Connection

News for our Participating Provider Partners

August 2023

Excellus BlueCross BlueShield

Everybody Benefits

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Stay in the Know!

Visit the Provider News and Updates page on our website to review recent communications. Be sure to log into our provider portal with your username and password to view all news updates.

To view topic specific bulletins, select one of the available categories or enter a keyword in the Search area. While viewing an article, you can click "Email this article" to share it with a friend or co-worker! Save our Provider News and Updates page as an online "favorite" for easy access.

Thank you for your continued Connection readership. We welcome your suggestions, questions and comments. Email Maria Valvo, editor, at maria.valvo@excellus.com.

2023 APEX® AWARDS FOR PUBLICATION EXCELLENCE

NEWS YOU CAN USE

Medicare Annual Physical Exam Outreach

It's our top priority to keep our valued members healthy, and we know that is your goal as well. One way to do that is to make sure that they schedule their annual physical exam.

We have started phone and email outreach to Medicare members who have not had an annual exam to remind them to schedule an appointment. We are also offering scheduling assistance to members who need it.

As a result of this outreach, you may receive calls to set up physical exam appointments. Please remember that Medicare members are entitled to one annual wellness visit (preventive visit) and one annual physical (hands-on exam) per year.

Thank you for collaborating with us to ensure the good health of our Medicare population.

New Institutional Inpatient BlueCard® Claim Prepayment Review Process

We remind you that Excellus BlueCross BlueShield has retained Zelis Healthcare, LLC ("Zelis"), an independent company, to assist in enhancing the process for prepayment reviews of itemized invoices for institutional inpatient BlueCard HOST DRG claims with an "outlier" or percent of charge over $100,000. The updated review process is effective with dates of service on or after August 1, 2023.

The Zelis prepayment review process applies to all BlueCard HOST claims except for claims priced at a per diem flat-fee case rate, or DRG rate without an outlier.

Please refer to our bulletin issued May 1, 2023 for additional details.

Erectile Dysfunction Procedure Preauthorization Requirement

We remind you that a 2007 New York state mandate excludes coverage of erectile dysfunction treatment for members enrolled in Medicaid Managed Care (HMOBlue Option, Blue Choice Option and Premier Option) and Health and Recovery Plan products (Blue Option Plus and Premier Option Plus) who are required to register as a sex offender. As a result, preauthorization is required for the following codes related to erectile dysfunction procedures:

37788, 37790, 54220, 54230, 54231, 54235, 54240, 54250, 54400, 54401, 54405, 54406, 54408, 54410, 54411, 54415, 54416, 54417, 55870, 93980, 93981, C1813, C2622, J0270, J0275, J0775, J2440, J2760, L7900, L7902.

If you have questions, please contact your Provider Relations representative.

Thank you for the care that you provide to our valued members.

Tools to be Removed from CareAdvance Provider™

The Utilization Management (UM) Program gives Excellus BlueCross BlueShield and its provider partners the opportunity to monitor medical episodes of care to prevent unnecessary treatment and duplication of services. The UM Program manages a subset of select services through InterQual® guidelines or corporate medical policy to ensure medically necessary care is provided. In some instances, there are provider-facing custom tools to aid in the request for services.

Effective September 22, 2023, these tools will be removed from the CareAdvance Provider portal.

Please refer to our bulletin issued July 5, 2023, for complete details including a list of the tools to be removed.

News You Can Use continued on next page

Be Aware of these Upcoming Medical Record Collection Initiatives

We would like to remind you of two important medical record collection initiatives the Health Plan will be initiating soon.

In the next few weeks, your office may receive medical records retrieval request from Ciox Health, LLC, an independent company, which retrieves medical records on our behalf. This record review is conducted annually and is required to comply with Centers for Medicare & Medicaid Services (CMS) requirements to ensure that the records properly reflect the clinical conditions of our members. The request is for January 1, 2022 through December 31, 2022 dates of service only and applies only to **Medicare Advantage members**.

If you have questions or concerns regarding this collection, please contact Ciox directly at **1-877-445-9293**, Monday through Friday, from 8:30 a.m. to 5:30 p.m. EST, or you may contact your Provider Relations representative.

Additionally, the Health and Human Services Risk Adjustment Data Validation (HHS-RADV) audit for 2022 calendar year will launch in the next few weeks.

If you delivered services to members during the 2022 calendar year who are randomly selected for this audit, you may be asked to participate by submitting medical records for these members.

As a reminder, under the Affordable Care Act (ACA), our Health Plan is required to participate in HHS-RADV audits. These audits apply to ACA **Commercial** lines of business only and are designed to validate diagnosis data previously submitted to CMS.

Our Health Plan has contracted with an independent company, Health Data Vision, Inc (D/B/A "Reveleer"), to gather medical records on our behalf. Reveleer is bound by the terms and conditions of a business associate agreement executed with us. As our business associate, under the Health Insurance Portability and Accountability Act (HIPAA), Reveleer is authorized to receive these records. In accordance with HIPAA, Reveleer is required to maintain the confidentiality of any protected health information it receives from you on our behalf.

If you receive a request for medical records for another initiative, please follow the instructions in the request. It's important to note that the time frame for retrieving records is extremely short, and CMS will not grant extensions.

Your assistance with the audits our Health Plan is required to perform is greatly appreciated.

Updated Forms Clarification

The Application for Practitioner Enrollment form available on our website is the most recent version. It is dated January 2023. The following forms were updated in May 2023:

- Application for Non-Physician Health Care Practitioner
- Practitioner Demographic Changes

Prepare Young Patients Now for Peak Asthma Season

If you have young patients with asthma, now is the time to revisit their asthma action plan so they are prepared for the annual increase in asthma attacks that occurs each year as kids return to the classroom. A dramatic rise in the number of asthma flare-ups occurs each year from late August through the end of September, according to a review of public health records by Excellus BlueCross BlueShield.

"All adults and schools or other sites that care for a child with asthma should have a copy of the asthma action plan and understand their responsibilities regarding the child's care," according to Lisa Y. Harris, M.D., senior vice president and chief medical officer at Excellus BCBS.

Tips to share with parents before school starts:

- Make sure your child takes all asthma medications as directed.
- Alert all adults at school and elsewhere who work with your child to recognize the signs of an asthma attack.
- Empower your child to notice and report asthma triggers and signs of a pending attack.
- Prevent the spread of germs by encouraging proper handwashing, social distancing, and making sure that every family member is current on all recommended vaccinations, including the annual flu shot.

Visit www.health.ny.gov/publications/4850.pdf for a free New York state asthma action plan template.

Lisa Y. Harris, M.D.
Senior Vice President &
Corporate Medical Director

Keep Your Practice Information Current

Our online Practitioner Demographic Changes submission form makes it easier and faster to update the demographic information we have for your practice.

Visit the Update Practice Information section of our website. Log in with your username and password to use the new online form. You still have the option to download a PDF version of this form if you choose.

We recommend that you verify demographic information every 90 days using our Find a Doctor/Provider tool.

Please also verify and update your demographic information on the NPI Registry. Log into your NPI record at https://nppes.cms.hhs.gov/#/.

If you need help using the new online form, please contact your Provider Relations representative. Thank you for helping us ensure we have the most up-to-date information available.

Don't Keep the Latest News and Updates to Yourself

Share this newsletter with your coworkers via the "Forward this email to a Friend" option in the eAlert!

We Can Help as You Care for Patients with Persistent Mental Illness Diagnosis

Has one of your patients recently been admitted to the hospital for a behavioral health-related issue? We want to help!

Studies show that individuals who do not engage in follow up care after hospitalization have a higher risk for readmission and an increase in negative outcomes. If they have a serious and persistent mental illness diagnosis such as schizophrenia or bipolar disorder, it may be even harder to engage them in care following a hospital discharge.

We want to partner with you to help support these members. Our case management services are free to our members and your practice.

How we can help:

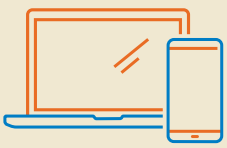
- Assist with discharge planning to support transition from inpatient to outpatient care
- Referral to Health Homes/Health Homes Plus Care Management services
- Referral to Home and Community Based Services/Community Oriented Recovery and Empowerment (HCBS/CORE) services to help improve patient independence and community participation
- Coordination and linkage to resources available to address State Department of Health needs
- Support if member is missing outpatient appointments
    - If patient is eligible for Medicaid transportation, we can assist with setting it up and walking the member through how to access

Please call us if you are struggling to identify resources or if you have other ideas of how we might be able to assist in the care of our members.

For support for you patient, please contact Kelly Robinson at Kelly.Robinson@excellus.com (585-485-6023).

Help Stop Fraud, Waste, and Abuse

To report potential fraud, waste or abuse, please call our Fraud Hotline at 1-800-378-8024 or visit our website to complete and submit our Fraud Reporting form. For federal employees, call 1-800-337-8440. All fraud, waste and abuse referrals are confidential and can be made anonymously. Those who report wrongdoing are protected from retaliation.



Chronic Pain – The Impact of Early Contact Decisions and Language

Well intentioned decisions made by providers in the early onset of a low back pain episode can actually trigger the evolution of chronic pain.

A 2020 JAMA article by Stevens et al[1] found unnecessary imaging (imaging in the absence of red flags), prescribing of opioids and early, inappropriate specialty referrals to be the most powerful predictors of which acute back pain patients would become a chronic pain sufferer. In fact, unnecessary imaging can have a strong iatrogenic effect with commonly used language on imaging reports, such as labeling normal age-related changes as "degenerative" can incite fear, misperceptions, passivity and catastrophizing behavior. There is a strong correlation between a patient's thoughts, ideas or beliefs about their pain experience and its associated chronicity[2], which can be positively or negatively influenced by the early contact provider[3,4] based on their early management decisions as well as the language used and education given. Our simple, and popular (98% PCP approval rating) evidence-based, online spine pathway workshop provides the early contact provider with the tools and support needed to enhance their acute back pain patients' ability to quickly recover and return to their normal lifestyle. And 24/7 access to the PSPN learning platform is always available to those who have taken the training. It offers many additional nuanced spine trainings, research updates, clinical forums and a toolbox with many helpful shared decision/ education handouts.

Want to learn more? Our nationally recognized Spine Health Pathway Training offered by Excellus BlueCross BlueShield is an online/on-demand, clinically relevant and impactful workshop, with a **$200 honorarium for PCPs** (MD, DO, NP, PA) as well as **Chiropractors** and **Physical Therapists.**

Helpful Language - Based in part on the work of Sherri Weiser, PhD

What You Say	What The Patient Hears
Your MRI doesn't show anything to worry about	There's nothing seriously wrong with my back
Your MRI shows normal things that come with aging, like gray hair	Those scary-sounding words are nothing to be afraid of
The cause of your pain may not show up on an MRI	My pain is real
Increasing activity as tolerated will help	Activity is good for me
Self-treatments and exercises are the most important aspects of spine care	I can take charge of this
Medication and injections are sometimes helpful so you can get more out of the self-treatments and exercises	Self-treatment and exercises are the keys to recovery
Having pain at times is a normal part of life but it can almost always be managed	The pain doesn't have to go away; I can learn to take charge of it

Unhelpful Language

What You Say	What The Patient Hears
Your MRI shows degenerative disc disease/ disc bulge/ arthritis/ bone spurs/ spondylosis, etc	I will never get better
Your MRI shows wear and tear	My spine is worn out
Your MRI shows a disc tear	I have a severe injury to my spine
You have damage	I have a severe injury to my spine
You have a chronic condition	I will never get better
There's nothing wrong with your back	He/ she thinks it's all in my head
Stop when you feel pain	Activity will harm my back

PCPs: Register for training https://network.primaryspineprovider.com/excellus-pcp-registration

DCs and PTs: Register for training https://pspn.app/excellus-dc-pt-registration

Already registered? Login here: https://pspn.app/login

References

1. Stevans JM, Delitto A, Khoja SS, Patterson CG, Smith CN, Schneider MJ, et al. Risk Factors Associated with Transition from Acute to Chronic Low Back Pain in US Patients Seeking Primary Care. JAMA Netw Open. 2021 Feb 1;4(2): e2037371.
2. Caneiro JP, Bunzli S, O'Sullivan P. Beliefs about the body and pain: the critical role in musculoskeletal pain management. Brazilian Journal of Physical Therapy. 2021; 25(1):17-29.
3. Lin IB, O'Sullivan PB, Coffin JA, Mak DB, Toussaint S, Straker LM. Disabling chronic low back pain as an iatrogenic disorder: a qualitative study in Aboriginal Australians. BMJ open. 2013; 3(4): e002654.
4. Darlow B, Dowell A, Baxter GD, Mathieson F, Perry M, Dean S. The enduring impact of what clinicians say to people with low back pain. The Annals of Family Medicine. 2013; 11(6):527-3

Chlamydia Screening in Women Important to Care

Chlamydia is the most reported bacterial sexually transmitted disease in the United States. It occurs most often among adolescents and young adult females. Untreated chlamydia infections can lead to serious and irreversible complications. This includes pelvic inflammatory disease, infertility and increased risk of becoming infected with HIV.

Approximately 75% of chlamydia infections in women and 95% in men are asymptomatic.[1] Screening for sexually transmitted infection is recommended by the American Academy of Pediatrics, the Centers for Disease Control and Prevention, the U.S. Preventive Services Task Force, the American Academy of Family Physicians, and the American College of Obstetricians and Gynecologists.

Please help us to ensure that women ages 16-24 who are identified as sexually active are tested for chlamydia. The following information may be helpful.

Strategies for Improvement

- In office-based settings, providing confidential care to adolescents is the first step in successful office-based screening. Setting the stage early for caregivers about clinic policy and what to expect at the adolescent health visit is helpful in decreasing anxiety.
- To help address apprehension towards testing, remind the patient that the test is a self-collected urine sample.
- In addition to preventive health visits, clinic staff should include a consideration for chlamydia screening for women 24 years and younger routinely in all visits, including walk-in visits, pregnancy testing, and emergency contraception counseling.
- Offering screening with normalizing language makes it a routine part of clinical services and is an effective way to build rapport with clients.

- The conversation around Chlamydia Screening is not just limited to OB/GYN.

The Family Planning National Training Center provides a complimentary toolkit to help increase chlamydia screening rates through implementation of best practice processes:

- *Best Practice 1:* Include chlamydia screening as a part of routine clinical preventive care.
- *Best Practice 2:* Use normalizing and opt-out language.
- *Best Practice 3:* Use the least invasive, high-quality recommended laboratory technologies.
- *Best Practice 4:* Use diverse payment options to reduce cost as a barrier.
- Sustain and spread improvements.

https://www.fpntc.org/resources/chlamydia-screening-

Helpful Tips for Conducting Optimal Well-Child Visits

Well-child visits are an important aspect of care. Comprehensive well-child care visits with a PCP or OB/GYN practitioner should be conducted for patients ages 3-21 years. Well-child visits must occur with a primary care practitioner or OB/GYN practitioner, but the practitioner does not have to be the practitioner assigned to the child.

Please consider the following strategies when delivering care to our members to ensure that that well-child visit guidelines are met:

- Schedule subsequent well care visit(s) at current visit.
- Tailor family/caregiver education and discussions to the patient's cultural and language preferences.

Regular visits create strong, trustworthy relationships among pediatrician, parent and child. The American Academy of Pediatrics (AAP) recommends well-child visits as a way for pediatricians and parents to serve the needs of children. This team approach helps develop optimal physical, mental and social health of a child.

AAP Schedule of Well-Child Care Visits: AAP Schedule of Well-Child Care Visits - HealthyChildren.org

Transitions of Care Measure Promotes Patient Safety

Transition from the inpatient (hospital) setting back to home often results in poor care coordination, including communication lapses between inpatient and outpatient (a setting other than a hospital) providers; intentional and unintentional medication changes; incomplete diagnostic workups; and inadequate patient, caregiver and provider understanding of diagnoses, medication and follow-up needs.[1]

Through improved coordination of care between health care providers and facilities, the HEDIS ® measure, Transitions of Care (TRC), aims to reduce hospital readmissions and medication errors after inpatient discharge to promote patient safety.

TRC assesses the percentage of inpatient discharges from acute and/or non-acute facilities for Medicare members who are 18 years of age or older, and who had each of the following indicators reported:

- ***Notification of Inpatient Admission*** – Documentation of receipt of notification of inpatient admission on the day of admission through two days after the admission (three total days)
- ***Receipt of Discharge Information*** – Documentation of receipt of discharge information on the day of discharge through two days after the discharge (three total days)
- ***Patient Engagement After Inpatient Discharge*** – Documentation of patient engagement (e.g., office visits, visits to the home, telehealth) provided within 30 days after discharge
- ***Medication Reconciliation Post-Discharge*** – Documentation of medication reconciliation on the date of discharge 30 days after discharge (31 total days)

Transitions of care have emerged as a critical point of vulnerability in the health care system where medical errors and clinical deterioration can occur. It is important to have processes in place to receive electronic notifications from the admitting facility. Documentation for all four sub-measures needs to be present and collected from one record – the record of the primary care physician or ongoing care provider.

Coding for TRC:

- Outpatient Visits
  - CPT: 99201-99205, 99211-99215, 99241-99245, 99341-99345, 99347-99350, 99381-99387, 99391-99397, 99401-99404, 99411, 99412, 99429, 99455, 99456, 99483
  - HCPCS: G0402, G0438, G0439, G0463, T1015
- Telephone Visits
  - CPT: 98966, 98967, 98968, 99441, 99442, 99443
- Online Assessments
  - CPT: 98969, 98970, 97971, 98972, 99421, 99422, 99423, 99444, 99458
  - HCPCS: G2010, G2012, G2061, G2062, G2063
- Medication Reconciliation
  - CPT: 99483, 99496 transition of care management (TCM) services within seven days, 99495 TCM within 14 days
  - CPTII: 1111F

References:

1. Rennke, S., O.K. Nguyen, M.H. Shoeb, Y. Magan, R.M. Wachter and S.R. Ranji. 2013. "Hospital-Initiated Transitional Care as a Patient Safety Strategy: A Systematic Review." *Annals of Internal Medicine* 158(5, Pt. 2), 433–40.

Documentation Specificity for Malignant Neoplasm

Malignant neoplasm may be coded when there is current treatment or evidence of current disease as documented by the evaluator.

- Support for current treatment: Current radiation or chemotherapy treatment; adjuvant medication; discussing treatment options; watchful waiting; refusing treatment
- Support for current malignancy: Inoperable; tumor or mass size/status; pathology results

To assign ICD-10 codes for malignant neoplasm, it is important to understand the following:

- The term "active surveillance" is not conclusive evidence cancer is active or current. Except with prostate cancer unless there is conflicting information that cancer may not still be active
- The term "recurrent" is not conclusive evidence cancer is active or current
- When leukemia and lymphoma are documented as "in remission" it is still considered active and should be coded from categories listed below:
  - Lymphoma: C81 – C88
  - Leukemia: C91 – C95

To code malignant neoplasm properly, the documentation in the medical record should specify:

- Cancer is currently active and being treated
- Adjuvant treatment should clearly specify if the treatment is prophylactic or actively treating the malignancy
- Highest level of specificity. For example, breast cancer – Male/Female; Right/Left; Quadrant
- Document and code any metastasis or active secondary neoplasms
  - Only code primary neoplasm if it is still currently active and being treated

ICD-10 Code	Descriptions
C18-	Colon
C34--	Bronchus and lung
C50---	Breast
C61	Prostate
C64-	Kidney

**Refer to the Official ICD-10-CM code book for a complete list of codes.*

Z85---, Personal history of malignant neoplasm, is used when there is no further treatment, and no evidence of any existing primary malignancy

- Avoid using the term 'history of' to describe a current neoplasm
  - This would also include lymphoma and leukemia

Important Reminders

- All diagnoses submitted on a claim should be supported by the **M**onitoring, **E**valuation, **A**ssessment and/or **T**reatment of the condition in the medical record documentation
- "Unspecified" codes should only be reported when a more specific diagnosis cannot be determined

For more information on how to receive coding and documentation tips specific to your office please contact Risk.Adjustment.Provider.Contact@excellus.com

Coding Corner continued on next page

Helpful HEDIS® Information

Quality Measures both screen for certain types of cancer AND can exclude members with a history of specific types of cancer.

- **Measures that screen for cancer include:**
  - Cervical Cancer Screening
  - Breast Cancer Screening
  - Colorectal Cancer Screening
- **Measures that exclude members with a history of specific types of cancer include:**
  - Colorectal Cancer Screening – members with a history of colorectal cancer can be excluded from the measure.
  - Use of Imaging Studies for low back pain: Members with a history of cancer can be excluded from this measure.
  - Non-recommended cervical cancer screening in adolescent females: members with a history of cervical cancer can be excluded from this measure.
  - Non-recommended PSA-based screening in older men – members with a history of prostate cancer can be excluded from this measure.
  - Antibiotic Utilization for Respiratory Conditions – members with malignant neoplasms can be excluded from the measure.
- Please make sure that if a member has a specific type of cancer that it is properly documented in the chart and coded properly to ensure the member is excluded from the measure.

For more information regarding HEDIS measures, please contact HEDIS.Clinical.Team@excellus.com

The Healthcare Effectiveness Data and Information Set (HEDIS) is a registered trademark of NCQA.

Access and Availability Standards

We follow appointment availability standards established by the New York State Department of Health. These standards, which apply to all lines of business, are used to improve patient access to routine, urgent, preventive and specialty care.

We also follow 24-hour access standards to measure after-hours access.

Learn more by viewing our Access and Availability tip sheet.

Web Self-Service Tools

We know how busy your work day can be. That's why we remind you of the time-saving tools and information available on our website. They are quick, convenient and available 24/7!

We require the use of our web self-service tools to check member eligibility and benefits. Keep your web account active by logging in at least every 30 days.

Medical Policy Updates

Excellus BlueCross BlueShield works to ensure that the development of corporate medical policies occurs through an open, collaborative process. We encourage participating providers to become actively involved in medical policy development. Each month, draft policies are available on our website for review and comment. To access the draft policies, click here. Providers may now attach supporting documentation related to their comments.

The following new and updated medical policies have been reviewed and were approved in **June 2023** by the Corporate Medical Policy Committee, including practitioner representatives from all our regions. A complete library of our medical policies can be found on our website.

Current Policies – Significant Updates

(#1.01.17) Pneumatic Compression Devices/Lymphedema Pump//New Policy Title: Powered Compression Devices/ Lymphedema Pump is a sleeve type device that mobilizes arm or leg edema through the use of pressure. The sleeve is alternatively inflated and deflated according to a controlled time cycle. Specific conditions for the use of non-segmental and segmental compression devices are outlined in the medical policy. *With this year's update, chest/trunk and neck/ head applications for lymphedema and a non-pneumatic compression pump or non-pneumatic sequential compression garment for any indication (e.g., Koya Dayspring) have been added to the policy as investigational.*

(#1.01.25) Orthotics are used to support, restore or protect body function. Coverage for orthotics is contract dependent. Orthotic devices are considered medically necessary when prescribed by a qualified provider for therapeutic support, protection or restoration of an impaired body part or when prescribed to improve the functioning of an impaired body part. Requests for duplicate orthotics when utilized for the same body part/ function are considered not medically necessary. *With this policy update, electronic/electromagnetic activated stance control KAFO devices, myoelectric and/or power enhanced upper extremity orthotic devices, and powered exoskeleton orthosis have been added to the policy as investigational.*

(#1.01.42) Home Automatic External Defibrillator (AEDs) and Wearable Defibrillator Vests (WCDs) is considered a medically appropriate option for a patient who meets the criteria for an implantable cardiac defibrillator (ICD) but who is not a candidate for implantation of the device due to contraindications. Approval of a home AED is also contingent on having a caregiver who is capable (trained) and available to use a home AED. Wearable Defibrillator Vests (WCDs) will be considered a medically appropriate option for those who meet one of the following: • ICD explanation for infection or lead displacement; or • Contraindications such as, systemic infection, that temporarily delay ICD implantation; or • Patients on the waiting list for heart transplantation. All other uses for a home AED or wearable defibrillator vest are considered investigational. *With this off-cycle update, new criteria have been added for wearable vests that are used as a bridge in consideration to ICD implantation for newly diagnosed dilated cardiomyopathy or post-myocardial infarction. New guidelines for provider documentation have also been added to the policy, with re-evaluation request requirements changing from 90 days to 60 days.*

(#2.01.10) Allergy Testing is divided into vivo and in vitro testing. In vivo tests include skin testing and in vitro tests include various techniques to test the blood for the presence of specific IgE antibodies to a particular antigen. Intracutaneous/intradermal tests (serial end point testing) are considered medically appropriate. Serial endpoint testing (SET), or intradermal dilutional testing (IDT) is a form of intradermal skin testing that uses increasing doses of antigen to determine the concentration at which the reaction changes from negative to positive (the "endpoint"). These tests have been used for diagnosing allergic disorders and to guide the initiation of immunotherapy by using the endpoint dilution as the starting antigen dose. The policy includes an extensive list of tests that are considered medically appropriate in the diagnosis of the allergic patient. The following allergy tests have not been medically proven to be effective and are considered investigational:

- Allergen-specific IgG; quantitative or semiquantitative
- Leukocyte histamine release (LHR) test
- Ophthalmic mucous membrane test
- Direct nasal mucous membrane test
- Cytotoxicity, Provocative testing (e.g., Rinkel test), Rebuck skin window test; and
- The peanut allergen specific IgE and quantitative assessment

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Medical Policy Updates, continued from page 12

With this policy update, a policy statement was added to address coverage of treatment programs that have not been medically proven to be effective and their associated allergy and laboratory testing.

(#2.01.11) Allergen Immunotherapy which includes desensitization or hyposensitization, involves regular injections of offending allergens in the form of antigen extract(s), over a period of time, with the goal of reducing symptoms. Allergen immunotherapy is medically appropriate in the following situations:

- for patients with demonstrated hypersensitivity that cannot be adequately managed by medications or avoidance
- when there is a desire to avoid long-term pharmacotherapy; or
- for patients with coexisting allergic rhinitis and asthma where symptoms of asthma occur after natural exposure to aeroallergens and there is demonstrable evidence of clinically relevant specific IgE
    - Specific methods of immunotherapy (e.g., DNA immunization, Intranasal therapy, Provocative-neutralization therapy, Non-FDA approved sublingual and oral therapies utilizing antigen drops/tablets, or other antigens under or on the tongue) which are considered investigational are outlined in the medical policy. Please note: Xolair or Palforzia are not addressed in this policy and are considered under Pharmacy Management Drug Policies.

With this policy update, a guideline was added to address coverage of treatment programs that have not been medically proven to be effective and their associated allergy and laboratory testing.

(#3.01.11) Applied Behavioral Analysis for the Treatment of Autism Spectrum Disorders and/or Rett Syndrome// New Policy Title: Applied Behavioral Analysis. This policy highlights Applied Behavioral Analysis (ABA) as a scientifically validated approach to understanding behavior and how it is affected by the environment and its treatment efficacy in functional areas for children. Effective 7/1/2023, per New York state mandate, the Health Plan must provide coverage for ABA services for members of any age, and for any diagnoses within the scope of practice of an ABA provider. The policy has been updated in accordance with the New York state mandate.

(#4.01.05) Assisted Reproductive Technologies (ART) policy is designed to outline NYS mandated coverage and contract coverage language for invitro fertilization (IVF) services. *With this current update, the policy is being revised to add statements addressing permanent birth control procedures as well as reversal of sterilization procedures, and clarifies ART related to treatment of patients with iatrogenic infertility and gender dysphoria.*

(#6.01.41) Positron Emission Tomography (PET) Cardiac Applications is considered medically necessary for the following: 1) To assess myocardial perfusion and thus diagnose coronary artery disease in patients when SPECT is inconclusive; 2) Use in place of SPECT in patients who are severely obese (body Mass Index greater than 40 kg/m2), have chest wall deformities, large breasts, breast implants or incapable of exercise due to physical (musculoskeletal or neurological) inability to achieve target heart rate; 3) To assess myocardial viability in patients with severe left ventricular dysfunction as a technique to determine candidacy for revascularization procedure; 4) Clinical suspicion of cardiac sarcoid in patients unable to undergo MRI scanning (e.g., patients with pacemakers, automatic implanted cardioverter-defibrillators [AICDs] or other metal implants); or 5) For the routine use in post heart transplant assessment to determine presence of coronary artery disease. Cardiac PET is also medically indicated for use in the assessment of suspected prosthetic heart valve endocarditis when echocardiography and/ or transesophageal echocardiography are equivocal or nondiagnostic and suspicion remains high and specific policy criteria are met. FDG PET is considered medically appropriate for use in the assessment of suspected left ventricular assist device (LVAD) infection if other studies and examination remain inconclusive. 3D rendering should not be billed in conjunction with PET. *With this policy update, positive coverage criteria for the absolute quantification of myocardial blood flow (AQMBF) were added to align with the eviCore Cardiac Imaging Guidelines V2.0.2023. The policy will have an effective date of 07/01/23.*

(#7.02.06) Heart and Heart-Lung Transplants are intended to prolong survival and improve function in patients with end-stage cardiopulmonary disease that has been unresponsive to any other therapies. Coverage is provided for these procedures when performed on selected patients who meet specific clinical criteria, as outlined in the medical policy. *With this policy update, guidelines regarding reevaluation criteria for heart transplant recipients have been added to the policy.*

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Medical Policy Updates, continued from page 13

Current Policies – Minor Updates

- **(#2.01.09)** Biofeedback
- **(#2.02.54)** Next Generation Sequencing for Measurable Residual Disease Assessment
- **(#7.01.100)** Ablation/Denervation Techniques for Knee Pain
- **(#7.01.16)** Automated Percutaneous Discectomy and Image-Guided, Minimally Invasive Decompression
- **(#7.01.21)** Dental and Oral Care Under Medical Plans
- **(#7.01.32)** Radiofrequency Tumor Ablation
- **(#7.01.35)** Bioengineered Tissue Products for Wound Treatment and Surgical Interventions
- **(#7.01.65)** Artificial Heart
- **(#7.01.83)** Minimally Invasive Techniques for Lumbar Interbody Fusion (A-LIF, X-LIF)
- **(#7.01.95)** Shoulder Arthroplasty (Total, Partial & Reverse) Total shoulder replacement
- **(#8.01.13)** Speech Pathology/Therapy
- **(#13.01.01)** Dental Implant
- **(#13.01.02)** Dental Crowns
- **(#13.01.03)** Indirect Dental Inlays and Onlays
- **(#13.01.04)** Periodontal Scaling and Root Planing
- **(#11.01.13)** Out-of-Area Services

Policies are archived either because the criteria for evaluating the procedure/technology have not changed or because there has been little utilization or few requests. Archived policies are available on our website.

Previously Archived

- **(#1.01.41)** Foot Orthotics
- **(#1.01.44)** Home Prothrombin Time Monitor
- **#1.01.50)** Lumbar Traction: Vertebral Axial Decompression and Home Lumbar Traction Devices
- **(#1.01.19)** Pelvic Floor Electrical Stimulation as a Treatment of Urinary Incontinence
- **(#13.01.05)** Periodontal Maintenance

Note: When policy criteria change, Excellus BCBS' requirements related to medical records may also change. Medical record requirements are available here. Failure to submit required records with the claim submission could delay claim processing and payment.

Although medical policies are effective, services may not be reviewed until our systems are updated.

Questions regarding medical policies should be directed to your Provider Relations representative.