Hematopoietic Stem-Cell Transplantation for Malignant Astrocytomas and Gliomas

Bariatric Surgery

Bronchial Thermoplasty

Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting

Computed Tomography (CT) To Detect Coronary Artery Calcification

Computed Tomography Angiography (CTA) for Evaluation of Coronary Arteries

Coverage of Routine Care Related to Clinical Trials

Cranial Electrotherapy Stimulation

Dalfampridine (Ampyra™)

Diagnosis and Treatment of Chronic Cerebrospinal Venous Insufficiency (CCSVI) in Multiple Sclerosis

Durable Medical Equipment (DME)

Expanded Cardiovascular Risk Panels

Expanded Molecular Panel Testing of Cancers to Identify Targeted Therapies

Facet Arthroplasty

Gene Expression Testing to Predict Coronary Artery Disease (CAD)

Genetic Testing for Cardiac Ion Channelopathies

Genetic Testing for Statin-Induced Myopathy

Hematopoietic Stem-Cell Transplantation for Acute Lymphoblastic Leukemia

Hematopoietic Stem-Cell Transplantation for Acute Myeloid Leukemia

Hematopoietic Stem-Cell Transplantation for Multiple Myeloma and POEMS Syndrome

Hematopoietic Stem-Cell Transplantation for Solid Tumors of Childhood

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

Hip Arthroplasty (Hip Replacement) and Hip Resurfacing

Hyperbaric Oxygen Therapy

Hyperhidrosis Treatments

Hypnotherapy

Implantable Middle Ear Hearing Aids (Semi-Implantable and Fully Implantable) for Moderate to Severe Sensorineural Hearing Loss

Infusion or Injection of Vitamins and/or Minerals

Injectable Clostridial Collagenase for Fibroproliferative Disorders

Interspinous Process Spacers

Intravenous Antibiotic Therapy and Associated Diagnostic Testing for Lyme Disease

Laboratory and Genetic Testing for Use of 5-Fluorouracil (5-FU) in Patients with Cancer

Laser and Photodynamic Therapy for Onychomycosis

Magnetic Esophageal Ring for Treatment of Gastroesophageal Reflux Disease (GERD)

Molecular Marker Evaluation of Thyroid Nodules

Orthognathic Surgery

Percutaneous Vertebroplasty, Kyphoplasty, and Sacroplasty

Progesterone Therapy to Reduce Preterm Birth in High-Risk Pregnancies

Quantitative Electroencephalogram (QEEG) or Brain Mapping for Mental Health or Substance-Related Disorders

Reduction Mammoplasty

Sacroiliac Joint Fusion

Single Photon Emission Computed Tomography (SPECT) for Cerebral Blood Flow in Behavioral Health Disorders

Single-Nucleotide Polymorphism (SNP) Breast Cancer Risk Assessment

Spinal Manipulation Under Anesthesia

Subtalar Arthroereisis

Surgical Treatment of Gender Identity Disorder

Testing of Fetal Nucleic Acids in Maternal Blood for Detection of Fetal Aneuploidy

Thermal Capsulorrhaphy

Transesophageal Endoscopic Therapies for Gastroesophageal Reflex Disease (GERD)

Treatment for Temporomandibular Disorder (TMD)

Wheelchairs

Wound Healing: Electrostimulation and Electromagnetic Therapy

Wound Healing: Non-Contact Ultrasound Treatment

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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