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</table>
| **Inpatient admissions:** urgent/emergent and out of network (noncontracted) | Apply InterQual® criteria, including BCN Local Rules. Document the specific criteria subset used in addition to all of the following information:  
• 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** | Must submit one or more of the following:  
• 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 |
| **Arthroscopy, knee** | Refer to the criteria posted on the Clinical Review & Criteria Charts page at ereferrals.bcbsm.com. |
| **Bariatric surgery** | 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. Requests for clinical review should be submitted using the following forms:  
• Bariatric Surgery Assessment Form: Patient Referral Information  
• Physician Supervised Weight Loss Program Documentation  
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.  
Note: For BCN AdvantageSM members, bariatric surgery must be performed at a BCN-contracted facility. |
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<td><strong>Biofeedback</strong></td>
<td>For adults, must submit evidence of all of the following:</td>
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<tr>
<td>(urinary and fecal incontinence and chronic constipation)</td>
<td>• Stress and/or urge incontinence</td>
</tr>
<tr>
<td></td>
<td>• That the member is cognitively intact</td>
</tr>
<tr>
<td></td>
<td>• 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</td>
</tr>
<tr>
<td></td>
<td>• Motivation to comply with treatment</td>
</tr>
<tr>
<td></td>
<td>• Some degree of rectal sensation and ability to contract the external anal sphincter</td>
</tr>
<tr>
<td><strong>For children 4 years of age and older, must submit evidence of all of the following:</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Neurologic, anatomic, infectious or functional causes are ruled out</td>
</tr>
<tr>
<td></td>
<td>• Ability to comprehend verbal instructions</td>
</tr>
<tr>
<td></td>
<td>• Motivation to comply with treatment</td>
</tr>
<tr>
<td></td>
<td>• Some degree of rectal sensation and ability to contract the external anal sphincter</td>
</tr>
<tr>
<td><strong>Blepharoplasty</strong></td>
<td>Must submit evidence as follows:</td>
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<tr>
<td></td>
<td>• Visual field testing taped and untaped reveals a 30 percent or 12 degree loss of superior visual field and</td>
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<tr>
<td></td>
<td>• Excessive skin redundancy correlates with the visual field impairment or</td>
</tr>
<tr>
<td></td>
<td>• Chronic eyelid dermatitis due to redundant skin</td>
</tr>
<tr>
<td><strong>Bone-anchored hearing aid</strong> (BAHA)</td>
<td>Must submit evidence as follows:</td>
</tr>
<tr>
<td></td>
<td>• Specialist’s consultation and</td>
</tr>
<tr>
<td></td>
<td>• Evidence of one or more of the following:</td>
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<tr>
<td></td>
<td>– Congenital or surgically induced malformations (e.g., atresia) of the external ear canal or middle ear</td>
</tr>
<tr>
<td></td>
<td>– Chronic external otitis or otitis media</td>
</tr>
<tr>
<td></td>
<td>– Tumors of the external canal and/or tympanic cavity</td>
</tr>
<tr>
<td></td>
<td>– Chronic dermatitis of the external canal prohibiting the use of an air-conduction hearing aid</td>
</tr>
<tr>
<td></td>
<td>– Inability to wear conventional bone-conduction hearing aids</td>
</tr>
</tbody>
</table>

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| Bone growth stimulator     | 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:  
  • 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.  
Bone growth stimulation may also be indicated as an adjunct to high-risk fusion cases that meet one or more of the following criteria:  
  • Prior fusion failure  
  • Multilevel fusion attempts  
  • Diabetics and others with poor bone healing  
  • Members with grade III or greater spondylolisthesis |

Note: Refer to the BCN Referral / Clinical Review Program for referral and review requirements.

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| Breast biopsy, excisional | Must submit evidence of **any** of the following:  
  • Physical constraints limiting positioning for stereotactic biopsy  
  • A failed or unsuccessful needle core biopsy (e.g., not enough tissue obtained for analysis; tissue obtained was nondiagnostic; results were inconsistent with findings)  
  • Atypical or high-risk pathology on a previous core biopsy (e.g., atypical ductal hyperplasia, atypical lobular hyperplasia, atypical fibroadenoma, lobular cancer in situ, papilloma, radial scar)  
  • A palpable breast mass in a **female** that is very superficial or located beneath the nipple or areola  
  • A palpable breast mass in a **male** that is very superficial or located beneath the nipple or areola that is **not** associated with male gynecomastia  
  • Suspicious palpable findings and **either** in an unfavorable location or too small for palpation-guided core biopsy.  
  • Recurrence of a breast cyst in the same area **either** after having two aspiration procedures or within 8 weeks after complete disappearance with an aspiration  
  • New mammographic mass or calcifications that are not amenable to image-guided core biopsy  
  • Inflammatory skin or nipple changes (e.g., ulceration, redness, excoriation, superficial loss of skin)  
  • **Either a known** fibroadenoma increasing in size on ultrasound in patient of any age **or likely** fibroadenoma >2 cm in a patient <25 years of age and **patient is uncomfortable with having image-guided needle biopsy under local anesthesia**  
  • Bloody fluid or positive fluid cytology (abnormal or suspicious cells) identified by aspiration of a breast cyst  
  • Spontaneous localized bloody nipple discharge or nonbloody nipple discharge from a single duct identified on physical exam or positive ductogram |

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<td>Breast implants — insertion, removal, replacement</td>
<td>Must submit all of the following:</td>
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<tr>
<td></td>
<td>• Mammogram or ultrasound results</td>
</tr>
<tr>
<td></td>
<td>• Signs and symptoms of breast condition</td>
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<tr>
<td></td>
<td>• Plastic surgeon consultation</td>
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<td></td>
<td>• Evidence that the member had:</td>
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<tr>
<td></td>
<td>− Mastectomy or trauma</td>
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<tr>
<td></td>
<td>− Rupture of silicone implants, infection, extrusion or Baker Grade IV contracture</td>
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<tr>
<td></td>
<td>− Ruptured saline implant that was originally implanted for reconstructive purposes</td>
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<tr>
<td></td>
<td>• Evidence that the original insertion was not for cosmetic reasons, if reinsertion of silicone or saline breast implant(s) is requested</td>
</tr>
<tr>
<td>Breast reconstruction</td>
<td>Must submit all of the following:</td>
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<tr>
<td></td>
<td>• Diagnosis</td>
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<tr>
<td></td>
<td>• Surgical consultation report</td>
</tr>
<tr>
<td></td>
<td>• Evidence of medically necessary reconstruction due to:</td>
</tr>
<tr>
<td></td>
<td>− Trauma to the breast(s)</td>
</tr>
<tr>
<td></td>
<td>− Mastectomy secondary to family or personal history of cancer of the breast</td>
</tr>
<tr>
<td></td>
<td>− Mastectomy due to current diagnosis of breast cancer</td>
</tr>
<tr>
<td></td>
<td>− Congenital defects, such as breast agenesis</td>
</tr>
<tr>
<td></td>
<td>− Developmental abnormalities, infection or follow up after therapeutic surgery</td>
</tr>
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| **Breast reduction** (reduction mammoplasty) | Must submit all of the following:  
• Evidence that two or more of the following criteria are met:  
  − 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 |
| **Cardiac rehabilitation** (extensions with previous cardiac event) | Must submit all of the following:  
• Diagnosis  
• Cardiology consultation  
• Current progress notes from rehabilitation phase |
| **Cognitive therapy** | Must submit all of the following:  
• 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 |
| **Colonoscopy, virtual** | Must submit all of the following:  
• Reason for test  
• Reason the member cannot undergo standard (conventional) colonoscopy |
| **Computerized tomography** | Services involving CT are reviewed by eviCore healthcare. For more information, refer to:  
• The *Procedures Managed by eviCore for BCN Web page*  
• The radiology guidelines at *evicore.com*. Click *Providers* (near “Login”). Click *Carecore*. Under eviCore Solutions and then Radiology, click *Radiology Tools and Criteria*. |

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<td>Cosmetic and/or reconstructive surgery</td>
<td>Must submit <strong>all</strong> of the following:</td>
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<tr>
<td></td>
<td>• Surgeon/plastic surgeon consultation</td>
</tr>
<tr>
<td></td>
<td>• Evidence of functional deficit</td>
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<tr>
<td>Dental anesthesia (in outpatient setting or provider office)</td>
<td>Must submit <strong>all</strong> of the following:</td>
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<tr>
<td></td>
<td>• Reason the procedure must be done in outpatient setting (or provider office) and not in the other location</td>
</tr>
<tr>
<td></td>
<td>• Behavioral problems or medical condition</td>
</tr>
<tr>
<td></td>
<td>• Dental treatment plan</td>
</tr>
<tr>
<td>Dental services for trauma</td>
<td>Must submit <strong>all</strong> of the following:</td>
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<tr>
<td></td>
<td>• Evidence that services will be provided within 72 hours of injury</td>
</tr>
<tr>
<td></td>
<td>• Date of dental trauma or injury</td>
</tr>
<tr>
<td></td>
<td>• Treatment received</td>
</tr>
<tr>
<td></td>
<td>• Type of injury</td>
</tr>
<tr>
<td>Dermabrasion (chemical peel)</td>
<td>Must submit specialist consultation that includes evidence of <strong>one</strong> of the following:</td>
</tr>
<tr>
<td></td>
<td>• More than 10 actinic keratoses or other premalignant skin lesions</td>
</tr>
<tr>
<td></td>
<td>• Active acne that failed previous treatment with a two-month trial of topical and/or antibiotic</td>
</tr>
<tr>
<td>Developmental delay treatment</td>
<td>Must submit <strong>all</strong> of the following:</td>
</tr>
<tr>
<td></td>
<td>• Specialist consultation, if applicable</td>
</tr>
<tr>
<td></td>
<td>• Condition for treatment</td>
</tr>
<tr>
<td></td>
<td>• Previous history and response to treatment</td>
</tr>
<tr>
<td>Drugs and biologicals covered under the medical benefit</td>
<td>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.</td>
</tr>
</tbody>
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</table>
| Durable medical equipment and prosthetics and orthotics | • 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:  
• Number of weeks pregnant as documented on ultrasound or amniocentesis  
• Medical condition of mother and/or fetus |
| Electrocardiographic rhythm recording and storage devices, long-term, continuous (such as the Zio® Patch and LifeStar ACT) | The use of long-term (greater than 48 hours) external ECG monitoring by continuous rhythm recording and storage (for example, Zio Patch® and LifeStar ACT) is established for the evaluation of patients suspected of having an arrhythmia as follows:  
• Following Holter monitoring, when the results of the Holter monitoring were nondiagnostic  
• Instead of Holter monitoring, for the evaluation of patients suspected of having an arrhythmia:  
  − When the arrhythmias/symptoms occur so infrequently that a Holter monitor is unlikely to provide a diagnosis; OR  
  − When the patient is unlikely to recognize symptoms as being cardiac-related or the suspected cardiac changes may be asymptomatic; OR  
  − When symptoms are so severe as to make the patient unable to activate an event monitor or the patient is unable to use the monitor due to cognitive or other patient-related factors; OR  
  − Following a recent radiofrequency ablation for an arrhythmogenic focus to assess an arrhythmia that may be asymptomatic or that may occur beyond 48 hours after initiation of monitoring; OR  
  − To assess the therapeutic effect of arrhythmia therapy and support therapy planning |

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<td><strong>Endometrial ablation</strong></td>
<td>• Must complete questionnaire and submit through e-referral system. See the sample <strong>Endometrial Ablation Questionnaire</strong>.</td>
</tr>
<tr>
<td>(provider office setting)</td>
<td>• <strong>In addition</strong>, must submit evidence that all of the following are documented in the member’s medical record:</td>
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<tr>
<td></td>
<td>▪ A discussion with the member about all alternative options</td>
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<td></td>
<td>▪ No current pregnancy or wish to be pregnant in the future</td>
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<tr>
<td></td>
<td>▪ No active pelvic inflammatory disease or hydrosalpinx (Fallopian tube blocked due to fluid rather than tubal ligation)</td>
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<tr>
<td></td>
<td>▪ No intrauterine device in place</td>
</tr>
<tr>
<td></td>
<td>▪ History of menorrhagia (heavy bleeding)</td>
</tr>
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<td></td>
<td>▪ D&amp;C or endometrial biopsy performed in the last two years and endometrial cancer or precancerous changes in the endometrium were ruled out</td>
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<tr>
<td></td>
<td>▪ No submucosal fibroids (below the lining of the uterus) larger than 3 cm</td>
</tr>
<tr>
<td></td>
<td>▪ For procedures other than nonresectoscopic, no anatomical condition where myometrium weakness could exist (e.g., previous classic C-section, removal of fibroid in uterus wall)</td>
</tr>
<tr>
<td></td>
<td>▪ For microwave only (e.g., Microwave Endometrial Ablation System), evidence that none of the following conditions exists: Essure contraceptive inserts, myometrial thickness is &lt;10 mm or endometrial cavity is &lt;6 cm long</td>
</tr>
<tr>
<td></td>
<td>▪ For microwave radiofrequency ablation only (e.g., NovaSure®), evidence that none of the following conditions exists: myometrial thickness is &lt;10 mm or endometrial cavity is &lt;6 cm long</td>
</tr>
<tr>
<td></td>
<td>▪ For microwave radiofrequency ablation (e.g., NovaSure®) with Essure contraceptive inserts present, evidence that correct insert placement has been confirmed by an Essure Confirmation Test</td>
</tr>
<tr>
<td></td>
<td>▪ For nonresectoscopic approaches (e.g., NovaSure, Cavaterm™, ThermaChoice®, Her Option®, Hydro ThermAblator®, HTA™ System), measured length of the endometrial cavity is &lt;10 cm</td>
</tr>
<tr>
<td></td>
<td>▪ For microwave (Microwave Endometrial Ablation System from Microsulis Medical/Hologic), measured length of endometrial cavity is &gt;6 cm and &lt;14 cm</td>
</tr>
</tbody>
</table>

Epidural injections  | See “Pain management: epidural injections.”

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<tbody>
<tr>
<td>Experimental or investigational procedures</td>
<td>Must submit all of the following:</td>
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<tr>
<td></td>
<td>• Complete description of service or procedure requested</td>
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<tr>
<td></td>
<td>• Diagnosis</td>
</tr>
<tr>
<td></td>
<td>• Clinical trial information or peer-reviewed literature to support the clinical efficacy of the service or treatment being performed</td>
</tr>
<tr>
<td>Facet injections</td>
<td>See “Pain management: facet injections.”</td>
</tr>
<tr>
<td>Fetal invasive procedures, unlisted</td>
<td>Must submit all of the following:</td>
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<tr>
<td></td>
<td>• Specialty consultation</td>
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<tr>
<td></td>
<td>• Fetal gestational age</td>
</tr>
<tr>
<td></td>
<td>• Description of fetal procedural plan</td>
</tr>
<tr>
<td>Genetic testing</td>
<td>See “Laboratory services and genetic testing.”</td>
</tr>
<tr>
<td>Hearing services, such as audiometric testing not in conjunction with hearing aid services</td>
<td>Must submit all of the following:</td>
</tr>
<tr>
<td></td>
<td>• Condition for which the service is being requested</td>
</tr>
<tr>
<td></td>
<td>• Reason for preforming the test</td>
</tr>
<tr>
<td></td>
<td>• Specialist’s consultation, if available</td>
</tr>
</tbody>
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| Hyperbaric oxygen therapy         | Must submit evidence of one of the following conditions effectively treated by systemic hyperbaric oxygen therapy:  
  • 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                                                                                                                                                     |
| Infertility evaluation, testing and treatment | Must verify benefit, then submit all of the following:  
  • Specialty consultation that includes member’s history, previous treatment and response  
  • Proposed treatment plan  
  Excludes in-vitro fertilization and related services.                                                                                                                                                                                                                                                                 |
| Knee arthroscopy                  | See “Arthroscopy, knee.”                                                                                                                                                                                                                                                                                                                                             |
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| Laboratory services and genetic testing | • For laboratory services, provider should contact JVHL at 1-800-445-4979 to request services.  
• For genetic testing, must submit all of the following:  
  – Name of the genetic test(s) requested  
  – Name of the laboratory that will process the specimen  
  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.  
  – 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 |
| Lumbar spine surgery | See “Surgery, lumbar spine.” |
| 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:  
  • Pubertal or adolescent gynecomastia of more than two years’ duration and full puberty  
  • Non-adolescent gynecomastia due to irreversible causes |
| Magnetic resonance imaging | Services involving MRIs are reviewed by eviCore healthcare. For more information, refer to:  
  • The Procedures Managed by eviCore for BCN Web page  
  • The radiology guidelines at evicore.com. Click Providers (near “Login”). Click Carecore. Under eviCore Solutions and then Radiology, click Radiology Tools and Criteria. |

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| **Not otherwise classified (NOC) medical codes (e.g., CPT*, HCPCS)** | Must submit **all** of the following:  
  - Diagnosis  
  - Full description of procedure or service requested  
  - Fee to be billed  
  *CPT codes, descriptions and two-digit numeric modifiers only are copyright 2015 American Medical Association. All rights reserved. |
| **Nuclear scans** | Nuclear scans are reviewed by eviCore healthcare. For more information, refer to:  
  - The [Procedures Managed by eviCore for BCN Web page](#)  
  - The radiology guidelines at [evicore.com](http://evicore.com). Click Providers (near “Login”). Click Carecore. Under eviCore Solutions and then Radiology, click [Radiology Tools and Criteria](#). |
| **Nutritional counseling** |  
  - Must submit evidence of **one** of the following conditions:  
    - 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:  
      - 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:  
    - Recommended diet plan  
    - Consultations for comorbid conditions for consideration  
    - Number of visits |

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</table>
| Occupational therapy | NOTE: For BCN and BCN Advantage members, requests for the evaluation and first therapy visit in office and outpatient settings, including hospital outpatient settings, must be approved by BCN Care Management. Subsequent therapy is managed by eviCore healthcare. Authorization guidelines for subsequent therapy visits are outlined in the Care Management chapter of the BCN Provider Manual. For providers not contracted with BCN, all occupational therapy is managed by BCN and the required clinical criteria and information are as follows:  
  • Must submit all of the following:
    − 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:
    − 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 | Must submit all of the following:
  • Evidence that procedure is considered medical/surgical rather than dental
  • Description of condition, such as tumors, cysts, or other lesions |

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| Orthognathic surgery | • All of the following criteria must be met:  
  − 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:  
    − 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 |

| Orthoptic and/or pleoptic training | Must submit all of the following:  
  • Eye condition for which vision therapy is being requested  
  • Specialist consultation  
  • Treatment plan |

| Out-of-network (noncontracted) providers for elective services | Must submit all of the following:  
  • 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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</table>
| Pain management: epidural injections | **For dates of service prior to Sept. 1, 2016:**  
  • Must complete questionnaire and submit through e-referral system. See the [Sample epidural injection questionnaire](#).  
  • **In addition,** must submit all of the following:  
    - 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  

**For dates of service on or after Sept. 1, 2016:**  
Services involving epidural injections are reviewed by eviCore healthcare. For more information, refer to:  
  • The [Procedures Managed by eviCore for BCN Web page](#)  
  • The interventional pain guidelines at [evicore.com](http://evicore.com). On the Solutions tab, click *Musculoskeletal*. Click *Clinical Guidelines*. Then click to open a specific guideline.

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| Pain management: facet joint injections | **For dates of service prior to Sept. 1, 2016:**
  - Must complete questionnaire and submit through e-referral system. See the [Sample facet injection questionnaire](#).
  - In addition, must submit all of the following:
    - 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

**For dates of service on or after Sept. 1, 2016:**

Services involving facet joint injections are reviewed by eviCore healthcare. For more information, refer to:

- The [Procedures Managed by eviCore for BCN Web page](#)
- The interventional pain guidelines at [evicore.com](http://evicore.com). On the Solutions tab, click Musculoskeletal. Click Clinical Guidelines. Then click to open a specific guideline.

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| Physical therapy (and physical medicine services provided by chiropractors) | For BCN 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 Care 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 BCN Provider Manual. 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:
  - Must submit all of the following:
    - 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:
    - 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

Note: Chiropractors contracted with BCN may provide physical medicine services for BCN HMO<sup>SM</sup> (commercial) members using select *97XXX procedure codes.

*CPT codes, descriptions and two-digit numeric modifiers only are copyright 2015 American Medical Association. All rights reserved.

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| Prostatic urethral lift procedures for the treatment of BPH | • 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:  
  - 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  
  - 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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<tr>
<td>Proton beam radiation therapy</td>
<td>See entry for “Radiation therapy.”</td>
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</tbody>
</table>
| Pulmonary rehabilitation | Must submit evidence of **all** of the following:  
  • 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 | Radiation therapy services are reviewed by eviCore healthcare. For more information, refer to:  
  • The [Procedures Managed by eviCore for BCN Web page](#)  
  • The radiology guidelines at [evicore.com](http://evicore.com). Click Providers (near “Login”). Click Carecor. 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 |

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| Sleep studies – outpatient facility and clinic | Must complete a questionnaire and submit it through the e-referral system. Must also submit evidence of all of the following:  
- That the sleep study is not being performed solely to meet a legal requirement (for example, as part of an application for or maintenance of air or ground vehicle licensure)  
- That the patient previously had a home sleep study that was nondiagnostic  
- That the patient has a high pretest probability for moderate to severe obstructive sleep apnea as indicated by:  
  o Observed apnea (pauses in breathing) during sleep OR  
  o A combination of at least two of the following:  
    ▪ Excessive daytime sleepiness present noted by Epworth Sleepiness Scale greater than 10 OR sleepiness interfering with daily activities not explained by other conditions.  
    ▪ Habitual snoring or gasping/choking episodes with wakenings  
    ▪ Treatment resistant (persistent) high blood pressure in a patient taking three or more blood pressure medications  
    ▪ Obesity, which is a body mass index greater than 35 or a neck circumference greater than 17 inches for a male or greater than 16 inches for a female  
    ▪ Soft tissue abnormalities of the upper airway, head, skull or face |

(continued on next page)

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<tbody>
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<td>Sleep studies – outpatient facility and clinic (continued)</td>
<td>Must also submit evidence of all of the following (continued):</td>
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<tr>
<td></td>
<td>• That the patient has either a confirmed diagnosis of or suspicion of at least one of the following, which is an exclusion or contraindication to having a home sleep study:</td>
</tr>
<tr>
<td></td>
<td>o Moderate to severe congestive heart failure, as defined by a New York Heart Association (NYHA) class III or IV</td>
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<tr>
<td></td>
<td>o Moderate to severe pulmonary disease defined by EITHER pulmonary function test results for arterial blood gas showing PO2 &lt;60 or PCO2 &gt;45; OR confirmed pulmonary congestion (fluid in the lungs); OR left ventricular ejection fraction &lt;45%</td>
</tr>
<tr>
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<td>o Central sleep disorder in which the effort to breath is diminished or absent for 10 seconds or longer</td>
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<td></td>
<td>o Narcolepsy</td>
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<td></td>
<td>o Periodic arm or leg movements during sleep</td>
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<tr>
<td></td>
<td>o Obesity hypoventilation syndrome, which is a breathing disorder in which poor breathing results in too much carbon dioxide (hypoventilation) and too little oxygen in the blood (hypoxemia)</td>
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<tr>
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<td>o Morbid obesity, defined as a body mass index (BMI) greater than 40 kg/m² or the patient is 100 pounds over the ideal body weight for his or her height</td>
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<td>o A neuromuscular disease such as Parkinson’s, myotonic dystrophy or amyotrophic lateral sclerosis (ALS)</td>
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<td></td>
<td>o A history of epilepsy (seizures)</td>
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<td></td>
<td>o REM behavior disorder in which the patient acts out his or her dreams, such as by sleeptalking, screaming, arm or leg movement or sleepwalking</td>
</tr>
<tr>
<td></td>
<td>o Another parasomnia (disruptive sleep disorder that involves undesirable physical, behavioral or emotional experiences while falling asleep) not listed above that would be a contraindication for a home sleep study</td>
</tr>
<tr>
<td></td>
<td>o Inability to use the test equipment in the home due to critical illness or another reason</td>
</tr>
</tbody>
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(For Services Not Involving Drugs / Biologicals Covered Under Medical Benefit)

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| Sleep studies – outpatient facility and clinic (continued) | Must also submit evidence of all of the following (continued):

- For repeat sleep studies, evidence of at least one of the following reasons the sleep study is being performed:
  - To initiate, titrate or re-evaluate CPAP for a patient with an apnea hypopnea index (AHI) of at least 15 per hour OR an AHI of at least 5 per hour with excessive daytime sleepiness or unexplained high blood pressure
  - Following surgery, to determine whether the surgery was effective
  - To assess the efficacy of a dental appliance on sleep
  - Due to equipment failure or less than six hours of recording or sleep
  - To re-evaluate the diagnosis of obstructive sleep apnea and need for continued CPAP -- for example, if there is a significant change in weight or change in symptoms suggesting that CPAP should be retitrated or possibly discontinued

Note: After completing and submitting this questionnaire and while still inside the e-referral system, providers should attach information from the patient’s medical record in the Case Communication field. This information must show evidence of a condition that is a contraindication or exclusion to having a sleep study in the home; previous sleep study results; BMI; pulmonary function test results; and arterial blood gas lab results.

For additional information on the Sleep Management Program, visit [ereferrals.bcbsm.com > BCN > Sleep Management Program](https://ereferrals.bcbsm.com).

Also see BCN’s medical policy on sleep studies. To access that policy, log in to Provider Secured Services, click BCN Provider Publications and Resources > Medical Policy Manual > Policies by Name > S > Sleep Disorders, Diagnosis and Medical Management.

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| Speech therapy    | NOTE: For BCN and BCN Advantage members, requests for the evaluation in office and outpatient settings, including hospital outpatient settings, must be approved by BCN Care Management. Subsequent therapy is managed by eviCore healthcare. Authorization guidelines for subsequent therapy visits are outlined in the Care Management chapter of the BCN Provider Manual. For providers not contracted with BCN, all speech therapy is managed by BCN and the required clinical criteria and information are as follows:  
  • Must submit all of the following:  
    - 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:  
    - Evidence that there is an acute exacerbation of the chronic condition  
    - Evidence that there is expectation of significant improvement within 60 days |
| Spine care        | Members are not required to see a physical medicine and rehabilitation provider for evaluation prior to referral to a neurosurgeon or orthopedic surgeon. (The requirement for a referral to a physical medicine and rehabilitation provider had been part of BCN's Spine Care Referral Program.) Clinical review is not required for the initial visit to a neurosurgeon or orthopedic surgeon and for office visits and procedures. These visits may require a referral from the member's primary care physician, depending on the region. These changes apply to BCN HMO℠ (commercial) and BCN Advantage℠ members who have a low back pain condition defined by the select ICD-10 diagnosis codes that were previously subject to these requirements as part of BCN's Spine Care Referral Program. |

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<tbody>
<tr>
<td>Surgery, cervical spine</td>
<td>Refer to the criteria posted on the <a href="ereferrals.bcbsm.com">Clinical Review &amp; Criteria Charts page</a> at ereferrals.bcbsm.com. These apply for dates of service on or after Oct. 3, 2016.</td>
</tr>
<tr>
<td>Surgery, joint replacement for hip, knee or shoulder</td>
<td>Refer to the criteria posted on the <a href="ereferrals.bcbsm.com">Clinical Review &amp; Criteria Charts page</a> at ereferrals.bcbsm.com. These apply for dates of service on or after Oct. 3, 2016.</td>
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<tr>
<td>Surgery, lumbar spine</td>
<td>Refer to the criteria posted on the <a href="ereferrals.bcbsm.com">Clinical Review &amp; Criteria Charts page</a> at ereferrals.bcbsm.com. These apply for dates of service on or after Oct. 3, 2016.</td>
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</tbody>
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| Surgery, lumbar spine – lumbar discectomy/hemilaminectomy with or without discectomy/foraminotomy (for dates of service prior to Oct. 3, 2016) | • Must complete questionnaire and submit through e-referral system. See the sample lumbar spine surgery questionnaires at ereferrals.bcbsm.com > BCN > Clinical Review & Criteria Charts.  
• In addition, must submit:  
  − Either evidence of all of the following:  
    − Nerve root compression as shown by imaging (MRI, CT or myelogram-CT)  
    − Severe weakness (less than 2 out of 5 muscle strength) or mild atrophy (muscle wasting) along a specific nerve root distribution  
  − Or evidence of nerve root compression as shown by imaging (MRI, CT or myelogram-CT) and one of the following:  
    − Pain with either mild to moderate weakness or sensory deficit (e.g., decreased sensation, numbness or tingling) along a specific nerve root distribution and all of the following:  
      − Symptoms that continue after treatment with appropriate NSAIDs for at least 3 weeks (unless contraindicated/not tolerated)  
      − Symptoms that continue after activity modification for at least 6 weeks  
    − Worsening weakness along a specific nerve root distribution that is progressively worsening and all of the following:  
      − Symptoms that continue after treatment with appropriate NSAIDs for at least 3 weeks (unless contraindicated/not tolerated)  
      − Symptoms that continue after activity modification for at least 6 weeks |

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| Surgery, lumbar spine – lumbar fusion (for dates of service prior to Oct. 3, 2016) | • Must complete questionnaire and submit through e-referral system. See the sample lumbar spine surgery questionnaires at ereferrals.bcbsm.com > BCN > Clinical Review & Criteria Charts.  
• In addition, must submit:  
  - Either evidence of any of the following:  
    - An acute traumatic spinal injury and both of the following:  
      - Vertebral fracture, subluxation or dislocation as shown by imaging  
      - Stabilization cannot be achieved nonsurgically (e.g., closed reduction, immobilization, brace)  
    - Spinal osteomyelitis identified by both of the following:  
      - Either bone aspiration/biopsy/bone scan or gallium scan  
      - Vertebral bone destruction as shown by imaging  
    - Bone tumor of the lumbar as identified by imaging (MRI, CT or myelogram-CT) and excision of the lesion would cause instability of the vertebrae  
  - Or evidence of all of the following for back pain not due to trauma:  
    - Back pain that interferes with activities of daily living (e.g., ability to perform personal hygiene, work effectively, manage home)  
    - X-ray results of sagittal plane translation >3 mm  
    - Back pain that continues after both activity modification and physical therapy for at least 6 months  
  - Or evidence of all of the following for back pain due to degenerative disc disease:  
    - Pain that continues after both activity modification and physical therapy for at least 6 months  
    - Degenerative disc disease identified on MRI imaging  
    - Continued pain from degenerative disc disease after treatment with appropriate NSAIDs for at least 3 weeks (unless contraindicated/not tolerated) |

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| Surgery, lumbar spine – lumbar laminectomy with or without discectomy/foraminotomy/fusion (for dates of service prior to Oct. 3, 2016) | • Must complete questionnaire and submit through e-referral system. See the sample lumbar spine surgery questionnaires at [ereferrals.bcbsm.com > BCN > Clinical Review & Criteria Charts](http://ereferrals.bcbsm.com).  
• **In addition,** must submit:
  - Imaging results (MRI, CT or myelogram-CT) showing one of the following:
    - Disc bulging and degeneration
    - Spondylosis with degenerative changes
    - Spondylolisthesis (vertebral displacement) or spinal stenosis (narrowing of spinal canal)
  - **In addition,** must submit:
    - Either evidence of at least one of the following symptoms:
      - Weakness, numbness or pain in both legs
      - Bowel incontinence
      - Bladder dysfunction
      - Decreased rectal sphincter tone as shown by exam
      - “Saddle anesthesia” (numbness in groin area)
    - Or evidence of both of the following:
      - Low back pain and lower-extremity symptoms (pain, tingling or numbness) that worsens with walking or spinal extension (backward bending) or forward flexion (bending)
      - Continued symptoms after both treatment with appropriate NSAIDs for at least 3 weeks (unless contraindicated/not tolerated) and activity modification for at least 12 weeks|
| Swallow therapy | Must submit evidence of all of the following:
- 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:
- Specialist consultation
- History/physical evaluation
- Previous treatment plan
- TMJ X-rays
- Other tests (e.g., tomographic studies, MRI)

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| Transcatheter aortic valve implantation (TAVI) and replacement (TAVR) | Must submit evidence of all of the following:  
• Specialist consultation  
• Evidence of severe aortic stenosis with a calcified aortic annulus and one or more of the following:  
  - 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) |
| Transgender surgery / gender reassignment surgery | Must submit specialist consultation that contains evidence of all of the following:  
• 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:  
  - 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 |
| 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. |

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BCN Clinical Review Medical Necessity Criteria / Benefit Review Requirements / UPD OCT 2016
Changes from previous publication are identified by a Blue Dot and explained on the final page of this document.

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| Transplant harvesting procedures (all except kidney, skin and cornea) | Must submit evidence of all of the following:  
- Member’s history  
- Previous treatment and response  
- Specialist’s consultations  
- Pre-transplant test and lab results |
| Varicose vein treatment | • Must complete questionnaire and submit through e-referral system. See the sample Varicose Vein Treatment Questionnaire.  
- In addition, must show:  
  - Either evidence of all of the following:  
  - The procedure is not being done as a treatment for spider veins  
  - There is moderate to severe aching or edema (swelling) of legs  
  - Varicosities were identified by physical exam  
  - There were continued symptoms after using prescription compression hose for a minimum of six weeks  
  - Or evidence of one of the following:  
  - More than two episodes of superficial thrombophlebitis (symptoms may include warmth, tenderness, redness, swelling, itching, tingling and tenderness or pain in the affected area)  
  - Continued superficial thrombophlebitis after a four-week treatment of nonsteroidal anti-inflammatory medication (e.g., aspirin, ibuprofen, naproxen, Celebrex®, Toradol®, Lodine®, Indocin®, etc.)  
  - Continued superficial thrombophlebitis and nonsteroidal anti-inflammatory medication is contraindicated or not tolerated  
  - Any one of the following: one or more episodes of bleeding from a varicose vein or bleeding from a varicose vein that is in an exposed location (e.g., ankle) or bleeding from a varicose vein that is one of multiple adjacent veins |
| Wireless capsule endoscopy | Must submit evidence of all of the following:  
- 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**

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<td>Knee arthroscopy and cervical spine, lumbar spine and joint replacement surgery</td>
<td>Entries are added that the criteria for these services are available on the Clinical Review &amp; Criteria Charts page at ereferrals.bcbsm.com. These apply for dates of service on or after Oct. 3, 2016.</td>
</tr>
<tr>
<td>Pain management procedures (epidural and facet joint injections)</td>
<td>Effective for dates of service on or after Sept. 1, 2016, pain management procedures (epidural and facet joint injections) are managed by eviCore healthcare. eviCore’s interventional pain guidelines are available at evicore.com. Additional information is found at ereferrals.bcbsm.com &gt; BCN &gt; eviCore-Managed Procedures.</td>
</tr>
<tr>
<td>Sleep studies</td>
<td>The criteria for sleep studies (outpatient facility and clinic) are updated. Home sleep studies no longer require clinical review.</td>
</tr>
</tbody>
</table>
| Spine care                                                             | The criteria for spine care services are updated. The revised criteria are effective March 1, 2016, and include:  
  • Members are not required to see a physical medicine and rehabilitation provider for evaluation prior to referral to a neurosurgeon or orthopedic surgeon.  
  • Clinical review is not required for the initial visit to a neurosurgeon or orthopedic surgeon and for office visits and procedures. These visits may require a referral from the member’s primary care physician, depending on the region. |
| Durable medical equipment and prosthetics and orthotics               | The contact information for Northwood is updated. 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.                                                                                       |
| Prostatic urethral lift procedures for the treatment of BPH            | The medical necessity criteria for prostatic urethral lift procedures for the treatment of benign prostatic hypertrophy are added to this document.                                                                                                                                                                                                   |
| Cardiology, radiation therapy and radiology procedures                | Various cardiology, radiation therapy and radiology procedures are reviewed by eviCore healthcare for BCN. Additional information is found at ereferrals.bcbsm.com > BCN > eviCore-Managed Procedures and at evicore.com. The information on these procedures in this document is changed to reflect this.                                           |
| Physical therapy (and physical medicine services delivered by chiropractors) | The physical therapy information is updated to reflect that:  
  • BCN-contracted chiropractors may provide physical medicine services to BCN’s commercial members.  
  • Physical therapy and physical medicine services are managed by eviCore healthcare for BCN.                                                                                                                                                                                                 |

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