Provider Press

Provider information

September 2016 / Vol. 21, No. 2

BlueCross BlueShield Minnesota

PREVENTIVE CARE CODING TIPS BROCHURE AND WEBINAR

Blue Cross and Blue Shield of Minnesota (Blue Cross) recognizes the importance of preventive care for our subscribers. The preventive care you provide helps people stay healthy, avoids the onset of disease, and reduces healthcare costs. Our goal is to work with providers to ensure our subscribers are receiving preventive care.

Because there is often confusion about appropriate coding for preventive care, Blue Cross developed a brochure with tips to assist providers with billing for these services. As a companion to the brochure, we have also posted a webinar on the same topic. In the webinar, Blue Cross medical director Dr. Andrea Hillerud reviews the components of a preventive visit and discusses the importance of appropriate and accurate coding for preventive care. She also provides tips on coding for these services, including the Medicare Annual Wellness Visit, and points you to additional resources. You can find both the preventive care coding tips brochure and the webinar on our website at **providers.bluecrossmn.com** under tools and resources. The preventive coding tips brochure and webinar were originally published a year ago but both have been updated to incorporate ICD-10 requirements.

Most Blue Cross plans cover preventive services such as well child checks, adult preventive visits, annual wellness visits, immunizations and certain screening tests with no out-of-pocket costs to the subscriber. Subscribers in those plans will not incur a cost for many preventive services if they use an in-network provider, and if the provider does not bill an additional problem-based office visit code.

Provider Press

Provider Press is a quarterly newsletter available online. Issues are published in March, June, September and December. Below is the URL (select "provider press" from the "Select a Category" drop down option):

https://www.bluecrossmn.com/healthy/public/personal/home/providers/forms-and-publications.

QUALITY IMPROVEMENT

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 Lisa at **(651) 662-2775** to request information about the Quality Improvement Program.

Inside preview

FYI

PUBLICATIONS AVAILABLE ONLINE

The following is a list of Quick Points and Bulletins published from June 2016 to August 2016 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
QP13-16	Provider Cost Data Update
QP14-16	July 2016 HCPCS Code Updates
QP15-16	Zenith American Solutions 835 Electronic Remittance Advice
QP16-16	Preventive Care Coding Tips Brochure and Webinar
QP17-16	Claims with Attachments
QP18-16	Medicare Stars Center of Excellence
QP19-16	Incomplete Information on Post Service Appeals
QP20-16	Child and Teen Checkups (C&TC) Referral Code for PMAP and MinnesotaCare Subscribers
QP21-16	Prescription Drug – Electronic Prior Authorization (EPA) Drug Requests
QP22-16	APR-DRG and EAPG Grouper Updates
QP23-16	Provider Surveys - We Need Your Feedback
BULLETINS	**TITLE**
P24-16	Providers will see a change in our Prior Authorization Process for Government Products
P25-16	Update to Attachment B: Definition of Outpatient Health Services Categories
P26R1-16	Revised: Update to Billing Guidelines for Reference and Outside Lab Services for Minnesota Health Care Programs Subscribers
P27R1-16	Revised: Changes to Prior Authorization Requirements for Select Services for Commercial Products
P28R1-16	Revised: Elimination of Prior Authorization Requirements for Select Services for Government Programs
P29-16	Non-Emergency Medical Transportation Services Decal Requirement
P30-16	New Prior Authorization Requirement for Lyme Disease: Diagnostic Testing and Intravenous Antibiotic Therapy
P31-16	Prior Authorization for Acupuncture Services for Government Program Subscribers
P32-16	New Drug-Related Prior Authorization Criteria with Quantity Limit for Kuvan
P33-16	New Drug-Related Prior Authorization Criteria with Quantity Limit for Northera
P34-16	New Drug-Related Prior Authorization Criteria for Hyperpolarization-Activated Cyclic Nucleotide-Gated Channel Blocker PA with Quantity Limit Program
P35-16	Requirement to Submit National Drug Codes and Related Information
P36-16	Case Management (T1016) Billing for Tuberculosis Related Services for Government Programs Subscribers
P37-16	Addition of a Drug (Epclusa) to the Hepatitis C Second Generation Prior Authorization with Quantity Limit Program

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FYI

PUBLICATIONS AVAILABLE ONLINE - continued

BULLETINS	TITLE
P38-16	Addition of Drugs to the Self-Administered Oncology Prior Authorization with Quantity Limit Program
P39-16	Expansion of Drug-Related Xenazine Prior Authorization Criteria with Quantity Limit to Minnesota Health Care Programs
P40-16	New Drug-Related Prior Authorization Criteria with Quantity Limit for Lidocaine Transdermal
P41-16	Live Attenuated Influenza Vaccine (LAIV) Will Not Be Covered During the 2016-2017 Flu Season
P42-16	Change in Medical Policy and Commercial Benefit Coverage of Cologuard Colorectal Cancer Screening Test
P43-16	Updated: Third Party Payments of Premium and/or Cost-Sharing

PROVIDER MANUAL UPDATES

The following is a list of Blue Cross provider manuals that have been updated from June 2016 to August 2016. 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 8, Claim Filing	Content change to Site of Service
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Durable Medical Equipment (DME) section	Content change to DME Rental Guidelines
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Medical Services section	Content change to Chemotherapy Administration
Provider Policy and Procedure Manual	Chapter 11, Coding Policies and Guidelines, Public Programs section	Content change to Transportation Services
Blue Plus Manual	Chapter 3, Government Programs	Content change to Transportation Services

2016 HOLIDAY SCHEDULE

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

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 Friday.

PHARMACY SECTION

PHARMACY UPDATES FOR QUARTER 3, 2016

Drug Formulary Changes

As part of our continued efforts to evaluate and update our formularies, Blue Cross and Blue Shield of Minnesota and Blue Plus evaluate drugs on a regular basis. This evaluation includes a thorough review of clinical information, including safety information and utilization. Based on our most recent review, the following BRAND name drugs have been added to or removed from drug formularies effective July 1, 2016:

ADDITIONS TO FlexRx FORMULARY	REMOVALS FROM FlexRx FORMULARY
NUWIQ	ASTEPRO
PRALUENT	AVODART
REPATHA	MACRODANTIN CAP 25 MG
STRENSIQ	NAMENDA ORAL SOLUTION
SYNJARDY	SUPRAX SUSPENSION 100 MG/5ML; 200 MG/5ML
TRESIBA FLEXTOUCH	VIRAMUNE XR TAB 100 MG
ZARXIO	ZYVOX SUSPENSION
ADDITIONS TO GenRx FORMULARY	**REMOVALS FROM GenRx FORMULARY**
ARNUITY ELLIPTA	AMOXICILLIN/CLAVULANATE POTASSIUM CHEW TABS
FLOVENT DISKUS; FLOVENT HFA	BROMFENAC OPTHALMIC SOLUTION 0.09%
NUWIQ	DEXAMETHASONE SODIUM PHOSPHATE OPHTHALMIC SOLUTION 0.1%
PRALUENT	HEPARIN SODIUM (PORCINE) 100 UNITS/ML IN D5W
REPATHA	INDIGO CARMINE
SEREVENT DISKUS	MORPHINE SULFATE INJECTION 15 MG/ML
STRENSIQ	VIRAMUNE XR TAB 100 MG
SYNJARDY	ZYVOX SUSPENSION
TRESIBA FLEXTOUCH	
VENTOLIN HFA	
ZARXIO	

Effective September 1, 2016, Roche brand diabetic products were removed from the FlexRx and GenRx formularies. Only Ascensia/Bayer brand diabetic products are covered.

Drug Formulary Exclusions

Effective July 1, 2016, Blue Cross and Blue Shield of Minnesota no longer covers prescription claims for kits that are not approved by the U.S. Food and Drug Administration (FDA). An example of an unapproved kit includes but is not limited to Dermacinrx Silapak. If a prescription drug claim for an unapproved kit is submitted on or after July 1, 2016, the claim will not be covered. Pharmacists may be contacting the prescribing physicians to consider switching the prescription to an FDA-approved product.

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PHARMACY SECTION

PHARMACY UPDATES FOR QUARTER 3, 2016 - continued

The complete list of formulary changes can be found at:

FlexRx -

https://www.myprime.com/content/dam/prime/memberportal/forms/2016/FullyQualified/Other/ALL/BCBSMN/COMMERCIAL/MNFLEXRX/MN_FlexRx_Formulary_Update.pdf

GenRx –

https://www.myprime.com/content/dam/prime/memberportal/forms/2016/FullyQualified/Other/ALL/BCBSMN/COMMERCIAL/MNGENRX/MNSM_Formulary_Update.pdf

UTILIZATION MANAGEMENT UPDATES

Blue Cross and Blue Shield of Minnesota implemented additional Prior Authorizations, Quantity Limits, and/or Step Therapy depending on the member's prescription drug benefit. Programs in this update include new Prior Authorizations (PA), Quantity Limits (QL), or Step Therapy (ST) for:

April 18, 2016

LAZANDA	PA	QL	

July 1, 2016

ADEMPAS	PA		
ADZENYS XR		QL	
ALLZITAL		QL	
DESCOVY		QL	
DYANAVEL DR		QL	
HUMULIN R U-500		QL	
ODEFSEY		QL	
QUILLICHEW ER		QL	
SPRITAM			ST
TALTZ		QL	ST
VRAYLAR CAPS/ THERAPY PACK		QL	
XELJANZ XR		QL	ST
ZEMBRACE		QL	

PA = Prior Authorization QL = Quantity Limit; ST = Step Therapy

A complete listing of all utilization management updates can be found at:

FlexRx -

https://www.myprime.com/content/dam/prime/memberportal/forms/2016/FullyQualified/Other/ALL/BCBSMN/COMMERCIAL/MNFLEXRX/MN_FlexRx_UM_Updates.pdf

GenRx -

https://www.myprime.com/content/dam/prime/memberportal/forms/2016/FullyQualified/Other/ALL/BCBSMN/COMMERCIAL/MNGENRX/MNSM_GenRx_UM_Updates.pdf

For tools and resources regarding Pharmacy please visit our website at bluecrossmn.com and select "Shop Plans" and "Prescription Drugs." Tools include our formulary updates (by formulary list) and frequently asked questions.

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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 or under-utilization of appropriate care and services.

PHARMACY SECTION

UTILIZATION MANAGEMENT UPDATES - continued

Formulary updates are completed quarterly and posted online for review. These updates can be found by selecting the "Search a Drug List" link under the "Prescription Drugs" section and then selecting the applicable formulary listing.

Additional information regarding Pharmacy is also located in the Provider Policy and Procedure Manual. To access the manual go online to **providers.bluecrossmn.com** and select "Forms and Publications" then "Manuals." Topics in the manual include, but are not limited to, formulary exceptions, quantity limits and step therapy.

CODING CORNER

APPEAL HINTS

We would like to remind you of a few important requirements for submitting an appeal.

- First, all post service claim appeals must be submitted on the AUC Appeal Request Form available on the AUC web site, (www.health.state.mn.us.auc), along with the supporting documentation and must be mailed or faxed to the Consumer Service Center.
- Second, the required information entered on the appeal form must be legible and correct. This includes submission of the correct claim number.

MODIFIERS

Modifiers are two-digit codes that are appended to a service as a means to indicate that the service/procedure is affected or altered by a specific circumstance and to add specificity, but not changed in its definition. It is important to append all appropriate modifiers the first time the claim is submitted. Additional information and guidance can be found in our reimbursement policy RP-General Coding-001.002 – Modifier found on the Blue Cross website under the Reimbursement Policies (https://www.bluecrossmn.com/healthy/public/personal/home/providers/reimbursement-policies).

DIAGNOSIS LINKING

In addition to submitting the most appropriate valid ICD diagnoses, submitted to its fullest specificity, on a medical claim, it is also essential to communicate the primary diagnosis for the service performed, especially if more than one diagnosis is related to a line item. Adjudication is based on the first linked diagnosis. Linking/sequencing rules:

- Sequence numbers relate to the ICD-10-CM diagnosis codes as 1, 2, 3 and 4.
- The primary diagnosis is listed first in the sequence if more than one diagnosis is related.

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 Outcomes Dept.
R472
P.O. Box 64179
St. Paul, MN 55164-0179

FYI WHO TO CONTACT?

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.	
For phone numbers, fax numbers and addresses for Care Management programs and services please refer to the Provider Policy and Procedure Manual, Chapter 1 "How to Contact Us" section.	

FYI

REMINDER: MEDICARE REQUIREMENTS FOR REPORTING PROVIDER DEMOGRAPHIC CHANGES

Blue Cross and Blue Shield of Minnesota (Blue Cross) has continually collaborated with providers in an effort to ensure accurate information is provided in all provider directories.

In accordance with Medicare requirements, Blue Cross is required to maintain accurate provider network directories for the benefit of our Subscribers. Blue Cross is hereby notifying all providers to submit a form to us when any of the following changes occur:

- Accepting new patients
- Demographic address and phone changes
- Office hours or other changes that affect availability
- Tax ID changes
- Practitioner additions or terminations
- Branch additions

Forms location
Based on what change has occurred, submit the appropriate form located on our website at **providers.bluecrossmn.com**. Select "Administrative Updates" in the "What's Inside" section to obtain instructions on completing the various forms or access the link below:
https://www.bluecrossmn.com/healthy/public/personal/home/providers/admin-updates.

How do we submit changes?
Send the appropriate form via fax as indicated below:
Fax: **651-662-6684, Attention: Provider Data Operations**

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

2016 PREVENTIVE SERVICES PROGRAM

Blue Cross and Blue Shield of Minnesota (Blue Cross) is committed to partnering with providers to improve clinical outcomes for the Medicare beneficiaries we jointly serve. As part of our ongoing efforts, Blue Cross will be encouraging patients to discuss preventive screenings with their provider. Blue Cross will be offering Medicare members reward cards for completing recommended screenings.

Beginning in late July 2016, Blue Cross mailed reminders and in home testing kits to your attributed, eligible patients with care gaps in the following measures:

- Colorectal Cancer Screening (in home testing kit)
- Breast Cancer Screening (reminder)
- Diabetes Care;

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FYI

2016 PREVENTIVE SERVICES PROGRAM - continued

- A1c testing (in home testing kit)
- retinal eye exam (reminder)
- nephropathy screening (in home testing kit)

Each member received up to three (3) kits and the testing kits include instructions for completion and submission. We will be posting more specific information regarding patient communications on the Star Rating Provider website in the coming weeks.

Notification of results

Patients will be instructed to send the home kit sample(s) to Home Access Health Company (HAHC). Once HAHC receives the sample(s) and completes the testing, the results will be sent to both the patient and the member's Primary Care Physician.

- Negative results will be sent by letter alone.
- Positive results will be communicated first by phone followed by an "Alert value" letter or fax.

We appreciate your assistance and are excited to offer these convenient screening options to your patients.

If you have any questions or require additional information/clarification, please send an email to the **ProviderStars@bluecrossmn.com** mailbox.

QUALITY IMPROVEMENT

UPCOMING SURVEYS

We Need Your Feedback:

As a participating network provider in the Blue Cross and Blue Shield of Minnesota and Blue Plus network, you provide quality care and service to our members. We want to hear from you, our network, on your experience with different aspects of the health care system. Below is a list of surveys that will be going out over the next few months. The survey participants are randomly selected so please keep an eye out for a mailed, telephone, or email survey. A strong response rate allows us an opportunity to properly analyze results thus identifying opportunities to improve your satisfaction with Blue Cross and Blue Shield.

SURVEY DESCRIPTION	SURVEY MODE	IN THE FIELD
Access to Care - This survey studies the network's ability to provide timely appointment access for routine and follow-up care. This study helps us identify if we have adequate network access to meet the needs of our members.	Telephone Calls	Aug - Oct
Utilization Management - This survey studies practitioners' satisfaction with the utilization management policies and procedures, including the appeals process.	Email	Aug - Sept
Accuracy of Provider Directory - This survey measures the accuracy of practitioner and hospital information available to members on our online provider directory.	Fax	Sept - Dec
Coordination of Medical and/or Behavioral Care - This survey studies continuity and coordination of care between medical and behavioral healthcare providers.	Telephone Calls	Oct - Nov

SHARING BEST PRACTICES: CONTINUITY OF CARE

Informational Continuity

In their 2008 BMC Family Practice article, *"What are the roles involved in establishing and maintaining informational continuity of care within family practice? A systematic review,"* Crooks and Argarwal explore the different roles of doctors, patients and technology in the context of informational continuity. Continuity refers to the degree to which care is linked and made coherent over time. [1]Central to ensuring continuity of care is the relationship between doctor and patient. Establishing a relationship built on trust aids in patients' willingness to share information both about their illness such as symptoms and of a more personal nature such as family situations, financial struggles, ethnic and cultural perspectives, education and literacy levels, etc. The ability to gather and document information is one of the first steps in building informational continuity.

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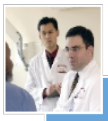
QUALITY IMPROVEMENT

SHARING BEST PRACTICES: CONTINUITY OF CARE - continued

Informational Continuity

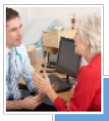
Information is the common thread linking care from one provider to another and from one healthcare event to another. Information continuity refers to the capacity of that information to 'travel' with the patient and throughout the health system, between providers and over time, to facilitate a continuous care experience. This requires the organized collection of a patient's information and relies on adequate medical records indicating episodes of illness, management and follow-up, as well as effective telecommunications, good referral systems, and feedback from other providers.

Below is a summary of the different roles extracted from the literacy review.



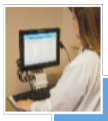
Doctors' Roles

- Knowing patient histories
- Using record keeping system(s) effectively
- Deciding what personal/social information is recorded
- Clarifying and updating record accuracy
- Delegating updating of records to nursing or office staff
- Ensuring confidentiality



Patients' Roles

- Establishing trust in doctor
- Willingness to share personal information
- Transferring information to other practitioners
- Remembering important information
- Awareness of types of medical and non-medical details that are important to share



Roles of Technology

- Serving as a tool to enhance continuity of care
- Prompting doctors to take action
- Being searchable
- Providing space for historical/contextual information
- Facilitating development of longitudinal record keeping enabling timely and patient-centered care

Consider the following strategies to review effectiveness of informational continuity in your clinic/practice:

1. Ensure standardized training in the clinic/practice record system.
2. Openly discuss confidentiality with patients and caregivers and explain who will have access to their records as a way of encouraging information sharing.
3. Regularly discuss with patients and caregivers the type of information that is helpful in order to effectively provide care. Doing so could increase patients' awareness of the need to share details beyond experiences of specific symptoms, and ultimately assist with creating the trusting relationship critical to providing optimal care.
4. Develop a mechanism that allows patients to evaluate the information stored within the electronic medical record to confirm accuracy, such as providing a printout or access to an online patient portal.

You may access the full article at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2626592/

[1] BMC Health Serv Res. 2014; 14: 590. *Improving coordination through information continuity: a framework for translational research,* Published online 2014 Nov 25.

HEALTH LITERACY

HEALTH LITERACY - BETTER INFORMATION, BETTER OUTCOMES

"Try both Aleve 2 pills bid with flexeril at hs."

"Everyone should get preventive screenings and vaccinations at the recommended timeframes."

According to the U.S. Department of Education, nearly 9 out of 10 Americans have some level of difficulty understanding and using the everyday health information that is routinely available to them – a skillset defined as "health literacy" – and **only 12 percent of English-speaking adults have proficient health literacy skills**.

Health literacy refers to our ability to obtain, process, and understand basic health information and services needed to make appropriate health decisions. However, the implications go far beyond being a smart consumer or following medical instructions. For some, low health literacy can lead to decisions or errors, resulting in unintentional long-term and perhaps even irreversible health consequences. A new set of recommendations developed by a broad-based Minnesota coalition attempts to reduce those risks.

In March 2016, the Minnesota Action Plan to Improve Health Literacy was developed after a six-month process with 43 Minnesota health organizations to identify barriers of health literacy and possible solutions. The Action Plan identifies six priorities with actionable strategies to improve Minnesotans' ability to obtain, understand, and act on health information.

Those with low health literacy represent all segments of society, including many who are highly educated. A corporate lawyer for example, may have trouble figuring out medication schedules while on a business trip. A computer programmer may wonder if they can drink coffee before a lab test that requires fasting. Busy parents may spend time searching the local drug store for the right medicine to reduce a 5-year-old's fever. **For Minnesotans to adopt healthy behaviors and make responsible, well-informed health decisions, they must have access to clear, understandable information**.

Please take the time to review these six priorities from the Minnesota Action Plan to Improve Health Literacy and see what improvements you can make in your practice. You may access the full Minnesota Action Plan to Improve Health Literacy at http://healthliteracymn.org/sites/default/files/images/files/MN_Health_Literacy_Action_Plan.pdf.

1. **Adopt and use health literacy best practices across all verbal, written, and visual communications.**
2. **Make information about health relevant and accessible.** Patients and their caregivers should have easy access to usable information presented in a variety of mediums.

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HEALTH LITERACY

HEALTH LITERACY - BETTER INFORMATION, BETTER OUTCOMES

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3. **Increase and improve patient-centered resources.** Health care professionals should provide patients with the necessary resources to understand the health care system and receive the most appropriate care. Whether individual assistance is provided in-person, by phone, or online, health care professionals should help patients coordinate and navigate health care.
4. **Implement and enhance education opportunities at all levels.** Health literacy concepts should be integrated into primary, secondary and professional education.
5. **Streamline processes within the health care system.** Productive partnerships within the health care system could identify and implement effective strategies to lessen the burden on patients to navigate the fragmented health care system.
6. **Invest in language and cultural resources.** Because limited English proficiency has a profound impact on health literacy, health care organizations need to take language and cultural differences into account when providing health information.

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: 07/18/16 Notification Posted: 05/27/16

Policies developed

None

Policies revised

Cytochrome P450 Genotyping

- CYP450 genotyping of CYP2D6 common variants ONLY to determine drug metabolizer status may be considered MEDICALLY NECESSARY for patients:
  - With Gaucher disease being considered for treatment with eliglustat; OR
  - With Huntington disease being considered for treatment with tetrabenazine in a dosage greater than 50 mg per day.
- All other genotyping to determine cytochrome p450 (CYP450) genetic polymorphisms is considered INVESTIGATIVE due to the lack of clinical evidence demonstrating an impact on improved health outcomes. This includes, but is not limited to, the following:
  - Selection or dosing of selective serotonin reuptake inhibitor (SSRI) or tricyclic antidepressants
  - Selection and dosing of selective norepinephrine reuptake inhibitors (e.g., atomoxetine HCL for treatment of attention-deficit/hyperactivity disorder)
  - Selection and dosing of antipsychotic drugs
  - Aiding in the choice of clopidogrel versus alternative antiplatelet agents, or in determining the optimal dosing for clopidogrel
  - Selection or dosing of beta blockers (e.g., metoprolol)
  - Selection or dosing of proton pump inhibitors in the treatment of H. pylori infection
  - Management of treatment with tamoxifen in women at high risk for or with breast cancer
  - Dosing and management of opioid analgesics (e.g., codeine, morphine sulfate, oxycodone hydrochloride)
  - Determining dose of efavirenz for treatment of HIV-1 infection
  - Determining dose of immunosuppressant for organ transplantation
  - Dosing and management of antituberculosis medications
  - Testing CYP450 polymorphisms other than CYP2D6 common variants in patients with Gaucher disease being considered for treatment with eliglustat or patients with Huntington's disease being considered for treatment with tetrabenazine in a dosage greater than 50 mg per day
- Use of genetic testing panels that include analysis of multiple CYP450 mutations and other gene polymorphisms for the purpose of aiding in the choice of drug or dose to increase efficacy and/or avoid toxicity are considered INVESTIGATIVE due to the lack of clinical evidence demonstrating an impact on improved health outcomes.

Subcutaneous Hormone Pellets

- Subcutaneous Administration of Testosterone
  - Use of Testopel® subcutaneous testosterone pellets may be considered MEDICALLY NECESSARY for testosterone replacement therapy in males who meet ALL the following criteria:

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- Diagnosis of ONE of the following:
  - Primary hypogonadism (congenital or acquired); OR
  - Secondary hypogonadism (congenital or acquired); OR
  - Delayed puberty;

  AND
- Laboratory testing confirms serum testosterone levels below the normal range as defined by the laboratory performing the test (e.g., total testosterone <300 ng/dL or free testosterone <9 ng/dL) when measured on at least two separate mornings; AND
- Oral, topical, and/or intramuscular testosterone replacement therapy have been tried and found to be ineffective or not tolerated.

- Use of Testopel® subcutaneous testosterone pellets is considered NOT MEDICALLY NECESSARY for the treatment of male infertility, due to adverse effects on sperm production and fertility.
- Use of Testopel® subcutaneous testosterone pellets is considered INVESTIGATIVE for all other indications, including but not limited to treatment of symptoms associated with female menopause or reduced libido, due to the lack of clinical evidence demonstrating an impact on improved health outcomes.
- The subcutaneous administration of formulations of testosterone other than Testopel® is considered INVESTIGATIVE for all indications due to lack of FDA approval of any other products.

- Subcutaneous Administration of Estrogen or Estrogen Combined with Testosterone
  - Subcutaneous hormone pellets containing estrogen alone OR estrogen combined with testosterone (including bioidentical hormone formulations) are considered INVESTIGATIVE for all indications, including but not limited to treatment of symptoms associated with female menopause, because there are no FDA-approved formulations of these products.

Microprocessor-Controlled Prostheses for the Lower Limb

- The use of a microprocessor-controlled knee may be considered MEDICALLY NECESSARY for transfemoral amputees or knee disarticulation amputees who meet ALL the following criteria:
  - Demonstrated need for long distance ambulation at variable rates (use of the limb in the home or for basic community ambulation is not sufficient to justify provision of the computerized limb over standard limb applications) OR demonstrated patient need for regular ambulation on uneven terrain or for regular use on stairs (use of the limb for limited stair climbing in the home or employment environment is not sufficient evidence for prescription of this device over standard prosthetic application); AND
  - Individual has a functional ambulation level of K3 or K4
    - Level K3: Has ability or potential for ambulation at variable cadence typical of the community ambulator who has the ability to traverse most environmental barriers and may have vocational, therapeutic, or exercise activity that demands prosthetic utilization beyond simple locomotion.
    - Level K4: Has ability or potential for prosthetic ambulation that exceeds basic ambulation skills such as those exhibiting high impact, stress, or energy levels typical of the prosthetic demands of an active adult or athlete; AND
  - Meets height and weight requirements of the device specified by the manufacturer; AND
  - Physical ability, including adequate cardiovascular and pulmonary reserve, for ambulation at variable walking speeds; AND

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- Cognitive ability to understand gait sequencing, use and care requirements for the technology; AND
- Adequate strength and balance to stride and activate the knee unit and use the swing and stance features of the unit, with no significant deformity of the remaining limb that would impair the ability to stride; AND
- Free of any condition, such as ataxia, that limits ambulation; AND
- Absence of significant hip flexion contracture (i.e., over 20 degrees); AND
- Microprocessor limb will not be used for long distance or competitive running; AND
- Microprocessor limb will not be used in environments that limit functional life of the device such as those with excessive moisture, dust, or inability to charge the prosthesis; or in extremely rural conditions where maintenance is limited.

- The microprocessor knee prosthesis with polycentric 3-D hip joint system may be considered MEDICALLY NECESSARY for patients who have sustained either a hip disarticulation amputation or hemipelvectomy when BOTH of the following are met:
  - Meets all indications for a microprocessor-controlled knee prosthesis outlined above; AND
  - Currently utilizes a microprocessor-controlled knee or is being fitted for a microprocessor-controlled knee at the time of 3-D hip joint system fitting.
- The following are considered INVESTIGATIVE due to a lack of evidence demonstrating improved health outcomes:
  - Use of a powered knee
  - Use of a microprocessor-controlled or powered ankle/foot

Stem-Cell Therapy for Peripheral Arterial Disease

- Stem-cell therapy (e.g., injection or infusion of stem cells concentrated from bone marrow aspirate) is considered INVESTIGATIVE for treatment of peripheral arterial disease, including but not limited to critical limb ischemia, due to a lack of clinical evidence demonstrating an impact on improved health outcomes.

Urine Drug Testing for Substance Abuse Treatment and Chronic Pain Management

- Qualitative Urine Drug Testing
  - Qualitative urine drug testing for substance abuse treatment may be considered MEDICALLY NECESSARY under any of the following conditions:
    - On initial entrance into substance abuse treatment when all of the following criteria are met:
      1. An adequate clinical assessment of patient history and risk of substance abuse is performed, including obtaining information from the state prescription drug monitoring program; AND
      2. Clinicians have knowledge of test interpretation; AND
      3. Clinical documentation specifies how the test result will be used to guide clinical decision making. During the stabilization phase of treatment no more frequently than once a week for a maximum of 4 weeks.
    - During the maintenance phase of treatment no more frequently than once a month unless patient is demonstrating aberrant behavior defined by one or more of the following:
      - Lost prescriptions;
      - Requests for early refills;
      - Obtained controlled substances from multiple providers;
      - Unauthorized dose escalation;

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- Apparent intoxication.

- Qualitative urine drug testing for chronic pain management may be considered MEDICALLY NECESSARY under any of the following conditions:
  - On initial entrance into a chronic pain management program when all of the following criteria are met:
    1. An adequate clinical assessment of patient history and risk of substance abuse is performed, including obtaining information from the state prescription drug monitoring program; AND
    2. Clinicians have knowledge of test interpretation; AND
    3. Clinical documentation specifies how the test result will be used to guide clinical decision making.
  - During subsequent monitoring of treatment no more frequently than the following times according to the risk level of the individual, as determined by a validated screening tool for assessing the risk of aberrant drug-related behaviors (e.g., the Opioid Risk Tool [ORT] or the Screener and Opioid Assessment for Patients with Pain-Revised [SOAPP-R]);
    1. Twice a year for patients who are low or moderate risk;
    2. Four times a year for patients who are high risk OR receiving an opioid dose >120 mg MED/d;
    3. For patients demonstrating aberrant behavior defined by one or more of the following:
       - Lost prescriptions;
       - Requests for early refills;
       - Obtained controlled substances from multiple providers;
       - Unauthorized dose escalation;
       - Apparent intoxication.
- Qualitative urine drug testing is considered NOT MEDICALLY NECESSARY in all other situations, including but not limited to routine testing and testing for non-medical purposes.

- Quantitative Urine Drug Testing
  - Quantitative urine drug testing for substance abuse treatment or chronic pain management may be considered MEDICALLY NECESSARY when ALL of the following criteria are met:
    - Qualitative urine drug testing was performed according to the medically necessary criteria described in section I; AND
    - The result of qualitative urine drug testing was one or more of the following:
      1. Positive for a non-prescribed drug with abuse potential; OR
      2. Positive for an illicit drug (e.g., methamphetamine or cocaine); OR
      3. Negative for prescribed medications; AND
    - Clinical documentation specifies supporting rationale for each quantitative test ordered; AND
    - Clinical documentation specifies how the test result will be used to guide clinical decision making.
  - Quantitative urine drug testing for substance abuse treatment or chronic pain management may be considered MEDICALLY NECESSARY when BOTH of the following criteria are met:
    - A qualitative test for the relevant drug(s) is not commercially available; AND
    - The testing is performed according to the medically necessary criteria described in section I, with the exception

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that it is quantitative rather than qualitative testing.

- Quantitative urine drug testing is considered NOT MEDICALLY NECESSARY in all other situations, including but not limited to routine testing and testing for non-medical purposes.

- Drug testing using oral fluid or hair samples in outpatient substance abuse treatment or outpatient chronic pain management settings is considered INVESTIGATIVE due to the lack of clinical evidence demonstrating an impact on improved health outcomes.

Cellular Immunotherapy for Prostate Cancer

- Sipuleucel-T therapy may be considered MEDICALLY NECESSARY for patients who meet ALL the following criteria:
  - Diagnosis of metastatic, castrate-resistant (also known as castration-recurrent, hormone-refractory, or androgen-independent) prostate cancer, as defined by:
    - Disease progression despite hormonal therapy (e.g., luteinizing hormone-releasing hormone [LHRH] analogs or anti-androgens); AND
    - Rising prostate-specific antigen (PSA) levels; AND
    - Evidence of extrahepatic metastases on advanced imaging.

    AND
  - Asymptomatic or minimally symptomatic disease; AND
  - Eastern Cooperative Oncology Group (ECOG) performance status 0-1; AND
  - No liver metastases.
- Sipuleucel-T therapy is considered INVESTIGATIVE for all other indications, including but not limited to treatment of patients with the following conditions, due to the lack of evidence demonstrating an impact on improved health outcomes:
  - Hormone-responsive prostate cancer;
  - Moderate to severe symptomatic metastatic prostate cancer.

Artificial Intervertebral Discs

- Artificial intervertebral cervical discs
  1. Artificial Intervertebral discs may be considered MEDICALLY NECESSARY when performed at one level or two contiguous levels from C3-C7 when ALL of the following criteria are met:
     - The device is approved by the U.S. Food and Drug Administration (FDA) for use at the level(s) being treated; AND
     - Patient is skeletally mature; AND
     - Patient is free from contraindication to cervical artificial disc implantation. These include:
       - Active systemic infection or infection localized to the site of implantation;
       - Osteoporosis defined as dual energy X-ray absorptiometry (DEXA) bone density measured T-score of negative 2.5 or worse
       - Marked cervical instability on neutral resting lateral or flexion/extension radiographs; with greater than 3 mm translation or greater than 11 degrees of angular difference to either adjacent level;
       - Clinically compromised vertebral bodies at the affected level due to:
         - Current or past trauma (for example, radiographically confirmed fracture callous, malunion or nonunion); or
         - Anatomical deformity (for example rheumatoid arthritis, ankylosing spondylitis); or
         - Cervical spine malignancy

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- Moderate or severe spondylosis at the level to be treated, characterized by any of the following:
  - Bridging osteophytes; or
  - Loss of greater than 50% normal disc height; or
  - Absence of motion less than 2 degrees
- Severe facet joint disease or degeneration

AND

- Patient has intractable radiculopathy and/or myelopathy due to herniated disc or osteophyte formation with ALL of the following:
  - Symptomatic nerve root and/or spinal cord compression documented by:
    - Neck/arm pain; AND/OR
    - Functional/neurological deficit;

    AND
  - Radiographic imaging (i.e., MRI or CT myelogram) demonstrates one or more of the following:
    - Decreased disc height in comparison to a normal adjacent disc;
    - Degenerative spondylosis;
    - Disc herniation;

    AND
  - Patient has failed at least six weeks of non-surgical therapy with the following:
    - Active pain management program or protocol, under the direction of a physician, with pharmacotherapy that addresses neuropathic pain and other pain sources; OR
    - Physical therapy.

  OR
- Patient has cervical nerve root compression verified by diagnostic imaging (i.e., MRI or CT myelogram) that results in severe pain or profound neuromotor or neurosensory deficit of the extremities requiring hospital admission for pain control or immediate surgery; AND ALL criteria for cervical disc arthroplasty except the criterion above for six-week non-surgical therapy are met.

2. Artificial intervertebral cervical discs are considered INVESTIGATIVE for treatment of disorders of the cervical spine for all other indications including disc replacement in combination with cervical spinal fusion (whether performed concurrently or sequentially); or disc replacement at greater than 2 contiguous levels. There is a lack of clinical evidence demonstrating their impact on improved health outcomes.

- Artificial intervertebral thoracic discs
  Artificial intervertebral thoracic discs are considered INVESTIGATIVE due to the lack of clinical evidence demonstrating their impact on improved health outcomes.
- Artificial intervertebral lumbar discs
  Artificial intervertebral lumbar discs are considered INVESTIGATIVE due to the lack of clinical evidence demonstrating their impact on improved health outcomes.

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Policies inactivated:

Artificial Intervertebral Disc: Lumbar Spine (combined policies—see revised policy)

Electrocardiographic (ECG) Body Surface Mapping

Lung Cancer Screening Using Low-Dose Computed Tomography (LDCT)

Rhinomanometry and Acoustic/Optical Rhinometry

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

Pulse Oximetry Device

H-Wave Stimulation

Continuous Rental of Life Sustaining Durable Medical Equipment (DME)

Transtympanic Micropressure Applications as a Treatment of Meniere's Disease

HIV Drug Susceptibility and Resistance Testing

Rapid Platelet Function Assay – ASA

Laboratory Test for Heart Transplant Rejection

MultiFunction Cardiogram

Policies Effective: 08/15/16 Notification Posted: 06/24/16

Policies developed

None

Policies revised

Respiratory Syncytial Virus (RSV) Prophylaxis

- Use of immune prophylaxis (e.g., palivizumab [Synagis®]) for RSV may be considered MEDICALLY NECESSARY when ONE of the following criteria are met:
  - Chronic Lung Disease (CLD) of Prematurity
    - Infant is ≤12 months of age at the onset of RSV season AND meets BOTH of the following:
      - Infant was born at <32 weeks, 0 days gestation AND
      - Infant requires >21% oxygen for at least the first 28 days after birth.

      OR
    - Child is 12 months to <24 months of age at the onset of RSV season AND meets BOTH of the following:
      - Child was born at <32 weeks, 0 days of gestation; AND
      - Child continues to require at least ONE of the following within 6 months of the start of RSV season:
        - Supplemental oxygen; OR
        - Chronic systemic corticosteroid therapy; OR
        - Diuretic therapy.
  - Congenital Heart Disease (CHD)

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- Infant is ≤12 months of age at the onset of RSV season AND meets ONE of the following:
  - Acyanotic CHD, when the infant is receiving medication to control congestive heart failure and will require a cardiac surgical procedure; OR
  - Cyanotic CHD, when palivizumab is recommended after consultation with a pediatric cardiologist; OR
  - Diagnosis of moderate to severe pulmonary hypertension.

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

- Anatomic Pulmonary Abnormalities OR Neuromuscular Disorder (e.g., cerebral palsy, muscular dystrophy)
  - Infant is ≤12 months of age at the onset of RSV season AND
  - Infant has a pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airway.
- Cystic Fibrosis
  - Child is <24 months of age at the onset of RSV season; AND
  - Child has cystic fibrosis with evidence of CLD and/or malnutrition.
- Immunocompromised Status
  - Child is <24 months of age at the onset of RSV season AND
  - Child is profoundly immunocompromised (e.g., due to solid organ transplantation, hematopoietic stemcell transplantation, or chemotherapy).
- Prematurity without CLD or CHD
  - Infant is <12 months of age at the onset of RSV season AND
  - Infant was born at <29 weeks, 0 days gestation (i.e., 28 weeks, 6 days, or less).

- Use of immune prophylaxis (e.g., palivizumab [Synagis]) for RSV is considered INVESTIGATIVE for all other indications due to the lack of evidence demonstrating an impact on improved health outcomes.

Sleep Studies/Polysomnograms in Children and Adolescents

- Polysomnography
  - Supervised polysomnography performed in a sleep laboratory may be considered MEDICALLY NECESSARY in children and adolescents with one of the following:

    1. Exhibit habitual snoring AND at least one of the following is present:
       - Excessive daytime sleepiness that interferes with daily activities and is not explained by other conditions; or the patient exhibits behavior that may indicate increased efforts to stay awake such as difficulty in attentiveness, hyperactivity, aggressive or disruptive behavior or headache on awakening
       - Failure to thrive
       - Cor pulmonale
       - Polycythemia

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- Down syndrome
- Craniofacial abnormalities resulting in mid or lower facial disorders (e.g., Pierre Robin syndrome)
- Sickle cell disease
- Obesity defined as BMI greater than the 90th percentile for age and gender
- Neuromuscular disorder
- Chest wall deformity that may interfere with respiratory function

OR

2. Observed apneas or labored breathing during sleep; OR
3. Suspicion of one of the following:
   - Narcolepsy
   - Idiopathic hypersomnia characterized by disabling daytime sleepiness (i.e., 1-2 hour episodes of non-REM non-rapid eye movement (NREM) sleep or prolonged (e.g., >10 hours) nighttime sleep, after exclusion of inadequate sleep hygiene
   - Restless legs syndrome when iron deficiency has been ruled out

   OR
4. Frequent NREM parasomnias or epilepsy when there is a suspicion for sleep-disordered breathing or periodic limb movement disorders; OR
5. Prior to removal of a tracheostomy tube; OR
6. Initiation and titration of positive airway pressure (PAP) in children and adolescents with confirmed obstructive sleep apnea, or re-evaluation/titration of PAP due to growth and development or recurrence of symptoms during ongoing PAP treatment; OR
7. Assessment of response to oral appliance therapy or upper airway surgery (e.g., adenotonsillectomy) in children and adolescents with confirmed obstructive sleep apnea.

- Use of supervised polysomnography performed in a sleep laboratory is considered INVESTIGATIVE for all other indications, including but not limited to sleep-related bruxism, circadian sleep rhythm disorders, sleep-related epilepsy, uncomplicated parasomnias, depression, or behaviorally-based insomnia due to a lack of evidence demonstrating improved health outcomes.
- Use of unattended (unsupervised) sleep studies or polysomnography in children and adolescents is considered INVESTIGATIVE due to a lack of evidence demonstrate an impact on improved health outcomes.

- Multiple Sleep Latency Testing (MSLT) and Maintenance of Wakefulness Testing (MWT)
  - MSLT may be considered MEDICALLY NECESSARY to evaluate symptoms of narcolepsy after PSG has ruled out OSA.
  - MSLT is considered INVESTIGATIVE for all other indications due to a lack of evidence an impact on improved health outcomes.
  - MWT is considered INVESTIGATIVE due to a lack of evidence demonstrating an impact on improved health outcomes

Hematopoietic Stem-Cell Transplantation for Non-Hodgkin Lymphoma

- For patients with non-Hodgkin's lymphoma (NHL) B-cell subtypes considered aggressive, either allogeneic

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hematopoietic stem-cell transplant (HSCT) using a myeloablative conditioning regimen or autologous HSCT may be considered MEDICALLY NECESSARY:

- As salvage therapy for patients who do not achieve a complete remission (CR) after first-line treatment (induction) with a full course of standard-dose chemotherapy; OR
- To achieve or consolidate a CR for those in a chemosensitive first or subsequent relapse; OR
- To consolidate a first CR in patients with diffuse large B-cell lymphoma with either an age-adjusted International Prognostic Index score that predicts a high- or high-intermediate risk of relapse or double-hit lymphoma.

- For patients with mantle cell lymphoma:
  - Autologous HSCT may be considered MEDICALLY NECESSARY to consolidate a first remission; OR
  - Allogeneic HSCT, myeloablative or reduced-intensity conditioning, may be considered MEDICALLY NECESSARY as salvage therapy; OR
  - Autologous HSCT is considered INVESTIGATIVE as salvage therapy; OR
  - Allogeneic HSCT is considered INVESTIGATIVE to consolidate a first remission.
- For patients with NHL B-cell subtypes considered indolent, either allogeneic HSCT using a myeloablative conditioning regimen or autologous HSCT may be considered MEDICALLY NECESSARY:
  - As salvage therapy for patients who do not achieve CR after first-line treatment (induction) with a full course of standard-dose chemotherapy; OR
  - To achieve or consolidate CR for those in a first or subsequent chemosensitive relapse, whether or not their lymphoma has undergone transformation to a higher grade.
- For patients with peripheral T-cell lymphoma:
  - Autologous HSCT may be considered MEDICALLY NECESSARY to consolidate a first complete remission in high-risk peripheral T-cell lymphoma; OR
  - Autologous or allogeneic HSCT (myeloablative or reduced-intensity conditioning) may be considered MEDICALLY NECESSARY as salvage therapy; OR
  - Allogeneic HSCT is considered INVESTIGATIVE to consolidate a first remission.
- Reduced-intensity conditioning allogeneic HSCT may be considered MEDICALLY NECESSARY as a treatment of NHL in patients who meet criteria above for an allogeneic HSCT but who do not qualify for a myeloablative allogeneic HSCT.
- Autologous HSCT or allogeneic HSCT is considered INVESTIGATIVE:
  - As initial therapy (i.e., without a full course of standard-dose induction chemotherapy) for any NHL;
  - To consolidate a first CR for patients with diffuse large B-cell lymphoma and an International Prognostic Index score that predicts a low- or low-intermediate risk of relapse;
  - To consolidate a first CR for those with indolent NHL B-cell subtypes.
- Tandem transplants are considered INVESTIGATIVE to treat patients with any stage, grade, or subtype of NHL.

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Policies inactivated:

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

Respiratory Assist Devices

Fluency-Enhancing Devices for the Treatment of Stuttering

KIF6 Genotyping for Predicting Cardiovascular Risk and/or Effectiveness of Statin Therapy

Laboratory Studies for Diagnosing and Managing Inflammatory Bowel Disease

Proteomic Assay Testing for Targeted Therapy in Non-Small Cell Lung Cancer (NSCLC)

There was no Medical and Behavioral Health Policy Activity for July 2016.

Policies reviewed with no changes in May 2016 and June 2016:

Acupuncture

Angioplasty and/or Stenting for Intracranial Aneurysms and Atherosclerosis

Belimumab

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

Chelation Therapy

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

Computerized Dynamic Posturography

Endoscopic Radiofrequency Ablation or Cryoablation for Barrett's Esophagus

H.P. Acthar Gel (Repository Corticotropin)

Hematopoietic Stem-Cell Transplantation for Primary Amyloidosis

Hematopoietic Stem-Cell Transplantation for Waldenstrom Macroglobulinemia

Image-Guided Minimally Invasive Lumbar Decompression for Spinal Stenosis

Liposuction

Molecular Marker Evaluation of Thyroid Nodules

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

Pneumatic Compression Devices in the Outpatient or Home Setting

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Psychoanalysis

Spinal Unloading Devices: Patient-Operated

Surgical Interruption of Pelvic Nerve Pathways for Treatment of Pelvic Pain (Primary and Secondary Dysmenorrhea)

Surgical Treatment of Femoroacetabular Impingement

Transcranial Magnetic Stimulation

Treatment of Obstructive Sleep Apnea and Snoring in Adults

Ustekinumab (Stelara)

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

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:

Network Management R317
Editor: Holly Batchelder
P.O. Box 64560
St. Paul, MN 55164-0560
(651) 662-2014
toll free: 1-800-382-2000, ext. 22014

Advisors/Faith Bauer, CPC, CPC-H, CPC-P; Jeannie Harp, CPC; Janine Utecht, CPC, CPC-H, CPC-P, CPMA; and Karen Kiemele, MPH

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Network Management R317
P.O. Box 64560
St. Paul, MN 55164-0560