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Blue Care Network Medical Necessity Criteria / Benefit Review Requirements



(For Services Not Involving Drugs / Biologicals Covered Under Medical Benefit)

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<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 all of 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>	<p>Must submit one or more of the following:</p> <ul style="list-style-type: none"> • Evidence of weight loss of at least 100 pounds • 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 • 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>Arthroscopy, knee</p>	<p>● Must complete questionnaire and submit through e-referral system. Refer to the preview questionnaires and authorization criteria posted on BCN's Authorization Requirements & Criteria page at ereferrals.bcbsm.com.</p>
<p>Bariatric surgery</p>	<p>Surgical procedures for severe obesity are considered established treatment options if all of the criteria are met that are outlined on the Physician-Supervised Weight Loss Program Procedure.</p> <p>Requests for clinical review should be submitted using the following forms:</p> <ul style="list-style-type: none"> • Bariatric Surgery Assessment Form: Patient Referral Information • Physician Supervised Weight Loss Program Documentation <p>Note: For dates of service on or after Sept. 24, 2013, CMS does not require that covered bariatric surgery procedures be performed in facilities specifically certified for bariatric surgery.</p> <p>Note: For BCN AdvantageSM members, bariatric surgery must be performed at a BCN-contracted facility.</p>

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<p>Biofeedback (urinary and fecal incontinence and chronic constipation)</p>	<p>For adults, must submit 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, must submit 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>	<p>• Must complete questionnaire and submit through e-referral system. Refer to the preview questionnaires and authorization criteria posted on BCN's Authorization Requirements & Criteria page at ereferrals.bcbsm.com.</p>
<p>Bone-anchored hearing aid (BAHA)</p>	<p>Must submit evidence as follows:</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 (e.g., 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>Bone growth stimulation 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>Breast biopsy, excisional</p>	<p>● Must complete questionnaire and submit through e-referral system. Refer to the preview questionnaires and authorization criteria posted on BCN's Authorization Requirements & Criteria page at ereferrals.bcbsm.com.</p>

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<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
<p>Breast reconstruction</p>	<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 agenesis – Developmental abnormalities, infection or follow up after therapeutic surgery

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<p>Breast reduction (reduction mammoplasty)</p>	<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 location, duration and intensity and 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
<p>Cardiac rehabilitation (extensions with previous cardiac event)</p>	<p>Must submit all of the following:</p> <ul style="list-style-type: none"> • Diagnosis • Cardiology consultation • Current progress notes from rehabilitation phase
<p>Cholecystectomy, laparoscopic</p>	<p>Must complete questionnaire and submit through e-referral system. Refer to the preview questionnaires and authorization criteria posted on BCN's Authorization Requirements & Criteria page at ereferrals.bcbsm.com.</p>
<p>Cognitive therapy</p>	<p>Must submit all of the following:</p> <ul style="list-style-type: none"> • Diagnosis • Evidence that the cognitive deficits are due to traumatic brain injury or stroke • Documentation of potential for improvement • Indication that the member is able to actively participate in the program
<p>Colonoscopy, virtual</p>	<p>Must submit all of the following:</p> <ul style="list-style-type: none"> • Reason for test • Reason the member cannot undergo standard (conventional) colonoscopy

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Computerized tomography	<ul style="list-style-type: none"> For dates of service on or after Oct. 1, 2018, services involving CT are reviewed by AIM Specialty Health®. For more information, refer to BCN's AIM-Managed Procedures page at ereferrals.bcbsm.com. Note: For dates of service prior to Oct. 1, 2018, including retrospective requests, these procedures are reviewed by eviCore healthcare. Refer to BCN's eviCore-Managed Procedures page at ereferrals.bcbsm.com.
Cosmetic and/or reconstructive surgery	Must submit all of the following: <ul style="list-style-type: none"> Surgeon/plastic surgeon consultation Evidence of functional deficit
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 one of the following: <ul style="list-style-type: none"> More than 10 actinic keratoses or other premalignant skin lesions 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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Drugs and biologicals covered under the medical benefit	The criteria for drugs covered under the medical benefit that require medical necessity review are moved to Clinical Information for Drugs Covered Under the Medical Benefit That Require Medical Necessity Review .
Durable medical equipment and prosthetics and orthotics	<ul style="list-style-type: none"> • For diabetic and insulin pump supplies only, contact J&B Medical Supply at 1-888-896-6233. • For nondiabetic supplies, call Northwood's customer service department at 1-800-393-6432 to identify a contracted supplier. The supplier submits the request to Northwood for review.
Elective termination of pregnancy	Must submit all of the following: <ul style="list-style-type: none"> • Number of weeks pregnant as documented on ultrasound or amniocentesis • Medical condition of mother and/or fetus
Endometrial ablation (provider office setting only)	<ul style="list-style-type: none"> • Must complete questionnaire and submit through e-referral system. Refer to the preview questionnaires and authorization criteria posted on BCN's Authorization Requirements & Criteria page at ereferrals.bcbsm.com.
Endoscopy, upper gastrointestinal, for gastroesophageal reflux disease	Must complete questionnaire and submit through e-referral system. Refer to the preview questionnaires and authorization criteria posted on BCN's Authorization Requirements & Criteria page at ereferrals.bcbsm.com .
Epidural injections	See "Pain management: epidural injections."
Experimental or investigational procedures	Must submit all of the following: <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
Facet injections	See "Pain management: facet injections."

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Fetal invasive procedures, unlisted	<p>Must submit all of the following:</p> <ul style="list-style-type: none"> • Specialty consultation • Fetal gestational age • Description of fetal procedural plan
Genetic testing	See “Laboratory services and genetic testing.”
Hearing services, such as audiometric testing not in conjunction with hearing aid services	<p>Must submit all of the following:</p> <ul style="list-style-type: none"> • Condition for which the service is being requested • Reason for performing the test • Specialist’s consultation, if available
Hyperbaric oxygen therapy	<p>● Must complete questionnaire and submit through e-referral system. Refer to the preview questionnaires and authorization criteria posted on BCN’s Authorization Requirements & Criteria page at ereferrals.bcbsm.com.</p>
Infertility evaluation, testing and treatment	<p>Must verify benefit, then submit all of the following:</p> <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>
Knee arthroscopy	See “Arthroscopy, knee.”

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<p>Laboratory services and genetic testing</p>	<ul style="list-style-type: none"> • For laboratory services, provider should contact JVHL at 1-800-445-4979 to request services. • For genetic testing, must submit all of the following: <ul style="list-style-type: none"> – Name of the genetic test(s) requested – Name of the laboratory that will process the specimen <p>Note: If an out-of-network or noncontracted laboratory will process the specimen, include the reason the out-of-network or noncontracted laboratory must be used.</p> <ul style="list-style-type: none"> – Specialist evaluation or genetic counseling consultation – Actual or suspected diagnosis – Past medical history, including the clinical features of the suspected genetic mutation or risk factors that place the member at risk of the suspected genetic mutation – Previous testing for the suspected condition, including the results – Indication that the disease is treatable or preventable – Indication that the test will directly influence the treatment of the member or the condition – Any additional pertinent medical information
<p>Lumbar spine surgery</p>	<p>See “Surgery, lumbar spine.”</p>
<p>Mastectomy for gynecomastia</p>	<p>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:</p> <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
<p>Magnetic resonance imaging</p>	<ul style="list-style-type: none"> • For dates of service on or after Oct. 1, 2018, services involving CT are reviewed by AIM Specialty Health®. For more information, refer to BCN’s AIM-Managed Procedures page at ereferrals.bcbsm.com. <p>Note: For dates of service prior to Oct. 1, 2018, including retrospective requests, these procedures are reviewed by eviCore healthcare. Refer to BCN’s eviCore-Managed Procedures page at ereferrals.bcbsm.com.</p>

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<p>Not otherwise classified (NOC) medical codes (e.g., CPT*, HCPCS)</p>	<p>Must submit all of the following:</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 2018 American Medical Association. All rights reserved.</p>
<p>Nuclear scans</p>	<p>● For dates of service on or after Oct. 1, 2018, services involving CT are reviewed by AIM Specialty Health®. For more information, refer to BCN's AIM-Managed Procedures page at ereferrals.bcbsm.com.</p> <p>Note: For dates of service prior to Oct. 1, 2018, including retrospective requests, these procedures are reviewed by eviCore healthcare. Refer to BCN's eviCore-Managed Procedures page at ereferrals.bcbsm.com.</p>
<p>Nutritional counseling</p>	<ul style="list-style-type: none"> • Must submit evidence of one of the following conditions: <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) • In addition, must submit all of the following: <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 BCN HMOSM (commercial) and BCN AdvantageSM members, requests for the evaluation and first therapy visit in office and outpatient settings, including hospital outpatient settings, must be approved by BCN Utilization Management. Subsequent therapy is managed by eviCore healthcare. Authorization guidelines for subsequent therapy visits are outlined in the Care Management chapter of the <i>BCN Provider Manual</i>.</p> <p>For providers not contracted with BCN, all occupational therapy is managed by BCN and the required clinical criteria and information are as follows:</p> <ul style="list-style-type: none"> • Must submit all of the following: <ul style="list-style-type: none"> – Occupational therapy evaluation – Evidence that member’s condition is subject to improvement within 60 days as the result of therapy – Evidence that the treatment is medically necessary • In addition, for members with a chronic condition, must submit all of the following: <ul style="list-style-type: none"> – Evidence that there is an acute exacerbation or a change in the status of the chronic condition – Evidence that there is expectation of significant improvement within 60 days
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

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<p>Orthognathic surgery</p>	<ul style="list-style-type: none"> • All of the following criteria must be met: <ul style="list-style-type: none"> – Inability to masticate (chew effectively) – 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. • In addition, two of the following criteria must be met: <ul style="list-style-type: none"> – Presence of severe swallowing deviation/pathology (e.g., tongue thrust, ankyloglossia, hyperglossia, etc.) – Severe abnormal respiratory (airway) complications – Maxillofacial deformity and concurrent dysfunction demonstrates 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
<p>Orthoptic and/or pleoptic training</p>	<p>Must submit all of the following:</p> <ul style="list-style-type: none"> • Eye condition for which vision therapy is being requested • Specialist consultation • Treatment plan
<p>Out-of-network (noncontracted) providers for elective services</p>	<p>Must submit all of the following:</p> <ul style="list-style-type: none"> • Reason for request for services to a noncontracted, out-of-network provider (e.g., 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).

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Blue Care Network Medical Necessity Criteria / Benefit Review Requirements



(For Services Not Involving Drugs / Biologicals Covered Under Medical Benefit)

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Requested service	Required clinical criteria and information
<p>Note: Refer to the <i>BCN Referral and Authorization Requirements</i> document for referral and review requirements.</p>	
<p>Pain management: epidural injections</p>	<p>For dates of service prior to Sept. 1, 2016:</p> <ul style="list-style-type: none"> • Must complete questionnaire and submit through e-referral system. See the Sample epidural injection questionnaire. • In addition, must submit all of the following: <ul style="list-style-type: none"> – Evidence of the absence of conditions for which spinal injections are contraindicated (e.g., infection, cancer, bleeding) – Severity and location of pain, including indication that pain is not psychogenic – Evidence of pain in a specific nerve root distribution – Previous treatment and response – For ongoing injections, evidence that the member received at least a 50 percent reduction in pain for at least six weeks with the most recent injection – For ongoing injections, indication that the member had four or fewer visits to the fluoroscopy suite for spinal injections for pain – For ongoing injections, indication that the time between planned injections is eight weeks or more <p>For dates of service on or after Sept. 1, 2016:</p> <p>Services involving epidural injections are reviewed by eviCore healthcare. For more information, refer to:</p> <ul style="list-style-type: none"> • The Procedures Managed by eviCore for BCN web page • The interventional pain guidelines at evicore.com. On the Solutions tab, click <i>Musculoskeletal</i>. Click <i>Clinical Guidelines</i>. Then click to open a specific guideline.

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Requested service	Required clinical criteria and information
<p>Note: Refer to the <i>BCN Referral and Authorization Requirements</i> document for referral and review requirements.</p>	
<p>Pain management: facet joint injections</p>	<p>For dates of service prior to Sept. 1, 2016:</p> <ul style="list-style-type: none"> • Must complete questionnaire and submit through e-referral system. See the Sample facet injection questionnaire. • In addition, must submit all of the following: <ul style="list-style-type: none"> – Evidence of the absence of conditions for which spinal injections are contraindicated (e.g., infection, cancer, bleeding) – Severity and location of pain, including indication that pain is not psychogenic – Symptoms and findings, including imaging results – Evidence of the absence of neurologic radicular symptoms or findings (e.g., extremity numbness, tingling, decreased sensation or weakness) – Previous treatment and response – For ongoing injections, evidence of a successful diagnostic injection (e.g., 50 percent or greater relief of pain and the ability to perform previously movements after receiving 1 cc or less of anesthetic) – For ongoing therapeutic injections, indication that the member had at least 50 percent relief of pain with the previous injection – For ongoing injections, indication that the member had six or fewer visits for injections to cervical/thoracic or lumbar/sacral spinal region in past 12 months – For ongoing injections, indication that the member received less than 1 cc of anesthetic per injection <p>For dates of service on or after Sept. 1, 2016:</p> <p>Services involving facet joint injections are reviewed by eviCore healthcare. For more information, refer to:</p> <ul style="list-style-type: none"> • The Procedures Managed by eviCore for BCN web page • The interventional pain guidelines at evicore.com. On the Solutions tab, click <i>Musculoskeletal</i>. Click <i>Clinical Guidelines</i>. Then click to open a specific guideline.

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Requested service	Required clinical criteria and information
<p>Note: Refer to the <i>BCN Referral and Authorization Requirements</i> document for referral and review requirements.</p>	
<p>Physical therapy (and physical medicine services provided by chiropractors)</p>	<p>For BCN HMO (commercial) and BCN Advantage members, requests for the evaluation (for physical therapists) and the first therapy visit (for physical therapists and chiropractors) in office and outpatient settings, including hospital outpatient settings, must be approved by BCN Utilization Management. (See note below.) Subsequent therapy is managed by eviCore healthcare. Authorization guidelines for subsequent therapy visits are outlined in the Care Management chapter of the <i>BCN Provider Manual</i>.</p> <p>For providers not contracted with BCN, all physical therapy/physical medicine services are managed by BCN and the required clinical criteria and information are as follows:</p> <ul style="list-style-type: none"> • Must submit all of the following: <ul style="list-style-type: none"> – Physical therapy evaluation (physical therapists only) – Evidence that member’s condition is subject to improvement within 60 days as the result of therapy – Evidence that the treatment is medically necessary • In addition, for members with a chronic condition, must submit all of the following: <ul style="list-style-type: none"> – Evidence that there is an acute exacerbation or a change in the status of the chronic condition – Evidence that there is an expectation of significant improvement within 60 days <p>Note: Chiropractors contracted with BCN may provide physical medicine services for BCN HMO (commercial) members using select *97XXX procedure codes.</p> <p>*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2017 American Medical Association. All rights reserved.</p>

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Requested service	Required clinical criteria and information
<p>Note: Refer to the <i>BCN Referral and Authorization Requirements</i> document for referral and review requirements.</p>	
<p>Prostatic urethral lift procedures for the treatment of BPH</p>	<ul style="list-style-type: none"> • Must submit evidence that the member is 50 years of age or older • Must also submit documentation of a diagnosis of symptomatic benign prostatic hypertrophy of the lateral lobes of the prostate, including but not limited to the following symptoms: <ul style="list-style-type: none"> – Difficulty starting and stopping urination (hesitancy and straining) – Decreased strength of the urine stream (weak flow) – Dribbling after urination – Feeling that the bladder is not completely empty – An urge to urinate again soon after urinating (urgency) – Pain during urination (dysuria) – Nocturia – waking up several times during the night with the urge to urinate – Frequent urinary tract infections secondary to urinary obstruction • Must also submit documentation of a failure of, inability to tolerate, or undesirable side effects of pharmacologic interventions for BPH, including, but not limited to <ul style="list-style-type: none"> – Alpha blockers such as Uroxatral®, Cardura®, Rapaflo®, Flomax® or Hytrin® – 5-alpha reductase inhibitors for BPH, such as Avodart® or Proscar® – Combination drugs using both an alpha blocker and a 5-alpha reductase inhibitor • Must also submit documentation by the attending surgeon and another physician (such as the patient’s primary care physician) of the patient’s inability to tolerate a surgical procedure requiring anesthesia due to physical factors or comorbid conditions including but not limited to coagulopathies, respiratory conditions or cardiovascular disease

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Requested service	Required clinical criteria and information
<p>Note: Refer to the <i>BCN Referral and Authorization Requirements</i> document for referral and review requirements.</p>	
Proton beam radiation therapy	See entry for “Radiation therapy.”
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
Radiation therapy	<p>Radiation therapy services are reviewed by eviCore healthcare. For more information, refer to:</p> <ul style="list-style-type: none"> • The Procedures Managed by eviCore for BCN web page • The radiology guidelines at evicore.com. Click <i>Providers</i> (near “Login”). Click <i>Carecore</i>. Under eviCore Solutions and then Radiology, click Radiology Tools and Criteria.
Radiology	See entries for “Computerized tomography,” “Magnetic resonance imaging” and “Nuclear scans.”
Rhinoplasty	Must submit ENT or surgical consultation
Scar excision / revision	Must submit dermatology or plastic surgery consultation
Sleep studies – outpatient facility and clinic	<p>• Must complete questionnaire and submit through e-referral system. Refer to the preview questionnaires and authorization criteria posted on BCN’s Authorization Requirements & Criteria page at ereferrals.bcbsm.com.</p> <p>Additional information is on the Sleep Management Program page at ereferrals.bcbsm.com.</p>

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Requested service	Required clinical criteria and information
<p>Note: Refer to the <i>BCN Referral and Authorization Requirements</i> document for referral and review requirements.</p>	
<p>Speech therapy</p>	<p>NOTE: For BCN HMO (commercial) and BCN Advantage members, requests for the evaluation in office and outpatient settings, including hospital outpatient settings, must be approved by BCN Utilization Management. Subsequent therapy is managed by eviCore healthcare. Authorization guidelines for subsequent therapy visits are outlined in the Care Management chapter of the <i>BCN Provider Manual</i>.</p> <p>For providers not contracted with BCN, all speech therapy is managed by BCN and the required clinical criteria and information are as follows:</p> <ul style="list-style-type: none"> • Must submit all of the following: <ul style="list-style-type: none"> – Speech therapy evaluation – Evidence that member’s condition is subject to improvement within 60 days as the result of therapy – Evidence that the treatment is medically necessary – Evidence that therapy is being ordered for the treatment of an organic medical condition or the immediate postoperative or convalescent state of the member’s illness • In addition, for members with a chronic condition, must submit all of the following: <ul style="list-style-type: none"> – Evidence that there is an acute exacerbation of the chronic condition – Evidence that there is expectation of significant improvement within 60 days
<p>Surgery, cervical spine</p>	<ul style="list-style-type: none"> • Must complete questionnaire and submit through e-referral system. Refer to the preview questionnaires and authorization criteria posted on BCN’s Authorization Requirements & Criteria page at ereferrals.bcbsm.com.
<p>Surgery, joint replacement for hip, knee or shoulder</p>	<ul style="list-style-type: none"> • Must complete questionnaire and submit through e-referral system. Refer to the preview questionnaires and authorization criteria posted on BCN’s Authorization Requirements & Criteria page at ereferrals.bcbsm.com.

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Requested service	Required clinical criteria and information
<p>Note: Refer to the <i>BCN Referral and Authorization Requirements</i> document for referral and review requirements.</p>	
Surgery, lumbar spine	<ul style="list-style-type: none"> Must complete questionnaire and submit through e-referral system. Refer to the preview questionnaires and authorization criteria posted on BCN's Authorization Requirements & Criteria page at ereferrals.bcbsm.com.
Surgery, lumbar spine – lumbar discectomy/ hemilaminectomy with or without discectomy/ foraminotomy	<ul style="list-style-type: none"> Must complete questionnaire and submit through e-referral system. Refer to the preview questionnaires and authorization criteria posted on BCN's Authorization Requirements & Criteria page at ereferrals.bcbsm.com.
Surgery, lumbar spine – lumbar fusion	<ul style="list-style-type: none"> Must complete questionnaire and submit through e-referral system. Refer to the preview questionnaires and authorization criteria posted on BCN's Authorization Requirements & Criteria page at ereferrals.bcbsm.com.
Surgery, lumbar spine – lumbar laminectomy with or without discectomy/ foraminotomy/ fusion	<ul style="list-style-type: none"> Must complete questionnaire and submit through e-referral system. Refer to the preview questionnaires and authorization criteria posted on BCN's Authorization Requirements & Criteria page at ereferrals.bcbsm.com.
Swallow therapy	Must submit evidence of all of the following: <ul style="list-style-type: none"> Condition for which the therapy is being requested Results of swallow study Evidence of potential for significant improvement within 60 days
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 (e.g., tomographic studies, MRI)

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Requested service	Required clinical criteria and information
<p>Note: Refer to the <i>BCN Referral and Authorization Requirements</i> document for referral and review requirements.</p>	
<p>Transcatheter aortic valve implantation (TAVI) and replacement (TAVR)</p>	<p>Must submit evidence of all of the following:</p> <ul style="list-style-type: none"> • Specialist consultation • Evidence of severe aortic stenosis with a calcified aortic annulus and one or more of the following: <ul style="list-style-type: none"> – Aortic valve area less than 0.8 cm² – Mean aortic valve gradient greater than 40 mmHg – Jet velocity greater than 4.0 m/sec • New York Heart Association (NYHA) heart failure Class II, III or IV symptoms • Member is not a candidate for open heart surgery, as judged by at least two cardiovascular specialists (cardiologist and/or cardiac surgeon)
<p>Transgender surgery / gender reassignment surgery</p>	<p>Must submit specialist consultation that contains evidence of all of the following:</p> <ul style="list-style-type: none"> • Persistent gender identity disorder • Member is able to make a fully informed decision and to consent to the treatment • Member is knowledgeable about the procedures, potential complications, and potential for rehabilitation • Twelve months of continuous hormonal therapy or 12 months of successful continuous full-time real-life experience living as a member of the opposite sex • Any significant medical or mental health conditions and evidence that they are well controlled • Psychological / psychiatric evaluation by an MD/DO psychiatrist or doctoral-level psychologist, limited-licensed psychologist or otherwise fully licensed master's level social worker or psychologist • Mental health care services rendered by a clinical behavioral specialist, including all of the following: <ul style="list-style-type: none"> – No undiagnosed nontranssexual psychiatric condition – Recommendation supporting this procedure from two clinical behavioral specialists, at least one of whom is a doctoral-level clinical behavioral scientist and at least one of whom has known the member professionally for six months
<p>Transplant requests (all except kidney, skin and cornea)</p>	<p>Must submit specialist consultation</p> <p>Note: Kidney, skin and cornea transplants to contracted providers require a referral but do not require clinical criteria review.</p>

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Requested service	Required clinical criteria and information
<p>Note: Refer to the <i>BCN Referral and Authorization Requirements</i> document for referral and review requirements.</p>	
<p>Transplant harvesting procedures (all except kidney, skin and cornea)</p>	<p>Must submit evidence of all of the following:</p> <ul style="list-style-type: none"> • Member's history • Previous treatment and response • Specialist's consultations • Pre-transplant test and lab results
<p>Varicose vein treatment</p>	<p>● Must complete questionnaire and submit through e-referral system. Refer to the preview questionnaires and authorization criteria posted on BCN's Authorization Requirements & Criteria page at ereferrals.bcbsm.com.</p>
<p>Wireless capsule endoscopy</p>	<p>Must submit evidence of all of the following:</p> <ul style="list-style-type: none"> • Condition or suspected condition for which the therapy is being requested • Symptoms • Previous diagnostic tests and results

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● Blue Dot Changes to the Blue Care Network Medical Necessity Criteria / Benefit Review Requirements (For Services Not Involving Drugs / Biologicals)

— A supplement to the *BCN Referral and Authorization Requirements* document —

Service	Change Description
<p>● Computerized tomography, magnetic resonance imaging and nuclear scans</p>	<p>Effective for dates of service on or after Oct. 1, 2018, select cardiology and high-tech radiology procedures are managed by AIM Specialty Health. These include computerized tomography, magnetic resonance imaging and nuclear scans.</p> <p>Note: eviCore healthcare manages these services for dates of service prior to Oct. 1, 2018, including retrospective requests.</p> <p>The information on these procedures is updated and a link to BCN's AIM-Managed Procedures page at ereferrals.bcbsm.com is added.</p>
<p>● Various</p>	<p>For the following services, authorization criteria and preview questionnaires are available on BCN's Authorization Requirements & Criteria page at ereferrals.bcbsm.com:</p> <ul style="list-style-type: none"> ● Arthroscopy, knee ● Blepharoplasty ● Breast biopsy, excisional ● Cholecystectomy, laparoscopic ● Endometrial ablation (provider office setting only) ● Endoscopy, upper gastrointestinal, for gastroesophageal reflux disease ● Hyperbaric oxygen therapy ● Sleep studies – outpatient facility and clinic ● Surgery, cervical spine ● Surgery, joint replacement for hip, knee or shoulder ● Surgery, lumbar spine ● Varicose vein treatment <p>The information on these procedures is updated.</p>

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