Concerns raised about potential cancer risks associated with CT scans are sobering and well worth noting.

Company Updates

Editor's Note: We are pleased to introduce the inaugural column of Roki Chauhan, MD, Senior Vice President, and Chief Medical Officer. His column will run periodically in future issues of Network News.

Radiation Risks Must be Part of the Discussion with Patients

Did you know a computed tomography (CT) scan of the abdomen exposes patients to radiation equivalent to 400 chest x-rays? Add a CT scan of the pelvis and the patient is exposed to a radiation dose equivalent to an additional 300 chest x-rays.

I often ask providers this question when visiting practices across the state. More often than not, the answer I hear from providers is that they were not aware of this. For me, this is just the beginning of the discussion.

While imaging studies play an important role in the diagnosis and management of certain conditions, it is critical that providers and patients discuss the pros and cons, including the medical need for the study as well as the risks.

In February of this year, the U.S. Food and Drug Administration announced an initiative to reduce unnecessary radiation exposure from CT, nuclear medicine studies, and fluoroscopy, citing them as the greatest contributors to total radiation exposure in the U.S. population. The FDA is advocating the adoption of two principles relating to radiation protection: appropriate justification for the radiation procedure and optimization of the radiation dose used during each procedure.

We absolutely support the FDA's initiative to make sure tests are appropriate and ensure radiation exposure is limited only to the extent needed for the exam—no more, no less.

The concerns raised in the recent Archives of Internal Medicine about potential cancer risks associated with CT scans are sobering and well worth noting:

“Our detailed calculations suggested that these scans would result in about 29,000 incident cancers, and assuming 50% mortality, these incident cancer cases would translate into about 14,500 cancer deaths.”

– Projected Cancer Risks from Computed Tomographic Scans
   Performed in the United States in 2007
   Arch Intern Med. 2009;169(22):2071-2077

Continued on page 2
“An estimated 1 in 270 women who underwent CT coronary angiography at age 40 years will develop cancer from that CT scan.”

– Radiation Dose Associated with Common Computed Tomography Examinations and the Associated Lifetime Attributable Risk of Cancer
Arch Intern Med. 2009;169(22):2078-2086

In 2008, we launched our Advanced Imaging Quality Initiative. Premera has partnered with Advanced Imaging Management (AIM) to ensure imaging studies are ordered using evidence-based guidelines. Through the AIM web site, ordering physicians have access to “Ask Aimee,” an interactive human model that provides the most up-to-date estimates of radiation dosage for commonly-ordered imaging studies, allowing providers to review common uses, alternative exams and radiation exposure levels associated with various imaging studies.

One beneficial feature of AIM is the radiation aggregator tool, which keeps track of the total radiation exposure for each health plan member. Once members exceed pre-defined limits for radiation exposure, providers ordering subsequent studies receive messages from AIM, informing them of the accumulated exposure.

My suggestion to all providers is to take a hard look at eliminating clinically inappropriate scans. It has been estimated that as much as one-third of all outpatient imaging is clinically unnecessary – meaning that the study did not influence the health management of the patient.

As noted in a recent American College of Radiology Study (supported by the University of Washington), fears of medical liability suits, economically-motivated in-office self-referrals, patient demand, and accommodating regional differences in practice style and physician experience and training are all causes of inappropriate utilization.

The study, published in the March issue of the Journal of American College of Radiology (J Am Coll Radiol. 2010;7:192-197) retrospectively reviewed 459 elective outpatient CT (284) and MRI (175) examinations ordered by primary care physicians between June 2007 and November 2007. Approximately 74% of these exams were considered appropriate. However, 118 of these exams, approximately 26% were considered inappropriate. Seventy-seven of these inappropriate exams were CT scans.

The discussion with patients shouldn’t end here. Providers should also consider the following — how much radiation has your patient been exposed to? Do they understand the risks and benefits of the tests you are ordering? Ultimately, they are the ones who could be exposed to unnecessary or inappropriate studies – and subject to the consequences.

Roki Chauhan, M.D. is Chief Medical Officer and a Senior Vice President at Premera Blue Cross.
Care Facilitation Becomes Integrated Health Management

Care Facilitation is the division within Premera that offers a range of products, programs and services to help employers and members take a more active role in managing overall health and related costs. Earlier this year, Care Facilitation changed its name to “Integrated Health Management.”

Since a full chapter of the provider manual is currently titled, “Care Facilitation,” we want you to be aware of this change. We believe the name better reflects our support for health promotion for the full continuum of care, as it relates to the care guidelines and the treatment you provide to Premera members.

A summary of key Integrated Health Management department offerings that support this care continuum follows:

Care Management is comprised of nurses, medical directors and other team members. It supports the timely medical intervention and access to appropriate clinical care for members. This includes voluntary benefit advisories and pre-certifications, which are required by the member's contract.

Medical Services and Quality provides physicians and hospitals with comparative information and data to support quality and evidence-based standards of care. A secondary but related activity includes encouraging cost-conscious action. This entails working with employers, members and providers to build an understanding of what is driving healthcare costs and how improved benefit designs and other initiatives can slow the rate of cost increases.

Pharmacy offers products, programs and services designed to help members and employers manage drug costs and the utilization of medications that can contribute to costs as well as utilization of the types of medications that offer the best health outcome at an affordable price. Offerings are designed to support member health, management of costs and patient safety. Here is one example:

Polypharmacy: Targets members using five or more medications to treat chronic conditions. In support of patient safety, we send a brown bag to these members and instruct them to fill the bag with all their current medications and supplements and bring to their provider for review at their next office visit.

As we implement this name change over the coming months, you may continue to see some references to our division as Care Facilitation until the transition to Integrated Health Management is complete.
IHM Resources Support Member/Provider Relationship

Integrated Health Management offers numerous products, programs and services to help members take a more active role in managing their overall health and related costs. These offerings also help members engage in maintaining or improving their health condition. These support the member/provider care relationship, positive health behaviors and clinical goals.

24/7 Access

All Premera members have 24-hour/seven-day-a-week access to phone and web-based pharmacy and medical care guideline tools to support every stage of the care continuum. Members can use our 24-hour NurseLine to obtain information from registered nurses about their immediate health concerns. This can help decrease unnecessary emergency room visits and additional costs.

Member Outreach

Premera’s member outreach benefits physicians and providers because patients are more aware of their health-conditions, informed about their medications, and know which questions to ask during an office visit.

- Our member portal sends registered members preventive care reminder messages. The messages suggest consulting with their provider about the importance of tests, screenings, and immunizations, depending on their particular age or demographic group.

- Pharmacy Point of Sale edits are transmitted electronically to pharmacists notifying them the prescription has a POS edit and they can only refill it once. Not all drugs qualify for this one-time over-ride. Premera mails information to the member about the drug, including a requirement to contact his/her provider to continue using it.

- Members enrolled in our voluntary Disease Management program receive outreach calls from nurses. Members receive Self-Care Goal Plans following these calls as well as education topic sheets (e.g. diet, exercise, medications, etc.). These resources encourage them to follow their physician’s treatment plan and work with their physician to manage any special health needs.

- Case Management offers voluntary support and coordination of care for members with complex or catastrophic medical conditions. Case Managers are typically registered nurses, licensed social workers or licensed behavioral health counselors. They help members understand their current health status, what they can do about it and why particular services or treatment are important.
Power System Upgrade Prompts Planned Data Outage

Premera is taking important steps to upgrade our power supply to help us continue providing quality and reliable service. As a result, our web site, email and phone systems will have limited availability from 6 p.m. Friday, May 7 through 5 a.m. Monday, May 10.

During this short outage period, providers and all Premera customers will have limited access to these systems:

**Phone/Fax:**
- All 800 phone numbers, voice mail, automated phone systems (Interactive Voice Response), and direct phone lines will be unavailable and callers will receive a maintenance message.

**Exceptions:** The 24-Hour Nurse Line and the Provider Appeals line will be available to callers during the outage period.

**Web/Email:**
- Access to the provider portal will be limited to non-secure areas that do not require provider sign-on. Areas that require sign-on, such as claims status, eligibility and benefits, and benefit advisory will be unavailable.

- Department email addresses will be operational, though there may be a slight delay in response time on the business day following the outage.

**Electronic Claims:**
- EDI trading partners (providers, billing agents, clearinghouses, etc.) will not be able to transmit/upload or retrieve/download electronic transaction files, including: claims, inquiry transactions, remittance advice, response transactions, and reports.

**Note:** To avoid slight delays, trading partners are encouraged to complete their EDI activities prior to the outages, before 5 p.m. (PST) on Friday, May 7.

We have taken steps to ensure this event has minimal impact to you and apologize for any inconvenience. If you have questions, call Physician and Provider Relations at 877-342-5258, option 4.
Last fall, Congress passed the Federal Mental Health Parity and Addiction Equity Act of 2008. The bill requires health plans offering mental health or substance use disorder benefits to provide financial requirements or treatment limitations that are no more restrictive than the most common or frequent limitations applied to medical and surgical benefits.

Beginning Nov. 1, 2009, Premera insured and self-funded group plans with 51 or more employees enroll or renew, will have unlimited mental health and chemical dependency benefits to comply with this legislation. Individual plans and small groups (2-50 employees) are exempt.

Effective July 1, 2010, Washington state parity law will remove mental health benefit limits and cost shares. The federal and state requirements are listed below:

### Federal Mental Health Parity
- Effective November 2009 as groups 51+ renew
- Requires financial requirements (deductibles, co-payments, coinsurance and out-of-pocket expenses) and treatment limits be no more restrictive than those applied to medical benefits
- Requires groups to offer parity if they choose to cover mental health or chemical dependency benefits, but does not require groups to offer mental health or chemical dependency coverage.
- No distinction between insured and self-funded groups

### Washington State Parity
- Effective July 2010
- Washington State Parity addresses mental health services for individual and small group. It does not include chemical dependency.
- Requires fully insured groups to provide coverage of mental health services and prescription drugs for mental health at parity with medical and surgical benefits.
- Requires Self-Funded Groups to offer parity if they choose to cover mental health benefits, but does not require groups to offer mental health benefits.
- Washington adds parity for mental health services (not chemical dependency) for individuals and small groups.
- Requires plans to offer out-of-network coverage for mental health and/or substance abuse benefits if out-of-network coverage is offered for medical and surgical benefits.

To learn more about the Federal Mental Health Parity and Addiction Equity Act, go to Parity Section 512 of the Emergency Economic Stabilization Act of 2008 (HR 1424) at the link below.

http://thomas.loc.gov/home/gpoxmlc110/h1424_enr.xml
Electronic Billing: Avoid Lost Claims and Eligibility Errors

Avoid eligibility errors and lost claims by downloading and reviewing clearinghouse reports from Secure Transport (ST). These reports contain rejected claim information, so you can compare them against your office reports to ensure accurate claim tracking.

The following are some key points to help you effectively use the reports:

- Reports are only available online via ST
- Retrieving (downloading) your reports regularly ensures notification that we received your claims, and alerts you to claim rejections
- Rejected claims are not processed; they must be corrected and re-billed
- When the 837 Transaction Error report is created, you will need to reference it against the Electronic Claim Transaction Report to accurately balance your electronic claims file
- These ‘reports’ are your only notification of claim receipt or rejections

For more information or assistance, please contact a member of our EDI Team at 800-435-2715.

Changes to Maintenance Code S8990

Effective Sept. 1, 2010 CPT Code S8990 Physical or manipulative therapy performed for maintenance rather than restoration will be determined to be not medically necessary and will not be covered under member benefits.

When billing for services using manipulation codes 97140, 98925-98929 or 98940-94943, you are indicating the service provided is medically necessary. Payment for these services will continue to be determined based on the member’s benefits.

When billing for maintenance manipulation using code S8990, you are indicating that services provided are for maintenance and are not medically necessary. Services that are not medically necessary are not covered and will show as member liability on the Explanation of Payment (EOP). You may collect payment directly from the member.

For additional support, please contact us at 877-342-5258. For claims related questions press option 2 for Customer Service, for questions about this change press option 4 for Physician and Provider Relations.
Bilateral Procedures and Modifier 50

Appropriateness for bilateral services is determined using the combined sources of the Medicare Physician Fee Schedule Database (MPFSDB) and the American Medical Association (AMA) data.

Bilateral surgeries are treated like any other multiple procedures. When multiple surgeries are performed in the same operative session, the payment adjustment for bilateral services is applied prior to the multiple surgical payment adjustment.

The following are billing guidelines for bilateral procedures and use of modifier 50 (also reference Figure 1 below):

- If an individual procedure is identified by the CPT terminology as being “bilateral” or “bilateral or unilateral,” do not report modifier 50.
- If an individual procedure is not identified by the CPT terminology, the bilateral procedure should be listed with the 50 modifier.
- Modifier 50 should be applied to any procedure performed on both sides (mirror image) during the same operative session.
- Physicians should not use modifiers RT and LT when Modifier 50 applies.
- Physicians should bill a bilateral procedure on one line using modifier 50.
- ASCs should bill a bilateral procedure on two lines utilizing modifiers LT and RT or Modifier 50, but not both. The quantity or units to use when modifier 50 is reported is one.

Modifiers 54, 55, 56

By third quarter 2010, we will update the Payment Policy for Modifiers 54, 55 and 56 to follow American Medical Association (AMA), Current Procedural Terminology (CPT), and Center for Medicare and Medicaid Services guidelines.

The following are the revised policy statements:

- Modifier 54 is billed to indicate when one physician performs the surgical care and another physician performs the pre-operative or post-operative care, each belonging to a different practice
- Modifier 55 is billed to indicate when one physician performs the post-operative management and another physician performs the surgical care, each belonging to a different practice
- Modifier 56 is billed to indicate when one physician performs the pre-operative management only and another physician performs the surgical care, each belonging to a different practice.

If you have any questions, call Physician and Provider Relations at 877-342-5258, option 4.

Figure 1: Bilateral Procedures and Modifier 50

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Description</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>Procedure performed unilaterally Or Procedure is bilateral by description</td>
<td>Unilateral procedure performed bilaterally</td>
</tr>
<tr>
<td>ASC</td>
<td>Bill on one line – no bilateral modifier should be appended to the code</td>
<td>Bill one line with modifier LT Bill other line with modifier RT Or Bill the first line with the procedure Bill the second line with the procedure appended with modifier 50 <strong>Note: do not use both modifier 50 and LT/RT modifiers on the same line</strong></td>
</tr>
</tbody>
</table>
Online Benefit Advisory Tool is Simple

W

e encourage providers to request a benefit advisory on some procedures up front to avoid a medical necessity review after submitting the claim. There are several ways to determine whether or not a Benefit Advisory is recommended on the service you will be providing. The fastest, easiest way is to use the online Benefit Advisory Tool located on the provider portal.

- Obtain the information immediately
- Receive instructions on how to submit your request if a review is necessary
- Reduce calls to Care Management and Customer Service

To get started, visit the premera.com/provider homepage and select Benefit Advisory/Cert tool on left navigation menu. It’s simple to use.
- Sign in
- Locate the member in the system
- Enter the procedure code and date of service
- A message will appear indicating if a request is necessary and instructions on how to submit the request.

Important! Advanced imaging services for Computerized Tomography (CT), MRI/MRA and Nuclear Cardiology are reviewed for medical necessity.

An order number through American Imaging Management may be required (varies by member plan):
- Online at americanimaging.net/goweb
- View our Medical Policies online at premera.com/provider.

For additional information about our clinical review programs, visit our library on the provider portal at premera.com/provider. From there, select Care Facilitation, and then click on Care Management.

Easy Access to OneHealthPort’s Training Center

We now have a link to OneHealthPort’s Training Center from our provider portal landing page at premera.com/provider. It is located under Resources and Tools (see Figure 1). Watch video tours of our secure provider portal tools including the Claims Editor What if Tool, Real-Time Estimates/Claims Tool, Eligibility and Benefits and Claims.

Figure 1: OneHealthPort’s Training Center on the provider portal
New BlueCard Members in Premera’s Service Area

As a participating provider of Premera Blue Cross you may render services to patients who are national account members of other Blue Cross and/or Blue Shield Plans who travel or live in Washington (or the Premera Blue Cross of Washington service area). The BlueCard Program lets you conveniently submit claims for members from other Blue Plans, directly to Premera.

When members of Blue Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card. The main identifier for out-of-area members is the alpha prefix. The ID cards may also have a ‘PPO in a suitcase’ logo, or a ‘blank suitcase’ logo.

For other coverage and eligibility information for BlueCard members, submit an electronic inquiry to Premera or call BlueCard Eligibility 800-676-BLUE to verify the patient’s eligibility and coverage.

### Table 1: Quality Index Report Measurements

<table>
<thead>
<tr>
<th>Employer/Account Name</th>
<th>Blue Plan</th>
<th>Alpha Prefix(es)</th>
<th>Washington Employees</th>
<th>Effective Date of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verizon</td>
<td>New York – Empire</td>
<td>DZV, EZV, FZV</td>
<td>4,970</td>
<td>January 1, 2010</td>
</tr>
<tr>
<td>Arby’s Restaurant</td>
<td>Blue Cross of California</td>
<td>DBY, KBV</td>
<td>414</td>
<td>January 1, 2010</td>
</tr>
<tr>
<td>Direct TV Group</td>
<td>Anthem Blue Cross Blue Shield of Colorado</td>
<td>DRT</td>
<td>403</td>
<td>January 1, 2010</td>
</tr>
<tr>
<td>Old Castle, Inc.</td>
<td>Blue Cross Blue Shield of Georgia</td>
<td>WQL</td>
<td>960</td>
<td>January 1, 2010</td>
</tr>
<tr>
<td>Wells Fargo and Company</td>
<td>Anthem Blue Cross Blue Shield of Ohio</td>
<td>WFQ</td>
<td>5,406</td>
<td>January 1, 2010</td>
</tr>
<tr>
<td>Hewlett Packard</td>
<td>Blue Cross of California</td>
<td>KHW</td>
<td>1,383</td>
<td>January 1, 2010</td>
</tr>
</tbody>
</table>
Save Time, Increase Efficiency

Using the Real-Time Estimates/Claims tool can save you time and increase efficiency in your office. Provider offices throughout the Northwest are using the Real-Time Estimates/Claims tool for services billed on a CMS 1500 claim form to generate estimates of the patient’s share of cost at the time of service.

“The estimator tool that is available through the Premera portal has been immensely helpful to our registration and other staff. We are able to use the tool to clearly define reimbursement levels and to see if there are any concerns with medical policy or payment policy with codes that are entered. This tool is useful for us to educate patients with regard to their benefits and patient responsibility. This tool saves our business office staff a great deal of time and improves their efficiency and accuracy.”

— Wendy Taylor, business manager at Overlake Surgery Center

In addition to generating an estimate for the provider's office, the tool also allows you to print a copy of the estimate results for the patient which clearly shows how their share of cost was estimated.

Terri Montano, director of business services at Spokane Eye Clinic, PS, states,

“We have found the online claim estimator to be very useful and we use it frequently. We are able to provide a more accurate estimate to patients about their out of pocket expense based on their benefits and their particular situation. Patients appreciate receiving the detailed information that is available. Because the estimator is online, we can access it at any time and utilize the most current information available for the patient. Using the estimator has reduced the number of times we need to call customer service.”

The Real-Time Estimates/Claims tool is web-based and easy to use. The calculation response is delivered within seconds based on the following:

- Contract pricing for each specific physician or provider
- Patient eligibility
- Patient current deductible, coinsurance, or copay
- All accumulators met to date and out-of-pocket maximum

Watch our video tours available on the Premera provider homepage. Select the OneHealthPort Training Center link under Resources and Tools. The Real-Time Estimates/Claims video tours are located under Health Plan Site Tours (each is approximately five minutes in length).

We encourage you to access and begin using the tool through the secure area of the provider portal at premera.com/provider, located under Tools.

For questions about Real-Time Estimates/Claims, please contact Physician and Provider Relations at 877-342-5258, option 4.
Physicians, Providers and Office Staff

Premera medical policies are guides in evaluating the medical necessity of a particular service or treatment. We adopt policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, we reserve the right to review and update our policies as appropriate. When there are differences between the member’s contract and medical policy, the member’s contract prevails. The existence of a medical policy does not guarantee that the member’s contract allows the service.

Medical policies are available on the premera.com/provider Click on the Medical Policies link under Reference Info in the provider Library. If you would like a copy of a particular medical policy and are unable to obtain it from our web site, email your request to medicalpolicy@premera.com. If you do not have Internet access, you may call Physician and Provider Relations at 877-342-5258, option 4.

Note: All policy numbers begin with CPMP and are listed here in numeric order.

The following policy changes are effective for dates of service of January 12, 2010 and later:

<table>
<thead>
<tr>
<th>Policy Number</th>
<th>Policy Description</th>
<th>Effective Date</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>BC.2.01.56</td>
<td>Low-Level Laser Therapy</td>
<td>January 12, 2010</td>
<td>Policy statement updated to expand beyond carpal tunnel syndrome to include other musculoskeletal conditions and wound healing as investigational.</td>
</tr>
<tr>
<td>BC.2.01.20</td>
<td>Esophageal pH Monitoring</td>
<td>January 12, 2010</td>
<td>This policy has been deleted and will no longer be reviewed. The policy was replaced by PR.2.01.520.</td>
</tr>
<tr>
<td>PR.2.01.520</td>
<td>Esophageal pH Monitoring, New Policy</td>
<td>January 12, 2010</td>
<td>Esophageal pH monitoring using either a catheter-based or wireless system may be considered medically necessary when certain clinical indications are met.</td>
</tr>
<tr>
<td>BC.2.01.68</td>
<td>Laboratory Tests for Heart Transplant Rejection</td>
<td>January 12, 2010</td>
<td>This policy has been deleted and will no longer be reviewed.</td>
</tr>
<tr>
<td>BC.2.02.11</td>
<td>Intra-arterial Brachytherapy for Prevention and Management of Restenosis After Percutaneous Transluminal Angioplasty (PTA)</td>
<td>January 12, 2010</td>
<td>This policy has been deleted and will no longer be reviewed.</td>
</tr>
<tr>
<td>BC.2.04.366</td>
<td>Assays of Genetic Expression in Tumor Tissue as a Technique to Determine Prognosis in Patients with Breast Cancer</td>
<td>January 12, 2010</td>
<td>Policy statements revised. All other indications for the 21-gene RT-PCR assay, including determination of recurrence risk in breast cancer patients who are lymph node-positive, are considered investigational. The use of THEROS Breast Cancer Index is considered investigational.</td>
</tr>
<tr>
<td>BC.5.01.07</td>
<td>Acute and Maintenance Tocolysis</td>
<td>January 12, 2010</td>
<td>Policy statements revised. Acute tocolytic therapy with betamimetics, calcium channel blockers, magnesium sulfate, and prostaglandin inhibitors may be considered medically necessary for the induction of tocolysis in patients with preterm (&lt;37 weeks gestational age) labor. Maintenance tocolytic therapy with any medication, including but not limited to subcutaneous or intravenous terbutaline is considered investigational.</td>
</tr>
<tr>
<td>BC.5.01.517</td>
<td>Use of Vascular Endothelial Growth Factor Receptor (VEGF) Inhibitors and Other Angiogenesis Inhibitors in Oncology Patients</td>
<td>January 12, 2010</td>
<td>Policy statement updated. Policy statement now specifically indicates that Avastin for advanced adenocarcinoma of the pancreas is investigational.</td>
</tr>
<tr>
<td>PR.5.01.603</td>
<td>Epidermal Growth Factor Receptor (EGFR)</td>
<td>January 12, 2010</td>
<td>Policy guidelines revised. Documentation of K-Ras analysis is not required for patients with squamous cell carcinomas of the head and neck.</td>
</tr>
<tr>
<td>BC.6.01.27</td>
<td>FDG Using Camera-Based Imaging (FDG-SPECT)</td>
<td>January 12, 2010</td>
<td>This policy has been deleted and will no longer be reviewed.</td>
</tr>
<tr>
<td>BC.7.01.15</td>
<td>Meniscal Allografts and Collagen meniscus Implants</td>
<td>January 12, 2010</td>
<td>Policy statement added. Collagen meniscus implants are considered investigational.</td>
</tr>
</tbody>
</table>
**Autologous Chondrocyte Implantation/Transplantation.** Policy statement added. Matrix-induced autologous chondrocyte implantation is considered investigational.

**Auditory Brain Stem Implant.** Policy statements revised and new statements added. Bilateral use of an auditory brain stem implant is considered investigational. Penetrating electrode auditory brainstem implant (PABI) is considered investigational.

**Hip Surgery for Femoroacetabular Impingement (FAI) Syndrome.** Policy statement updated. Hip arthroscopy to address labral tears, in the absence of loose bodies, is considered investigational.

**Intra-Operative Neurophysiologic Monitoring (Sensory-Evoked Potentials, Motor-Evoked Potentials, EEG Monitoring).** This policy has been deleted and will no longer be reviewed. This policy was replaced by PR.7.01.541.

**Hematopoietic Stem Cell Transplantation for CNS Embryonal Tumors and Ependymoma.** Policy statement changed regarding autologous consolidation therapy in patients with previously untreated embryonal tumors showing complete or partial response to, or stable disease after, induction therapy; now considered medically necessary.

**Hematopoietic Stem Cell Transplantation for Hodgkin Lymphoma Disease.** Policy statements added. Tandem autologous SCT and reduced-intensity conditioning (RIC) allogeneic SCT may be considered medically necessary in specific situations and that a second autologous stem-cell transplantation for relapsed lymphoma after a prior autologous hematopoietic stem cell transplant is considered investigational.

**Hematopoietic Stem Cell Transplantation for the Treatment of Chronic Myelogenous Leukemia.** Policy statement revised. Allogeneic SCT using reduced intensity conditioning may be considered medically necessary as a treatment of chronic myelogenous leukemia in patients who meet clinical criteria for an allogeneic SCT but who are not considered candidates for a myeloablative conditioning allogeneic SCT.

**Cardiac Rehabilitation.** This policy has been deleted and will no longer be reviewed.
The following policy changes are effective for dates of service of February 9, 2010 and later:

**BC.2.01.80** Endoscopic Radiofrequency Ablation or Cryoablation for Barrett’s Esophagus. Policy statement revised. Radiofrequency ablation, previously considered investigational, may now be considered medically necessary for Barrett’s esophagus with high-grade dysplasia. New policy statement added. Cryoablation is considered investigational for Barrett’s esophagus, with or without dysplasia.

**PR.2.01.503** Diagnosis and Treatment of Obstructive Sleep Apnea Syndrome and Upper Airway Resistance Syndrome. Policy statements added. Unattended (unsupervised) sleep studies are considered investigational in pediatric patients (i.e. less than 18 years of age). A repeat unattended (unsupervised) home sleep study with a minimum of 4 recording channels (including oxygen saturation, respiratory movement, and airflow) may be considered medically necessary in adult patients under the following circumstances: to assess efficacy of surgery or oral appliances/devices; OR to re-evaluate the diagnosis of obstructive sleep apnea and need for continued CPAP. CPAP may be considered medically necessary in patients with clinically significant obstructive sleep apnea. Auto-adjusting or bi-level positive airway pressure may be considered medically necessary in certain situations. Introral appliances may be considered medically necessary with clinically significant OSA when certain criteria are met.

**BC.7.01.123** Plugs for Fistula Repair. New policy. Biosynthetic fistula plugs, including plugs made of porcine small intestine submucosa or of synthetic material are considered investigational for all indications including, but not limited to, repair of anal and rectal fistulas.

**PR.7.01.529** Electrical Bone Growth Stimulation of the Appendicular Skeleton. Policy statement added. Implantable and semi-invasive electrical bone growth stimulators are considered investigational.

**PR.8.03.504** Cognitive Rehabilitation. Policy statements revised. Cognitive rehabilitation, previously considered investigational, may now be considered medically necessary, (as a component of a comprehensive rehabilitation program), in either the inpatient or outpatient setting, for traumatic brain injury and stroke patients. Cognitive rehabilitation is investigational for all other applications, including but not limited to: post-encephalopathy patients; and the aging population including Alzheimer’s patients.

**BC.9.03.01** Keratoprosthesis. Policy statement revised. The Boston Keratoprosthesis, previously considered investigational, may now be considered medically necessary when certain conditions are met.
The following policy changes are effective for dates of service of **March 9, 2010** and later:

**BC.2.01.34** Cutaneous Electrogastrography (ECG). This policy has been deleted and will no longer be reviewed.

**BC.2.01.63** Electrical Impedance Scanning of the Breast. This policy has been deleted and will no longer be reviewed.

**BC.2.02.19** Radiofrequency Catheter Ablation of the Pulmonary Veins as Treatment for Atrial Fibrillation. Policy statement added. Repeat procedures may be considered medically necessary in specific situations.

**BC.2.03.06** Microwave Thermotherapy for Primary Breast Cancer. This policy has been deleted and will no longer be reviewed.

**BC.2.04.09** Monolayer Slide Preparation and Automated Slide Reading Systems, and Human Papillomavirus Testing for Cervical Cancer Screening. This policy has been deleted and will no longer be reviewed.

**BC.2.04.49** Laboratory Testing for HIV Tropism. This policy has been deleted and will no longer be reviewed.

**BC.2.04.60** Tyrosine Kinase Mutations in Myeloproliferative Neoplasms. **New policy.** JAK2 tyrosine kinase and MPL mutation testing may be considered medically necessary in the diagnosis of patients presenting with clinical, laboratory, or pathological findings suggesting myeloproliferative neoplasms particularly polycythemia vera, essential thrombocytosis, or primary myelofibrosis. JAK2 tyrosine kinase and MPL mutation testing may be considered investigational in the diagnosis of acute lymphoblastic leukemia in patients with Down syndrome, for molecular profiling of MPNs and determining disease prognosis, for predicting response to or monitoring either established or experimental (tyrosine kinase inhibitors) therapies.

**BC.4.01.13** Hysteroscopic Placement of Microinserts in the Fallopian Tubes as a Form of Permanent Sterilization. This policy has been deleted and will no longer be reviewed.

**PR.5.01.605** Medical Necessity Criteria for Pharmacy Edits. Policy statements updated. Medically necessary indications added for Provigil and Nuvigil when certain criteria met.

**PR.6.01.505** Oncologic Applications of PET Scanning. This policy has been deleted and will no longer be reviewed.

**BC.7.01.83** Auditory Brain Stem. This policy has been deleted and will no longer be reviewed.

**BC.7.01.94** Continuous Local Delivery of Analgesia to Operative Sites Using an Elastomeric Infusion Pump. This policy has been deleted and will no longer be reviewed.

**BC.7.01.122** Electromagnetic Navigation Bronchoscopy. **New policy.** Electromagnetic navigation bronchoscopy is considered investigational for use with flexible bronchoscopy for the diagnosis of pulmonary lesions and mediastinal lymph nodes and placement of fiducial markers.

**PR.7.01.539** Hip Surgery for Femoroacetabular Impingement (FAI) Syndrome. Policy statement added to indicate that hip arthroscopy to remove/repair cartilage dysplasia, loose bodies, foreign body or labral tears may be considered medically necessary under certain conditions. Hip surgery (Osteotomy performed by arthroscope or by open procedure) for the treatment of femoroacetabular impingement (FAI) syndrome is considered investigational.

**PR.7.03.510** Small Bowel, Small Bowel/Liver and Multivisceral Transplant. Small bowel policy statements added indicating using a living donor only when a cadaveric intestine is not available may be medically necessary. Small bowel transplant using living donors is considered not medically necessary in other situations.

**BC.8.01.03** Extracorporeal Immunoabsorption Using Protein A Columns. This policy has been deleted and will no longer be reviewed.
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