

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



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.

Requested service	Required clinical criteria and information
Inpatient admissions: urgent/emergent and out of network (noncontracted)	<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
Abdominoplasty	<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
Asthma education	<ul style="list-style-type: none"> • Past medical history • Previous education • Proposed treatment plan
<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>The surgical procedures for severe obesity are considered established treatment options if all the following criteria are met:</p> <ul style="list-style-type: none"> • The patient has either a 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 patients 18 to 65 years of age. <ul style="list-style-type: none"> – Requests for bariatric surgery for patients less than 18 years of age should include documentation that the primary care physician has addressed the risk of surgery on future growth, the patient’s maturity level, an ability to understand the procedure and comply with postoperative instructions, as well as the adequacy of family support. – Patients above 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.

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Bariatric surgery (continued)	<ul style="list-style-type: none"> • The patient 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 patient’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). – 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 patients, 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 patient as a treatment option. • Documentation that the primary care physician and the patient have a good understanding of the risks involved and reasonable expectations that the patient will comply with all post-surgical requirements.

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Bariatric surgery (continued)	<ul style="list-style-type: none"> • A psychological evaluation must be performed as a pre-surgical assessment by a mental health professional contracted with BCN, in order to establish the patient's emotional stability and ability to comply with post-surgical limitations. • In cases in which a revision of the original procedure is planned, the patient 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 patient's inability to maintain the weight loss. • Physicians need to be aware of long-term complications of gastric surgery with these patients and follow up with these individuals. • 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.
Biofeedback (urinary and fecal incontinence and chronic constipation)	<p>Biofeedback is considered experimental for all conditions except the treatment of stress and/or urge incontinence in females and males who meet the following criteria:</p> <ul style="list-style-type: none"> • The patient is cognitively intact. • The patient has failed a trial of pelvic muscle exercise training. A failed trial of pelvic muscle exercise training is defined as one in which there is no clinically significant improvement in urinary incontinence after completing four weeks of an ordered plan of PME's to increase periurethral muscle strength. <p>Biofeedback for fecal incontinence or constipation is covered when the following criteria are met:</p> <ul style="list-style-type: none"> • The patient is motivated. • The patient is mentally capable. • The patient has some degree of rectal sensation and can contract the external anal sphincter.
Blepharoplasty	<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

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Bone growth stimulator	<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 patient 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 • Patients with grade III or greater spondylolisthesis
Botox® injections	<ul style="list-style-type: none"> • Diagnosis • Previous treatment • Response to previous treatment
Breast implants – insertion, removal, replacement	<ul style="list-style-type: none"> • Mammogram or ultrasound results • Signs and symptoms of breast condition • Plastic surgeon consultation
Breast reconstruction	<ul style="list-style-type: none"> • When requested for reconstruction of one or both breasts following any medically necessary mastectomy, for example, breast cancer • Diagnosis • Surgical consultation report

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Breast reduction (reduction mammoplasty)	<p>Two or more of the following must be met:</p> <ul style="list-style-type: none"> • Pain, including both: <ul style="list-style-type: none"> — Location, duration, intensity — 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 not responding to treatment • Lordotic posture • Ulnar paresthesia <p>Both of the following criteria must also be met:</p> <ul style="list-style-type: none"> • The patient must be fully grown. • The amount of breast tissue removed from each breast must be equal to or greater than the 22nd percentile cutoff for body surface area <p>Photographs of shoulder grooving may be required.</p>
Cardiac rehabilitation (extensions with previous cardiac event)	<ul style="list-style-type: none"> • Diagnosis • Cardiology consultation • Current progress notes from rehabilitation phase
Chiropractic services	<p>Submit referral for spinal manipulation and X-rays. Note: Do not submit global referral.</p>
Colonoscopy, virtual	<ul style="list-style-type: none"> • Reason for test • Reason patient is not having a regular (conventional) colonoscopy
Cosmetic and reconstructive surgery	<ul style="list-style-type: none"> • Indication that surgery is being performed to reconstruct a patient's facial and body defects due to birth disorders, trauma, burns and disease • Indication that the surgery is intended to correct dysfunctional areas of the body and is reparative in nature. Its primary purpose is to restore the patient to a "whole" or normal appearance and/or function.

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<p>CT of abdomen</p> <p>Note:</p> <ul style="list-style-type: none"> • Excludes BlueCaid and BCN 65 members. • Requests should be submitted via e-referral. • Completing the questionnaire for CT of the abdomen on e-referral may lead to an approval and may avoid further review by BCN. 	<ul style="list-style-type: none"> • Prior abnormal imaging study that requires follow-up CT • Palpable abdominal pain (pain when the abdomen is touched) • Unexplained abdominal mass • Enlarged abdominal organ(s) • Unexplained weight loss (greater than 10 percent of body weight) • Unexplained jaundice (yellow skin), elevated liver enzymes • Symptoms of abdominal bleeding, such as blood in stool, black or tarry stool, tiredness, pale skin or shortness of breath • Symptoms of abdominal abscess, such as fever of unknown origin and abdominal pain • Clinical symptoms of appendicitis • Clinical symptoms of diverticulitis (a digestive disease accompanied by nausea, vomiting, cramping, pain, constipation, or diarrhea) • Clinical symptoms of bowel obstruction, such as abdominal pain, nausea, vomiting, diarrhea or constipation • Suspected complications of inflammatory bowel disease • Clinical symptoms of pancreatitis • Unexplained hematuria (blood in the urine) • Suspected kidney stone(s) • Symptoms of abdominal aortic aneurysm, such as a pulsing sensation in the abdomen, rigid abdomen, nausea, vomiting, rapid heart rate when rising to stand or abdominal mass • Suspected abdominal aortic dissection (tear in the wall of the aorta) • Suspected abdominal hernia (an abdominal protusion due to weak abdominal muscles) • Significant abdominal trauma/injury • History of malignancy (cancer), for follow-up surveillance (no prior CT for 6 months) • Right upper quadrant pain. If yes, consider ultrasound first.* • Recent abdominal MRI study (within 3 months)* • Symptoms in pediatric age group (younger than 16 years) If yes, consider ultrasound first.* • Current pregnancy (CT generally contraindicated)* <p>*If CT is still desired, call 800-392-2512.</p>

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<p>CT of brain</p> <p>Note:</p> <ul style="list-style-type: none"> • Excludes BlueCaid and BCN 65 members. • Requests should be submitted via e-referral. • Completing the questionnaire for CT of the brain on e-referral may lead to an approval and may avoid further review by BCN. 	<ul style="list-style-type: none"> • Abnormal neurological evaluation in which a neurology or neurosurgery specialist has requested a CT study • History of acute head trauma with clinical symptoms • Worst headache of life (“thunderclap headache”) • Persistent headaches for more than 6 months or with neurological symptoms, nausea and vomiting • New-onset stroke symptoms • New-onset seizures • Suspicion of brain abscess or inflammatory disease, with documented new-onset clinical symptoms such as fever, neck stiffness or headache • History of cancer, with new or increasing clinical symptoms such as gait/motor disturbances, visual field defects or confusion • Progressive neurologic deficits, with worsening of neurologic symptoms or mental status changes • Hearing loss, with abnormal ear, nose and throat (ENT) evaluation • History of immunosuppression, now with documented new-onset neurological symptoms such as mental status change, motor/gait disturbances or visual field changes • Ventricular shunt that needs follow up • Prior imaging study that requires CT evaluation • History of vascular abnormality of the brain, such as an aneurysm, arteriovenous malformation, thrombosis, or fistula • Bone abnormality of the skull, such as fracture or pediatric craniosynostosis (skull deformity) • One of the conditions above or another suspected brain abnormality, with a contraindication to MRI

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<p>CT of lumbar spine</p> <p>Note:</p> <ul style="list-style-type: none"> • Excludes BlueCaid and BCN 65 members. • Requests should be submitted via e-referral. • Completing the questionnaire for CT of the lumbar spine on e-referral may lead to an approval and may avoid further review by BCN. 	<p>For a positive (yes) response to one or more of the next seven items, consider MRI of the lumbar spine (CPT¹ code 72148, 72149 or 72158) by requesting the appropriate CPT code and completing the questionnaire for MRI of the lumbar spine. If CT is not approved but is still desired, call 800-392-2512.</p> <ul style="list-style-type: none"> • Normal CT/MRI scan of lumbar spine within 30 days • Low back pain with no other symptoms • Low back pain with mild neurologic symptoms² • Pediatric-aged patient with the following:³ <ul style="list-style-type: none"> – Possible congenital anomaly (birth defect) of spinal cord – Abnormal soft tissues of spine • Low back pain with mild neurologic symptoms² and the following:³ <ul style="list-style-type: none"> – Lack of response to conservative measures such as acetaminophen or nonsteroidal anti-inflammatory drugs (NSAIDs), limitation of activities that aggravate symptoms or physical therapy for greater than six weeks – Worsening clinical symptoms – Loss of motor strength (muscle weakness in the legs) • Low back pain with major neurologic symptoms^{3,4} • Low back pain with any of the following:³ <ul style="list-style-type: none"> – Fever, elevated WBCs – Unexplained weight loss – History of IV drug abuse – Significant steroid use – Prior lumbar spine surgery – Age greater than 70 years – History of osteoporosis (bone loss) – History of immunosuppression, such as that related to a transplant, radiation therapy, chemotherapy, steroid medication or HIV <p>CT is generally approved for:</p> <ul style="list-style-type: none"> • Post-surgical evaluation of surgery/hardware in patient with symptoms • Significant spine trauma with symptoms: any age • Spinal fracture evaluation • Abnormal imaging study in which CT was recommended • Pediatric patient (younger than 18 years) with bony anomaly, for evaluation of bone • Evaluation of complex spinal tumor <p>¹CPT codes, descriptions and two-digit numeric modifiers only are copyright 2008 American Medical Association. All rights reserved. ²Mild neurologic symptoms include numbness and tingling, with or without radiating pain. ³CT generally not approved. MRI generally recommended. ⁴Major neurologic symptoms include loss of motor strength, foot drop and loss of bowel or bladder function.</p>

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<p>CT of pelvis</p> <p>Note:</p> <ul style="list-style-type: none"> Excludes BlueCaid and BCN 65 members. Requests should be submitted via e-referral. Completing the questionnaire for CT of the pelvis on e-referral may lead to an approval and may avoid further review by BCN. 	<ul style="list-style-type: none"> Prior abnormal imaging study requiring follow-up CT Unexplained weight loss (greater than 10 percent of body weight) Symptoms of abdominal bleeding Symptoms of abdominal abscess, such as fever of unknown origin and abdominal pain Clinical symptoms of appendicitis Clinical symptoms of diverticulitis (a digestive disease accompanied by nausea, vomiting, cramping, pain, constipation, or diarrhea) Clinical symptoms of bowel obstruction Suspected complications of inflammatory bowel disease Unexplained hematuria (blood in the urine) Suspected kidney stone(s) Symptoms of abdominal aortic aneurysm Suspected abdominal aortic dissection Suspected pelvic hernia Significant pelvic trauma History of malignancy, follow-up surveillance (no prior CT for 6 months) Enlarged pelvic organ(s). If yes, consider ultrasound first.* Recent pelvic MRI study (within 3 months)* Symptoms in pediatric age group (younger than 16 years) If yes, consider ultrasound first.* Current pregnancy (CT generally contraindicated)* <p>*If CT is still desired, call 800-392-2512.</p>
<p>Dental services for trauma</p>	<ul style="list-style-type: none"> Services must be provided within 72 hours of injury Treatment received Date of dental trauma or injury Type of injury
<p>Dermabrasion (chemical peel)</p>	<p>Specialist consultation that includes:</p> <ul style="list-style-type: none"> Number of actinic keratoses or other premalignant skin lesions Description of previous failed treatment
<p>Developmental delay treatment</p>	<ul style="list-style-type: none"> Specialist consultation, if applicable Condition for treatment Previous history and response to treatment
<p>Drugs administered by professionals</p>	<p>Avastin® (for non-cancer conditions):</p> <ul style="list-style-type: none"> Condition for which the service is being requested

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Drugs not covered under pharmacy benefit	<p>Amevive®</p> <ul style="list-style-type: none"> • All of the following criteria must be met: <ul style="list-style-type: none"> – Evidence of a minimum involvement of 10 percent of body surface area – Response to previous therapies – Cd4+ count greater than 250 cells/uL — monitored weekly – Past medical history • If request is for second course of therapy: <ul style="list-style-type: none"> – Response to first course of therapy <p>Flolan® and Remodulin®</p> <ul style="list-style-type: none"> • Specialist consultation (cardiology and/or pulmonary) • Treatment plan <p>Remicade® and Orencia®</p> <ul style="list-style-type: none"> • For infusion in an outpatient setting only • Evidence of previous adverse infusion reaction to Remicade
Durable medical equipment and prosthetics and orthotics	<ul style="list-style-type: none"> • For BlueCaid DME, contact MedEquip at 800-530-0714. • For BlueCaid P&O, contact the U-M Orthotics & Prosthetics Center at 800-530-0714. • For HMO and BCN Advantage, for both DME and P&O, contact Northwood, Inc. at 800-667-8496.
Elective termination of pregnancy	<ul style="list-style-type: none"> • Number of weeks pregnant as documented on ultrasound or amniocentesis • Medical condition of mother and/or fetus
Enteral/parenteral home infusion therapy	<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 this manual.</p>
Experimental or investigational procedures	<ul style="list-style-type: none"> • Complete description of service or procedure requested • Clinical trial information • Diagnosis

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Fetal invasive procedures, unlisted	<ul style="list-style-type: none"> • Specialty consultation • Fetal gestational age • Description of fetal procedural plan
Frenulum surgery: frenectomy, frenotomy, frenulectomy or frenoplasty	<ul style="list-style-type: none"> • Evidence of an infant's inability to feed, causing failure to thrive • Speech therapy evaluation documents expressive of language difficulties as a result of tongue immobility in a patient at least four years of age
Home care services	Apply InterQual Home Care criteria, including BCN Local Rules: <ul style="list-style-type: none"> • Long- and short-term goals • Skilled service requested including frequency and duration • Treatment plan
Hyperbaric oxygen therapy – systemic	<ul style="list-style-type: none"> • Condition being treated • Reason for treatment • Previous treatment
Infertility evaluation, testing and treatment	<ul style="list-style-type: none"> • Verify benefit • Specialty consultation that includes patient history, previous treatment and response • Proposed treatment plan <p>Excludes in vitro fertilization and related services.</p>
Mastectomy for gynecomastia	<p>All of the following criteria must be met:</p> <ul style="list-style-type: none"> • Male • Tissue to be removed is glandular breast tissue over 2 cm in size.

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<p>MRI of brain</p> <p>Note:</p> <ul style="list-style-type: none"> • Excludes BlueCaid and BCN 65 members. • Requests should be submitted via e-referral. • Completing the questionnaire for MRI of the brain on e-referral may lead to an approval and may avoid further review by BCN. 	<ul style="list-style-type: none"> • If symptoms consist of new-onset headache, a noncontrast CT is the test of choice. • Abnormal neurological evaluation in which a neurology or neurosurgery specialist has requested an MRI study • History of old head trauma, with symptoms such as headache, confusion, speech or vision difficulty or poor coordination • Suspicion of brain infection or inflammation, with documented new-onset clinical symptoms such as fever, neck stiffness or headache • History of cancer, with new or increasing clinical symptoms such as difficulty walking, vision problems or confusion • New-onset seizures • Progressive neurologic deficits, with worsening of neurologic symptoms such as inability to speak, loss of balance, weakness or poor ability to think • New-onset mental status changes • Hearing loss, with abnormal ear, nose and throat (ENT) evaluation • History of immunosuppression, such as organ or bone marrow transplant, radiation or chemotherapy, cortisone medication or HIV, now with documented new-onset neurological symptoms such as mental status change, motor/gait disturbances or visual field changes • Documented symptoms of multiple sclerosis such as visual/speech abnormalities, gait/motor disturbances, numbness and tingling, muscle weakness, or loss of coordination • Neuroendocrine abnormalities with documented symptoms such as change in menstruation, nipple discharge, excess sweating, paralysis, excessive thirst and urination, nausea, fatigue or laboratory evidence of pituitary abnormality • Ventricular shunt (placed previously to relieve pressure from extra spinal fluid in the brain) that needs follow up • Prior imaging study that requires MRI evaluation • History of vascular abnormality of the brain, such as aneurysm, arteriovenous malformation (abnormal collection of blood vessels), thrombosis (blood clot) or fistula (abnormal passageway between two body parts) • Pediatric patient (younger than 16 years): developmental delay or congenital anomaly <p>Note: For all circumstances, if MRI is not approved but is still desired, call 800-392-2512.</p>

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MRI of breast	<ul style="list-style-type: none"> • Condition for which the service is being requested • Reason for performing the test • Previous tests and results • Previous surgical treatment for this condition 										
MRI of lumbar spine Note: <ul style="list-style-type: none"> • Excludes BlueCaid and BCN 65 members. • Requests should be submitted via e-referral. • Completing the questionnaire for MRI of the lumbar spine on e-referral may lead to an approval and may avoid further review by BCN. 	<ul style="list-style-type: none"> • Normal CT/MRI scan of lumbar spine within 30 days • Low back pain with no other symptoms • Low back pain with mild neurologic symptoms¹ • Low back pain with mild neurologic symptoms¹ and one or more of the following: <ul style="list-style-type: none"> – Lack of responsiveness to conservative measures (acetaminophen or nonsteroidal anti-inflammatory drugs (NSAIDs), limitation of activities that aggravate symptoms or physical therapy) for more than 6 weeks – Worsening clinical symptoms – Loss of motor strength (muscle weakness in the legs) • Low back pain with major neurologic symptoms² • Low back pain with any of the following: <table border="0" style="width: 100%;"> <tr> <td>– Fever, elevated WBCs</td> <td>– History of osteoporosis (bone loss)</td> </tr> <tr> <td>– Unexplained weight loss</td> <td>– Prior lumbar spine surgery</td> </tr> <tr> <td>– History of IV drug abuse</td> <td>– Age greater than 70 years</td> </tr> <tr> <td>– Significant steroid use</td> <td>– History of immunosuppression, such as that related to a transplant, radiation therapy, chemotherapy, steroid medication or HIV</td> </tr> <tr> <td>– History of malignancy with possible metastasis</td> <td></td> </tr> </table> • Abnormal prior imaging study: MRI is recommended. • Pediatric patient (younger than 18 years) with congenital anomaly (birth defect) • Significant spine trauma with symptoms: any age • Mild spine trauma with symptoms: age greater than 70 years <p>Note: For all circumstances, if MRI is not approved but is still desired, call 800-392-2512.</p> <p>¹Mild neurologic symptoms include numbness and tingling, with or without radiating pain. ²Major neurologic symptoms include loss of motor strength, foot drop, and loss of bowel or bladder function.</p>	– Fever, elevated WBCs	– History of osteoporosis (bone loss)	– Unexplained weight loss	– Prior lumbar spine surgery	– History of IV drug abuse	– Age greater than 70 years	– Significant steroid use	– History of immunosuppression, such as that related to a transplant, radiation therapy, chemotherapy, steroid medication or HIV	– History of malignancy with possible metastasis	
– Fever, elevated WBCs	– History of osteoporosis (bone loss)										
– Unexplained weight loss	– Prior lumbar spine surgery										
– History of IV drug abuse	– Age greater than 70 years										
– Significant steroid use	– History of immunosuppression, such as that related to a transplant, radiation therapy, chemotherapy, steroid medication or HIV										
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Not otherwise classified (NOC) medical codes (for example, CPT*, HCPCS)	<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>
Nuclear scan of heart muscle (myocardial perfusion imaging) Effective Oct. 1, 2008 Note: <ul style="list-style-type: none"> • Excludes BlueCaid and BCN 65 members. • Requests should be submitted via e-referral. • Completing the questionnaire for nuclear scan of heart muscle on e-referral may lead to an approval and may avoid further review by BCN. 	<ul style="list-style-type: none"> • A body mass index greater than 40. (If BMI is greater than 40, providers should consider referring the member to a cardiologist or for cardiac catheterization.) • At least three of the following risk factors for coronary artery disease: <ul style="list-style-type: none"> – Age greater than 40 (men) or 60 (women) – History of diabetes mellitus (high blood sugar) – Elevated cholesterol – History of hypertension (high blood pressure) – Smoking history – Family history of premature coronary artery disease (first-degree relatives) • Chest pain with exertion/exercise • Atypical chest pain, with two significant risk factors (as listed above) • Recent abnormal EKG or exercise treadmill test (within the past year) • New onset congestive heart failure or cardiac arrhythmia (irregular heartbeat) (within the past year) • Known heart disease, planned major surgery • Recent myocardial infarction (heart attack) (within the past 7 to 14 days) • Known coronary artery disease, with new or worsening symptoms. (For this condition, providers should consider referring the member to a cardiologist.)
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	<ul style="list-style-type: none"> • Description of condition, such as tumors, cysts, other lesions • Comorbid condition

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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>One of the following criteria must be met:</p> <ul style="list-style-type: none"> • Severe obstructive sleep apnea or • Maxillofacial deformity and concurrent dysfunction demonstrates: <ul style="list-style-type: none"> – Inability to close lips to adequately chew food – Significantly impacted speech (lip incompetency) and – Deformity severe enough to clearly demonstrate a severe medical condition for which surgical intervention unequivocally provides positive functional rehabilitation
Out-of-network (noncontracted) providers for elective services	<ul style="list-style-type: none"> • Reason for request of service to 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	<ul style="list-style-type: none"> • Smoking history • Diagnosis of a chronic but stable respiratory system impairment, such as chronic obstructive pulmonary disease • Pulmonary function tests • Member's ability to participate in the rehabilitation program
Rhinoplasty	ENT or surgical consultation
Scar excision/revision	Dermatology or plastic surgery consultation
Speech therapy	<p>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>.</p>

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



Requested service	Required clinical criteria and information
Temporomandibular joint treatment and surgery	<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 evaluations (all except kidney, skin and cornea)	Specialist consultation Note: Kidney, skin and cornea transplants to contracted providers require a referral but do not require clinical criteria review.
Transplant harvesting (all except kidney, skin and cornea)	<ul style="list-style-type: none"> • Patient 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.
Transplant procedures (all except kidney, skin and cornea)	<ul style="list-style-type: none"> • Patient history • Previous treatment and response • Specialist's consultations • Pretransplant test and lab results Note: Kidney, skin and cornea transplants to contracted providers require a referral but do not require clinical review.
Voluntary sterilization	Subject to a member's contract and certificate for contraceptive coverage

In effect as of 01/01/09, unless otherwise noted.