BlueCross BlueShield of Texas

A resource: Services for which predeterminations can be requested: This is not an all inclusive list. Refer to the Medical Policy link or contact our Customer Advocates (800-451-0287) for additional assistance.

Abdominoplasty –

May be considered reconstructive when there is supporting medical documentation:

- History and Physical and/or historical medical record documentation and may include:
- Letter of Medical Necessity - Include information on size and status of the panniculus (**photos are helpful**) and the skin condition related to the panniculus
- Office records or clinical documentation of prior tried and failed medical treatment:
- Medical therapy that includes systemic antibiotics, topical anti-infectives, anti-inflammatory medication and appropriate skin hygiene.

Medical Policy Reference: **SUR716.001**

Breast Reduction – Reduction Mammaplasty for Systematic Breast Hypertrophy or Hypermastia – No Photos Needed

Reduction Mammaplasty for symptomatic breast hypertrophy or hypermastia **may be considered allowable for coverage** when there is supporting medical documentation and **ALL** of the medical criteria are met:

- ❖ Records documenting the patient's significant symptoms that interfere with activities of daily living, including but not limited to, the following –
    - Pain in the upper back, neck, and shoulders which is long-standing duration and increasing in intensity and is not related to other musculoskeletal causes (e.g., poor posture, acute strains, post traumatic conditions, poor lifting techniques, or other evidence of over use), AND/OR
    - Persistent, clinical, non-seasonal sub mammary intertrigo, which is refractory and unresponsive to comprehensive local hygiene and topical anti-infective therapy, AND/OR
    - Ulnar nerve paresthesia or compression, which results in pain and/or numbness in the arms and/or hands.
- ❖ The patient's physical exam that documents the following –
    - Significant shoulder grooving or ulceration of the skin of the shoulder, AND
    - Obvious breast hypertrophy, AND
    - Physical exam consistent with symptoms precipitating request for reduction Mammaplasty.

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❖ Documentation of tried and failed comprehensive conservative measures including –

- A minimum of six (6) weeks of physical therapy for back, neck or shoulder pain including a maintenance home exercise program, AND
- Appropriate support bra with weight distributing straps, AND
- Anti-inflammatory agents unless medically contraindicated, AND
- Symptomatic measures, including application of heat and cold, AND
- Appropriate local hygiene and topical pharmacologic treatments for intertrigo.

❖ Documentation of patient's body surface area (BSA), based on the Schnur Sliding Scale (SSS), in which the patient's breast weight (per breast) is estimated at greater than the 22nd percentile line (Refer to SSS and calculation of BSA at the end of the Rationale Section) consisting of breast tissue, not fatty tissue to be removed.

Medical Policy Reference: **SUR716.012**

Blepharoplasty – Eye Lid Surgery – Photos Needed

Upper eyelid Blepharoplasty **may be considered medically necessary** in a small subset of patients when there is the supporting medical documentation:

- Medical record documentation of all eye care for the 24 months preceding the request for services
- Full face frontal photo documentation, face plane parallel to film plane and visual axis perpendicular to film plane and centered in the camera lens
- Full face lateral photo documentation, each side, and visual axis parallel to film plane and perpendicular with the horizon.

Lower eyelid Blepharoplasty, brow lift and brow ptosis repair are considered cosmetic.

Medical Policy Reference: **SUR716.004**

Botox Injection –

- Medical record documentation of patient condition including historical treatment information
- Usage indication

Medical policy reference: RX501.019

Breast MRI – Magnetic Resonance Imaging (MRI) of the Breast (BMRI)

- Documentation of all family members with history suggestive of hereditary breast cancer (list all first-and/or second-degree relatives with breast, ovarian, or colon cancer; OR
- Documentation of BRCA-1 or BRCA-2 mutation do; OR
- Documentation of the current health status for those who have known breast cancer.

Medical policy reference: RAD603.009

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Dental Services/ Orthognathic “Jaw”Surgery – No X-rays Needed

- Documentation of the history of the patient’s condition and physical examination
- Planned procedure codes
- Date of accident – If service is a result of accidental injury and contract covers dental services for accidental injury.
- Digital tracings/computer generated facial measurements if orthognathic jaw surgery

Medical Policy Reference: **TMJ - SUR705.010**
Orthognathic - SUR706.009

DRUGS:

Lupron –

- History of the patient and patient condition
- Documentation of previous medical treatments, treatment alternatives, previous surgery and results

Medical Policy reference: RX501.041

Remicade –

- History and physical
- Office or clinic notes with documentation of 3 months of tried and failed therapy

Medical Policy reference: RX501.051

Tysabri –

- History and physical
- Documentation of prior treatment response
- Recent MRI report
- Documentation of enrollment and criteria met in the TOUCH prescribing program

Medical Policy Reference: RX501.059

Growth Hormone –

- Documented initial evaluation and diagnosis
- Letter of Medical Necessity that includes detailed reason for GH
- Documentation of two (2) Provocative test results

Medical Policy Reference: **Submit Growth Hormone Fax/Mail Form if available (RX501.040 Form)**

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Intravenous Immunoglobin Therapy (IVIG) –

A form is available for optional use to assist in requesting review for consideration of coverage of Immunoglobulin Therapy. The form is available on the Provider / Forms page of the applicable Blue Cross Blue Shield web site, i.e., <www.BCBSIL.com>, <www.BCBSNM.com>, <www.BCBSOK.com>, or <www.BCBSTX.com>.
Please view the BCBS medical policy for a complete listing of each condition and related criteria.

Medical Policy Reference: RX504.003

Gastric Bypass –

- History and Physical with co-morbidities, height and weight
- Letter of Medical Necessity including documented **5 year history** of obesity
- Office or clinic notes of **6 months** of non-surgical weight management efforts supervised by an M.D., D.O., or Nurse Practitioner
- Psychiatric evaluation
- *Documentation of the non-surgical weight management program should consist of:*
- Nutritional or Medical Nutritional – type of very low calorie diet they are on
- Therapy
- Behavior modification or behavioral health interventions
- Supervised increase in activity
- Pharmacologic therapy (unless contraindicated)
- Maintenance support to continue to encourage nutrition choices to reduce health risk factors and maintain a healthy lifestyle.

Medical Policy Reference: **SUR716.003**

Gynecomastia –

Is excluded, always cosmetic unless eligible by individual health care plan – check with your provider representative for benefits
DO NOT SUBMIT ANY RECORDS

Medical Policy Reference: **SUR716.017**

Intensity Modulated Radiation Therapy (IMRT) –

- A written prescription that defines the goals and requirements of the treatment plan, including the specific dose constraints for the target(s) and nearby critical structures; AND
- A statement from the treating physician that documents the medical necessity for IMRT instead of conventional or 3DCRT treatment planning and delivery, including the need to protect at least three vital structures.

Medical Policy Reference: **RAD601.067**

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Nasal Surgery - (Rhinoplasty) **– No Photos Needed**

- Documented history of nasal deformity, functional impairment, and past trauma
- Clinical records of all conservative therapies
- Results of imaging or diagnostic studies

Medical Policy Reference: **SUR706.001**

PET Scan – Follow AIM guideline if applicable

Positron emission tomography (PET) or positron emission tomography/computed tomography (PET/CT) **may be considered medically necessary** for known or suspected malignancy **(except screening, surveillance, and ovarian, pancreatic, small cell lung or soft tissue sarcoma)** when the:

- findings on other imaging modalities are inconclusive and/or discordant; AND
- results of PET or PET/CT will be the deciding factor in determining medical and/or surgical intervention.

NOTE: Once PET or PET/CT has been approved, subsequent use of PET or PET/CT for treatment monitoring or disease staging **will be considered medically necessary** without requirement for retesting with traditional imaging modalities, providing it otherwise meets medical necessity criteria.

Medical Policy Reference: RAD605.001

Prosthesis - Lower Limb/Microprocessor Knee –

- Physician prescription for the prosthesis as a result of a recent physician evaluation.
- Functional level of recipient of the prosthetic
- Status of current prosthesis, if applicable
- FOR MICROPROCESSOR KNEE – ambulatory status and PAVET evaluation and score

Medical Policy reference: DME104.012

Varicose Veins Management – New policy effective 5/15/08

VEIN HIGH LIGATION, DIVISION AND STRIPPING, ENDOLUMINAL RADIOFREQUENCY ABLATION AND/OR ENDOLUMINAL LASER ABLATION

- History and Physical
- Patient's subjective symptoms or objective findings
- Documentation of **4 MONTHS** of tried and failed alternative non surgical treatments
- Ultrasound report

Medical Policy reference: SUR707.016

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SCLEROTHERAPY, STAB AVULSION, HOOK PHLEBECTOMY, TRANSILLUMINATED POWERED PHLEBECTOMY: documentation of –

- Subjective symptoms and Objective findings
- Venous insufficiency / incompetence
- **Four months** of tried and failed alternative non surgical treatments

Medical Policy reference: SUR707.016

Wheelchairs/Scooter –

NOTE: The Health Plan will REQUIRE an inspection of the home to determine that the home environment and design allows for and supports the unhindered operation of the wheelchair, including but not limited to manual (only customized manual), motorized or power wheelchair or vehicle, and to evaluate the member's ability to safely operate the equipment.

In addition, the provider MUST FILL OUT AND SUBMIT the "Wheelchair Medical Necessity and Home Evaluation Verification" form, which can be found on the Provider / Forms page of the applicable plan web site, i.e., <www.BCBSIL.com>, <www.BCBSNM.com>, <www.BCBSOK.com>, or <www.BCBSTX.com>.

Medical Policy reference: DME101.010

Wireless Capsule Endoscopy (WCE) –

Documentation of obscure small bowel bleeding that:

- has been undetected by standard diagnostic methods (i. e., colonoscopy and upper gastric endoscopy), AND
- is evidenced by recurrent or persistent iron-deficiency anemia that is not attributable to other etiology (such as malabsorption, dietary insufficiency, etc.), positive fecal occult blood test, or visible bleeding; or
- documented of other small bowel pathology that has been undetected by standard diagnostic methods (i.e., colonoscopy and upper gastric endoscopy).

Medical Policy Reference: **RAD601.042**