

Blue Care Network 2009 Clinical Review Program Medical Necessity Criteria / Benefit Review Requirements



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Requested service	Required clinical criteria and information
<p>Note: Refer to the BlueCaid and BCN Referral and Clinical Review Programs for referral and review requirements.</p>	
<p>Inpatient admissions: urgent/emergent and out of network (noncontracted)</p>	<p>Apply InterQual® criteria, including BCN Local Rules. Document the specific criteria subset used in addition to the following information:</p> <ul style="list-style-type: none"> • Signs and symptoms indicated by Severity of Illness, including reason for visit to ER or physician's office • Treatment plan indicated by Intensity of Service, including response to medical treatment in ER and physician's office • Diagnosis • Past medical history • Vital signs • Diagnostic tests and labs with results, if available
<p>Abdominoplasty</p>	<ul style="list-style-type: none"> • Evidence of weight loss of at least 100 pounds or • Panniculus hangs below the level of the pubis and causes uncontrolled intertrigo, unresponsive to conservative treatment and maximum weight loss and weight stability for a minimum of six months has occurred or • Surgery necessary to correct abnormal structures of the body caused by congenital defect, developmental abnormality, trauma, infection or tumors and accompanied by a functional impairment
<p>Amevive® (alefacept)</p>	<p>Amevive is given in 12 weekly doses and is used in the treatment of adults with moderate to severe chronic plaque psoriasis when all of the following criteria have been met:</p> <ul style="list-style-type: none"> • Minimum involvement of 10 percent of body surface area or severe plantar and palmar involvement • Must have tried other therapies (phototherapy or other systemic medications such as methotrexate or cyclosporine) • CD4+ count greater than 250 cells/μL, monitored weekly • No history of systemic malignancy <p>Note: If the member has a positive response of at least 50 percent, treatment can be repeated for one additional 12-week cycle after waiting 12 weeks. Data are limited on the safety and effectiveness beyond two courses of treatment.</p>
<p>Avastin® (bevacizumab)</p>	<p>The intraocular use of bevacizumab is shown to be safe and effective in the treatment of proliferative, or "wet," macular degeneration. Other ocular uses of bevacizumab are considered investigational.</p>

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<p>Bariatric surgery</p> <p>BCN commercial HMO members: Bariatric surgery must be performed at a BCN Center of Excellence</p> <p>BCN Advantage members: Bariatric surgery must be performed at a BCN-contracted and Medicare-approved facility</p> <p><i>(continued on next page)</i></p>	<p>The surgical procedures for severe obesity are considered established treatment options if all of the following criteria are met:</p> <ul style="list-style-type: none"> • The member has either a body mass index (BMI) greater than 40 or a BMI greater than 35 with comorbid conditions (such as degenerative joint disease, hypertension, hyperlipidemia, coronary artery disease, presence of other atherosclerotic diseases, Type II diabetes mellitus, sleep apnea and/or congestive heart failure). • Bariatric surgery may be indicated for members 18 to 65 years of age. <ul style="list-style-type: none"> – Requests for members younger than 18 years of age should include documentation that the primary care physician has addressed the risk of surgery related to future growth, the member’s maturity level, an ability to understand the procedure and comply with postoperative instructions, as well as the adequacy of family support. – Members older than 65 years of age may be considered if it is documented in the medical record that the member’s physiologic age and comorbid condition(s) result in a positive risk/benefit ratio. • The member has been clinically evaluated by an M.D. or D.O. who has documented failure of nonsurgical management, including a structured, professionally supervised (physician or nonphysician) weight loss program for a minimum of six consecutive months within the last four years prior to the recommendation for bariatric surgery. Documentation should include periodic weights, dietary therapy and physical exercise, as well as behavioral therapy, counseling and pharmacotherapy, as indicated. The member’s medical record must demonstrate assessment and a therapeutic plan for each of the following elements: diet, physical activity, behavioral interventions and pharmacology. These criteria are to be documented in the concurrent medical record for six consecutive months prior to the request for bariatric surgery. There is a minimum of three physician office visits required in the first 90 days (more frequently, as clinical circumstances dictate) and one visit in the subsequent three months, at which all of these elements must be documented. <p>Note: The six-month criterion is waived for individuals with a BMI greater than 50.</p> <ul style="list-style-type: none"> – Diet: It must be demonstrated that the appropriate caloric restriction was prescribed and explained and that the member’s dietary intake was reviewed since the previous visit and the caloric intake documented. The aim is to create a daily deficit of 500 to 1000 calories (resulting in a one- to two-pound weight loss per week).

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<p>(continued) Bariatric surgery</p>	<ul style="list-style-type: none"> – Physical activity: A physical exercise prescription appropriate for the member’s age and physical condition should be developed and compliance should be monitored and documented at each visit. This prescription should be consistent with current guidelines from BCN and the National Institutes of Health. A regimen generally recommended includes 60 to 90 minutes of physical activity of moderate intensity (swimming, walking, bicycling, etc.) five to seven days per week. – Behavioral intervention: Specific strategies to provide tools for overcoming barriers and improving dietary compliance should be reviewed as appropriate. Examples of these strategies include but are not limited to the self-monitoring of eating habits and physical activity (log book), stress management, stimulus control, problem solving and social support. – Pharmacotherapy: In some members, FDA-approved weight loss drugs may augment caloric restriction, physical activity and behavioral modification. The documentation should indicate that pharmacotherapy for weight loss was considered and was discussed with the member as a treatment option. • Documentation that the primary care physician and the member have a good understanding of the risks involved and reasonable expectations that the member will comply with all post-surgical requirements. • A psychological evaluation must be performed by a mental health professional contracted with BCN, in order to establish the member's emotional stability and ability to comply with post-surgical limitations. • In cases in which a revision of the original procedure is planned, the member must meet all of the initial criteria. Additional documentation of all of the following is required: <ul style="list-style-type: none"> – Date and type of previous procedure – The factor(s) that precipitated failure – Any complications from the previous procedure that mandate (necessitate) the takedown – The member’s inability to maintain the weight loss • Physicians need to be aware of long-term complications of gastric surgery with these members and follow up with them. • Previous gastric restrictive procedures that have failed for anatomic or technical reasons (for example, obstruction, staple dehiscence, etc.) are determined to be medically appropriate for revision without consideration of the criteria outlined here.

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<p>Biofeedback (urinary and fecal incontinence and chronic constipation)</p>	<p>For adults, evidence of all of the following:</p> <ul style="list-style-type: none"> • Stress and/or urge incontinence • That the member is cognitively intact • A documented failed trial of pelvic muscle exercise (PME) training, defined as no clinically significant improvement in urinary incontinence after completion of four weeks of an ordered plan of PMEs to increase periurethral muscle strength • Motivation to comply with treatment • Some degree of rectal sensation and ability to contract the external anal sphincter <p>For children 4 years of age and older, evidence of all of the following:</p> <ul style="list-style-type: none"> • Neurologic, anatomic, infectious or functional causes are ruled out • Ability to comprehend verbal instructions • Motivation to comply with treatment • Some degree of rectal sensation and ability to contract the external anal sphincter
<p>Blepharoplasty</p>	<ul style="list-style-type: none"> • Visual field testing taped and untaped reveals a 30 percent or 12 degree loss of superior visual field and • Excessive skin redundancy correlates with the visual field impairment or • Chronic eyelid dermatitis due to redundant skin
<p>Bone-anchored hearing aid (BAHA)</p>	<p>The following must be submitted:</p> <ul style="list-style-type: none"> • Specialist's consultation and • Evidence of one or more of the following: <ul style="list-style-type: none"> – Congenital or surgically induced malformations (for example, atresia) of the external ear canal or middle ear – Chronic external otitis or otitis media – Tumors of the external canal and/or tympanic cavity – Chronic dermatitis of the external canal prohibiting the use of an air-conduction hearing aid – Inability to wear conventional bone-conduction hearing aids

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<p>Bone growth stimulator</p>	<p>Bone growth stimulation may be considered appropriate for the treatment of fracture nonunions or congenital pseudoarthroses in the appendicular skeleton, including the bones of the shoulder girdle, upper extremities, pelvis and lower extremities. The diagnosis of fracture nonunion must meet all of the following criteria:</p> <ul style="list-style-type: none"> • At least three months have passed since the date of fracture. • Serial radiographs have confirmed that no progressive signs of healing have occurred. • The member can be adequately immobilized and is of an age likely to comply with non-weight bearing. <p>May also be indicated as an adjunct to high-risk fusion cases that meet one or more of the following criteria:</p> <ul style="list-style-type: none"> • Prior fusion failure • Multilevel fusion attempts • Diabetics and others with poor bone healing • Members with grade III or greater spondylolisthesis
<p>BOTOX® (botulinum toxin type A) injections</p>	<p>The following information must be submitted:</p> <ul style="list-style-type: none"> • Diagnosis and • Previous treatment and • Response to previous treatment
<p>Breast implants – insertion, removal, replacement</p>	<p>Must submit all of the following:</p> <ul style="list-style-type: none"> • Mammogram or ultrasound results • Signs and symptoms of breast condition • Plastic surgeon consultation • Evidence that the member had: <ul style="list-style-type: none"> – Mastectomy or trauma – Rupture of silicone implants, infection, extrusion or Baker Grade IV contracture – Ruptured saline implant that was originally implanted for reconstructive purposes • Evidence that the original insertion was not for cosmetic reasons, if reinsertion of silicone or saline breast implant(s) is requested

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Breast reconstruction	<p>Must submit all of the following:</p> <ul style="list-style-type: none"> • Diagnosis • Surgical consultation report • Evidence of medically necessary reconstruction due to: <ul style="list-style-type: none"> – Trauma to the breast(s) – Mastectomy secondary to family or personal history of cancer of the breast – Mastectomy due to current diagnosis of breast cancer – Congenital defects, such as breast agensis – Developmental abnormalities, infection or follow-up after therapeutic surgery
Breast reduction (reduction mammoplasty)	<p>Must submit all of the following:</p> <ul style="list-style-type: none"> • Evidence that two or more of the following criteria are met: <ul style="list-style-type: none"> – Pain, including both (a) location, duration, intensity and (b) failure of a minimum of three months' conservative therapy – Ulceration of skin of shoulder or shoulder grooving – Intertrigo between the breasts and the chest wall does not respond to treatment – Lordotic posture – Ulnar paresthesia • Height and weight of the member and the amount of breast tissue to be removed from each breast (photographs of shoulder grooving may be required) • Evidence that the member is old enough that the breasts are fully grown
Cardiac rehabilitation (extensions with previous cardiac event)	<p>Must submit all of the following:</p> <ul style="list-style-type: none"> • Diagnosis • Cardiology consultation • Current progress notes from rehabilitation phase
Cosmetic and reconstructive surgery	<p>Must submit all of the following:</p> <ul style="list-style-type: none"> • Surgeon/plastic surgeon consultation • Evidence of functional deficit
CT of abdomen	Refer to Radiology Questionnaire for CT of the Abdomen .

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CT of brain	Refer to Radiology Questionnaire for CT of the Brain .
CT of chest	Refer to Radiology Questionnaire for CT of Chest .
CT of face and jaw	Refer to Radiology Questionnaire for CT of Face and Jaw (Maxillofacial area) .
CT of lumbar spine	Refer to Radiology Questionnaire for CT of the Lumbar Spine .
CT of pelvis	Refer to Radiology Questionnaire for CT of the Pelvis .
Dental anesthesia—in outpatient setting (or provider office)	Must submit all of the following: <ul style="list-style-type: none"> • Reason the procedure must be done in outpatient setting (or provider office) and not in the other location • Behavioral problems or medical condition • Dental treatment plan
Dental services for trauma	Must submit all of the following: <ul style="list-style-type: none"> • Evidence that services will be provided within 72 hours of injury • Date of dental trauma or injury • Treatment received • Type of injury
Dermabrasion (chemical peel)	Must submit specialist consultation that includes evidence of: <ul style="list-style-type: none"> • More than 10 actinic keratoses or other premalignant skin lesions or • Active acne that failed previous treatment with a two-month trial of topical and/or antibiotic
Developmental delay treatment	Must submit all of the following: <ul style="list-style-type: none"> • Specialist consultation, if applicable • Condition for treatment • Previous history and response to treatment

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<p>Durable medical equipment and prosthetics and orthotics</p>	<ul style="list-style-type: none"> • For BlueCaid: <ul style="list-style-type: none"> – For DME, contact MedEquip at 800-530-0714. – For P&O, contact the U-M Orthotics & Prosthetics Center at 800-530-0714. • For HMO and BCN Advantage: <ul style="list-style-type: none"> – For diabetic and insulin pump supplies only, contact J&B Medical Supply at 888-896-6233. – For nondiabetic supplies, contact Northwood at 800-667-8496.
<p>Elective termination of pregnancy</p>	<p>Must submit all of the following:</p> <ul style="list-style-type: none"> • Number of weeks pregnant as documented on ultrasound or amniocentesis • Medical condition of mother and/or fetus
<p>Enteral/parenteral home infusion therapy</p>	<p>Must submit all of the following:</p> <ul style="list-style-type: none"> • Diagnosis • Type of tube and method of administration • Type of feeding, including K/cal per day • Oral feeding (if applicable) K/cal per day • Weight and height, including ideal body weight • Expected duration <p>See the <i>Nutrition Assessment/Follow Up</i> form in the <i>Forms</i> chapter of the <i>BCN Provider Manual</i> or on the web-DENIS Forms page.</p>
<p>Experimental or investigational procedures</p>	<p>Must submit all of the following:</p> <ul style="list-style-type: none"> • Complete description of service or procedure requested • Diagnosis • Clinical trial information or peer-reviewed literature to support the clinical efficacy of the service or treatment being performed
<p>Fetal invasive procedures, unlisted</p>	<p>Must submit all of the following:</p> <ul style="list-style-type: none"> • Specialty consultation • Fetal gestational age • Description of fetal procedural plan

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Flolan® (epoprostenol sodium) therapy	Must submit all of the following: <ul style="list-style-type: none"> • Pulmonary hypertension therapy with New York Heart Association Class III or Class IV symptoms • Failure to respond to medical management (for example, oral vasodilator therapy)
Frenulum surgery: frenectomy, frenotomy, frenulectomy or frenoplasty	Must submit one or more of the following: <ul style="list-style-type: none"> • Evidence of an infant's inability to feed, causing failure to thrive • Physical examination of a young child (may be as young as 9 months old) confirms the presence of "tongue tie," causing the child difficulty in learning to speak because of inability to manipulate the tongue. • Speech therapy evaluation documents expressive language difficulties as a result of tongue immobility.
Hyperbaric oxygen therapy	Must submit evidence of one of the following conditions effectively treated by systemic hyperbaric oxygen therapy: <ul style="list-style-type: none"> • Rapid onset of bone inflammation caused by infection • Injury of the arms or legs that causes a decrease in oxygen to the area • Rapid onset of carbon monoxide poisoning • Extra fluid in the brain • Crushing injuries to the arms or legs or the loss of a limb • Rapid onset of cyanide poisoning • A painful condition known as the bends, caused by diving • A gas bubble in the body's bloodstream • An infection that produces gas in the tissues and causes tissue death in the affected area • Severe blood loss with low levels of oxygen in the blood (anemia), when a transfusion is impossible or delayed • A bone that has died as a complication of radiation therapy • Preparation or preservation of a skin graft that is compromised • Bone or joint infections that produce a gas in the affected area after trauma or surgery • Severe fungal infections that are not improving with antibiotics or surgery • Diabetic wound(s) of the feet or legs (Wagner Grade III or higher) that have not responded to an adequate course of standard wound therapy

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Immune globulin replacement therapy (intravenous and subcutaneous)	Must submit all of the following: <ul style="list-style-type: none"> • Diagnosis • Specific immune globulin drug product name • Dosage of drug • Frequency of administration • Length of treatment • Member's weight • Previous medications used to treat this condition, including dosage, regimens, dates of therapy and response • Any additional pertinent medical information
Infertility evaluation, testing and treatment	Verify benefit, then submit all of the following: <ul style="list-style-type: none"> • Specialty consultation that includes member's history, previous treatment and response • Proposed treatment plan <p>Excludes in-vitro fertilization and related services.</p>
Lab services and genetic testing	Provider should contact JVHL at 800-445-4979 to request services.
Mastectomy for gynecomastia	Must submit evidence of the presence of glandular breast tissue equal to or greater than 2 cm in size by physical exam and/or radiographic imaging and one of the following: <ul style="list-style-type: none"> • Pubertal or adolescent gynecomastia of more than two years' duration and full puberty or • Non-adolescent gynecomastia due to irreversible causes
MRI of abdomen	Refer to Radiology Questionnaire for MRI of the Abdomen .
MRI of brain	Refer to Radiology Questionnaire for MRI of the Brain .

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<p>MRI of breast</p>	<p>Must submit evidence that the MRI is being performed for one of the following reasons:</p> <ul style="list-style-type: none"> • To find a possible breast tumor in members with cancer of the lymph nodes under the arm • For surgical planning • For evaluation after chemotherapy • To look for cancer in the chest wall and muscle • To evaluate the opposite breast for those newly diagnosed with cancer • Following removal of a breast lump with a biopsy • To determine whether a silicone breast implant has ruptured <p>Must also submit evidence of one of the following:</p> <ul style="list-style-type: none"> • Increased risk due to family history of a BRCA1 or BRCA2 gene mutation • Increased risk (more than 15 percent) of developing breast cancer according to standard risk models used by physicians • Previous diagnosis of breast cancer • Either the member or a first-degree relative has a genetic disorder that increases the risk for breast cancer • Radiation therapy to the chest between the ages of 10 and 30 years
<p>MRI of cervical spine</p>	<p>Refer to Radiology Questionnaire for MRI Cervical Spine.</p>
<p>MRI of lower extremities</p>	<p>Refer to Radiology Questionnaire for MRI Lower Extremities.</p>
<p>MRI of lumbar spine</p>	<p>Refer to Radiology Questionnaire for MRI of the Lumbar Spine.</p>
<p>MRI of thoracic spine</p>	<p>Refer to Radiology Questionnaire for MRI of Thoracic Spine.</p>
<p>MRI of upper extremities</p>	<p>Refer to Radiology Questionnaire for MRI Upper Extremities.</p>

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<p>Not otherwise classified (NOC) medical codes (for example, CPT*, HCPCS)</p>	<ul style="list-style-type: none"> • Diagnosis • Full description of procedure or service requested • Fee to be billed <p>*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2008 American Medical Association. All rights reserved.</p>
<p>Nuclear blood pool imaging/ cardiac MUGA</p>	<p>Refer to Radiology Questionnaire for Nuclear Blood Pool Imaging, Cardiac Blood Pool, Heart Muscle Cardiac MUGA.</p>
<p>Nuclear scan of biliary tract/HIDA</p>	<p>Refer to Radiology Questionnaire for Nuclear Scan of Biliary Tract/ Hepatobiliary Duct (HIDA).</p>
<p>Nuclear scan of heart muscle (myocardial perfusion imaging)</p>	<p>Refer to Radiology Questionnaire for Nuclear Scan of the Heart Muscle (myocardial perfusion imaging).</p>
<p>Nuclear scan of liver and spleen/ SPECT</p>	<p>Refer to Radiology Questionnaire for Nuclear Scan of Liver and Spleen, SPECT, Vascular Flow (Liver-Spleen Scan).</p>
<p>Nuclear scan of liver function</p>	<p>Refer to Radiology Questionnaire for Nuclear Scan of Liver Function.</p>
<p>Nutritional counseling</p>	<p>Must submit evidence of one of the following conditions:</p> <ul style="list-style-type: none"> • Condition(s) for which diet therapy is part of an active treatment program for a chronic disease for which appropriate diet and eating habits are essential to the overall treatment plan • Condition of obesity, as evidenced by: <ul style="list-style-type: none"> – BMI greater than 30 (adult) – Children and teens at risk for being overweight (85th to 95th percentile for weight) – Children and teens who are overweight (greater than the 95th percentile for weight) <p>Must also submit all of the following:</p> <ul style="list-style-type: none"> – Recommended diet plan – Consultations for comorbid conditions for consideration – Number of visits

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Occupational therapy	<p>NOTE: For occupational therapy in office and outpatient settings, including hospital outpatient settings, requests for the evaluation and first therapy visit must be approved by BCN Care Management. Authorization guidelines for subsequent therapy visits are outlined in the <i>Care Management</i> chapter of the <i>BCN Provider Manual</i>.</p>
Oral surgery, medical	<p>Must submit all of the following:</p> <ul style="list-style-type: none"> • Evidence that procedure is considered medical/surgical rather than dental • Description of condition, such as tumors, cysts, or other lesions
Orencia® (abatacept)—outpatient setting	<p>Must submit all of the following reasons for treatment in outpatient setting:</p> <ul style="list-style-type: none"> • Member’s treatment history • Current medications • Evidence of previous moderate or severe adverse infusion reaction
Orthognathic surgery	<p>All of the following criteria must be met:</p> <ul style="list-style-type: none"> • Inability to masticate (chew effectively) and • Reports of cephalometric studies documenting developmental skeletal discrepancies of the maxilla and mandible that cannot be corrected by nonsurgical procedures. These cephalometric and other radiographic studies should demonstrate severe deviations from the norm sufficient to preclude other than surgical correction. <p>Two of the following criteria must be met:</p> <ul style="list-style-type: none"> • Presence of severe swallowing deviation/pathology (for example, tongue thrust, ankyloglossia, hyperglossia, etc.) or • Severe abnormal respiratory (airway) complications or • Maxillofacial deformity and concurrent dysfunction demonstrates: <ul style="list-style-type: none"> – Inability to close lips to adequately chew food and – Significantly impacted speech (lip incompetency) and – Deformity is severe enough to clearly demonstrate a severe medical condition for which surgical intervention unequivocally provides positive functional rehabilitation

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Out-of-network (noncontracted) providers for elective services	<p>Must submit all of the following:</p> <ul style="list-style-type: none"> Reason for request for services of a noncontracted, out-of-network provider (for example, recommendation from a contracted specialist, service not available in network) Note whether the member has been previously evaluated and/or treated by a contracted provider for the same condition. If so, identify the provider name(s).
Physical therapy	<p>NOTE: For physical therapy in office and outpatient settings, including hospital outpatient settings, requests for the evaluation and first therapy visit must be approved by BCN Care Management. Authorization guidelines for subsequent therapy visits are outlined in the <i>Care Management</i> chapter of the <i>BCN Provider Manual</i>.</p>
Pulmonary rehabilitation	<p>Must submit evidence of all of the following:</p> <ul style="list-style-type: none"> Physical ability to participate in a pulmonary rehabilitation program Motivation and willingness to participate in a pulmonary rehabilitation program Smoking cessation or enrollment in a smoking cessation program Diagnosis of a chronic but stable respiratory system impairment that is under medical management Pulmonary function tests (PFTs) that reveal forced vital capacity (FVC), forced expiratory volume in 1 second (FEV1) or diffusing capacity of the lungs for carbon monoxide
Remicade® (infliximab) — outpatient setting	<p>Must submit all of the following reasons for treatment in an outpatient setting:</p> <ul style="list-style-type: none"> Member treatment history that supports outpatient care Evidence that member requires outpatient monitoring due to previous moderate or severe adverse infusion reaction (Evidence of previous moderate or severe infusion reaction must also be provided.)
Remodulin® (treprostinil sodium)	<p>Must submit evidence of all of the following:</p> <ul style="list-style-type: none"> Pulmonary hypertension therapy with New York Heart Association Class III or Class IV symptoms Failure to respond to medical management (for example, vasodilator therapy)
Rhinoplasty	Must submit ENT or surgical consultation

Note: If service is retrospective, include reason for late notification in the e-referral “Comments” section. Examples: 1) Member received service without PCP referral. 2) Member received service with PCP recommendation.

— These requirements are effective as of 07/01/09, unless otherwise noted. —

Blue Care Network 2009 Clinical Review Program Medical Necessity Criteria / Benefit Review Requirements



To facilitate the clinical review process, consult this guide and follow the required clinical criteria and information guidelines outlined here when submitting your request.

Requested service	Required clinical criteria and information
Note: Refer to the BlueCaid and BCN Referral and Clinical Review Programs for referral and review requirements.	
Scar excision/ revision	Must submit dermatology or plastic surgery consultation
Sleep studies	Refer to Sleep Study Medical Appropriateness Questionnaire: Outpatient Setting .
Speech therapy	NOTE: For speech therapy in office and outpatient settings, including hospital outpatient settings, requests for the evaluation must be approved by BCN Care Management. Authorization guidelines for therapy visits are outlined in the <i>Care Management</i> chapter of the <i>BCN Provider Manual</i> .
Temporomandibular joint (TMJ) treatment and surgery	Must submit evidence of all of the following: <ul style="list-style-type: none"> • Specialist consultation • History/physical evaluation • Previous treatment plan • TMJ X-rays • Other tests, for example, tomographic studies, MRI
Transplant requests (all except kidney, skin and cornea)	Must submit specialist consultation Note: Kidney, skin and cornea transplants to contracted providers require a referral but do not require clinical criteria review.
Transplant harvesting procedures (all except kidney, skin and cornea)	Must submit evidence of all of the following: <ul style="list-style-type: none"> • Member's history • Previous treatment and response • Specialist's consultations • Pre-transplant test and lab results Note: Kidney, skin and cornea transplants to contracted providers require a referral but do not require clinical criteria review.
Voluntary sterilization	Subject to a member's contract and certificate for contraceptive coverage

Note: If service is retrospective, include reason for late notification in the e-referral "Comments" section. Examples:
1) Member received service without PCP referral. 2) Member received service with PCP recommendation.

— These requirements are effective as of 07/01/09, unless otherwise noted. —