BLUE KC

Authorization Required for Provider Appeals on Behalf of the Member

Did you know that Blue Cross and Blue Shield of Kansas City's (Blue KC) appeal process for participating providers has changed? At this time, the Blue KC member contract requires members to provide written permission for any provider to submit an appeal on their behalf. As a result, effective, July 1, 2017, if a provider wishes to appeal on a member's behalf, based on an adverse benefit determination, the member must execute written permission allowing the provider to do so by completing a Blue KC Member Authorization form or completing an authorization form your office is using today.

The authorization form must be signed and dated by the member (or an authorized representative) in order for a provider to appeal on their behalf. Once the authorization is signed and dated, the provider will need to fax or mail the form and appeal letter to Blue Cross and Blue Shield of Kansas City – Appeals.

Please note: Federal law says that Psychotherapy notes cannot be released using the same authorization form as other records. In order to release Psychotherapy notes, you need to fill out a separate authorization form.

For more information, please visit the Blue KC Provider Portal at Providers.BlueKC.com, or call the Provider Hotline at (800) 456-3759 or (816) 395-3929.

Could You Identify a BDTC Member ID Card?

As you may know, effective January 1, 2016, the Blue KC Medical Home Program, also known as PCMH, became a part of the Blue Cross and Blue Shield Association's (BCBSA) initiative to brand all value-based programs across all Blues plans with one nationally-consistent program name, called Blue Distinction Total Care (BDTC). As a result, Blue Cross and Blue Shield plans nationwide now include hosted membership (accounts sold in other markets) in their local medical home/Accountable Care Organizations (ACO) programs.

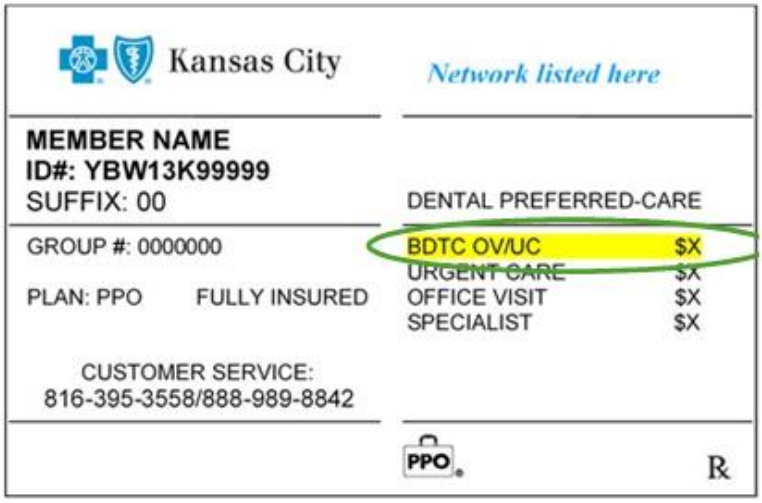
This BDTC designation is easily found on the *Blue KC Doctor & Hospital*

Provider Finder on BlueKC.com when searching for providers. Many materials, such as member ID cards, still reference "BDTC" as opposed to "medical home" and "PCMH."

When Blue KC members arrive at your office or facility, please continue to ask to see their current member ID cards at each visit. Doing so will help you:

- More clearly identify copays
- Process payments more quickly
- Reduce member issues
- Reduce post visit reconciliation

The below is an overview of the important details specific to the BDTC member ID card:



- **BDTC** - Blue Distinction Total Care (previously PCMH)
- **OV** - Office Visit
- **UC** - Urgent Care
- **BDTC OV** - indicates the cost to the member for their office visit (OV) only; **Important: Do not charge the OFFICE VISIT amount as that indicates the member cost-share for non-BDTC visits**
- **BDTC OV/UC** - indicates the cost to the member for their office visit (OV) and urgent care (UC) visit

Remember: ID cards are for identification purposes only; they do not guarantee eligibility or payment of the claim. You should always verify patient eligibility via either the online Provider Portal by visiting Providers.BlueKC.com, or by calling the Provider Hotline at (800) 456-3759 or (816) 395-3929.

Update to Ownership Change Notice Process

In order to streamline contract and system updates associated with changes in ownership, a new e-form is available to the following provider types: Ambulatory Surgery Center, Home Health, Hospice, Skilled Nursing Facility, and Durable Medical Equipment. As a reminder, where applicable, Blue KC contracts require advance written notice of changes such as facility ownership. This form will help ensure the changes are accepted, and processed accurately and timely. This document will be available on the provider portal soon, in the *Forms* section.

For more information, please visit Providers.BlueKC.com or contact your Blue KC provider representative.

HEALTHCARE

2018 Shingles Vaccine Update

A new shingles vaccine, Shingrix, was approved by the U.S. Food and Drug Administration (FDA) on October 20, 2017. The U.S. Centers for Disease Control and Prevention (CDC) recommends Shingrix for healthy adults 50 years and older. As you may know, Zostavax is the shingles vaccine that has been in use and licensed by the FDA since 2006. For all plans that are required to meet the Affordable Care Act (ACA) preventive care requirements, Shingrix is covered at no cost to the member at age 50 and Zostavax at age 60 when received from an in-network provider.

The Zostavax vaccine is billed using CPT code 90736 and the Shingrix vaccine is billed using CPT code 90750. Blue KC provides reimbursement based on the member's benefits. These vaccines may not be covered on plans currently permitted to exclude coverage for preventive care services. The claims payment system has been reviewed to make sure the age guidelines are in place.

If you have any questions related to this communication, please contact your provider relations representative or the Blue KC provider hotline at (816) 395-3929.

Policy Updates

New policies effective January 1, 2018

Biofeedback as a Treatment of Chronic Pain
Policy Number: 2.01.30

- Biofeedback as a treatment of chronic pain, including but not limited to low back pain, is **investigational**.

Note: This is a type of biofeedback that may be excluded in some contracts.

Circulating Tumor DNA for Management of Non-Small-Cell Lung Cancer (Liquid Biopsy)
Policy Number: 2.04.143

***EGFR* TESTING**

- Except as noted below, analysis of 2 types of somatic sensitizing variants within the epidermal growth factor receptor (*EGFR*) gene — small deletions in exon 19 and a point mutation variant in exon 21 (L858R)— using the cobas® EGFR Mutation Test v2 with plasma

specimens to detect circulating tumor DNA (ctDNA) may be considered **medically necessary** as an alternative to tissue biopsy to predict treatment response to an EGFR tyrosine kinase inhibitor (TKI) therapy in patients with non-small-cell lung cancer (NSCLC). The cobas® test is a companion diagnostic for erlotinib (Tarceva®; OSI Pharmaceuticals, Melville NY).

- Analysis of other *EGFR* sensitizing variants within exons 18 to 24 using ctDNA for applications related to NSCLC, is considered **investigational.**
- Analysis of *EGFR* T790M resistance variant for targeted therapy with osimertinib using ctDNA or for other applications related to NSCLC, is considered **investigational.**
- Analysis of 2 types of somatic mutations variants within the *EGFR* gene—small deletions in exon 19 and a point mutation variant in exon 21 (L858R)—using ctDNA is considered **investigational** for patients with advanced NSCLC of squamous cell type.

Note: This is a type of genetic testing that may be excluded in some contracts. Verify benefits prior to review for Medical Necessity.

Temporomandibular Joint Dysfunction
Policy Number: 2.01.21

- Note: Medical treatment for temporomandibular joint (TMJ) dysfunction may be a benefit exclusion. Please review benefit language.
- Policy statements:
    - The following *diagnostic procedures* may be considered **medically necessary** in the diagnosis of temporomandibular joint (TMJ) dysfunction:
        - Diagnostic x-ray, tomograms, and arthrograms;
        - Computed tomography (CT) scan or magnetic resonance imaging (MRI) (in general, CT scans and MRIs are reserved for presurgical evaluations);
        - Cephalograms (x-rays of jaws and skull);
        - Pantograms (x-rays of maxilla and mandible).

(Cephalograms and pantograms should be reviewed on an individual basis.)

The following *nonsurgical treatments* may be considered **medically necessary** in the treatment of TMJ dysfunction:

- Intraoral removable prosthetic devices/appliances (encompassing fabrication, insertion, adjustment);

- Pharmacologic treatment (e.g., anti-inflammatory, muscle relaxing, analgesic medications).

The following *surgical treatments* may be considered **medically necessary** in the treatment of TMJ dysfunction:

- Arthrocentesis;
- Manipulation for reduction of fracture or dislocation of the TMJ;
- Arthroscopic surgery in patients with objectively demonstrated (by physical examination or imaging) internal derangements (displaced discs) or degenerative joint disease who have failed conservative treatment;
- Open surgical procedures (when TMJD is the result of congenital anomalies, trauma, or disease in patients who have failed conservative treatment) including, but not limited to, arthroplasties; condylectomies; meniscus or disc plication, and disc removal.

The following *diagnostic procedures* are considered **investigational** in the diagnosis of TMJ dysfunction:

- Electromyography (EMG), including surface EMG;
- Kinesiography;
- Thermography;
- Neuromuscular junction testing;
- Somatosensory testing;
- Transcranial or lateral skull x-rays; intraoral tracing or gnathic arch tracing (intended to demonstrate deviations in the positioning of the jaws that are associated with TMJD);
- Muscle testing;
- Standard dental radiographic procedures;
- Range-of-motion measurements;
- Computerized mandibular scan (measures and records muscle activity related to movement and positioning of the mandible and is intended to detect deviations in occlusion and muscle spasms related to TMJD);
- Ultrasound imaging/sonogram;
- Arthroscopy of the temporomandibular joint (TMJ) for purely diagnostic purposes;
- Joint vibration analysis.

The following *nonsurgical treatments* are considered **investigational** in the treatment of TMJ dysfunction:

- Electrogalvanic stimulation;
- Iontophoresis;
- Biofeedback;

- Ultrasound;
- Devices promoted to maintain joint range of motion and to develop muscles involved in jaw function;
- Orthodontic services;
- Dental restorations/prostheses;
- Transcutaneous electrical nerve stimulation;
- Percutaneous electrical nerve stimulation;
- Acupuncture;
- Hyaluronic acid

Changes to existing policies effective January 1, 2018

Wearable Cardioverter-Defibrillators - Administrative Update
Policy Number: 2.02.15

- Added Medically Necessary indications:
  - Use of wearable cardioverter-defibrillators for the prevention of sudden cardiac death is considered medically necessary in the following situations.
    - A previously implanted defibrillator now requires explanation; or
    - Either documented prior myocardial infarction or dilated cardiomyopathy and a measured LVEF less than or equal to 35%; or
    - Familial or inherited conditions with a high risk of life-threatening VT such as long QT syndrome or hypertrophic cardiomyopathy.
- Removed from Investigational statement:
  - Patients with newly diagnosed non-ischemic cardiomyopathy

Artificial Pancreas Device Systems
Policy Number: 1.01.30

- Added Investigational Statement:
  - Use of hybrid closed loop insulin delivery system as an artificial pancreas device system is considered **investigational.**

Cryosurgical Ablation of Miscellaneous Solid Tumors Other than Liver, Prostate, or Dermatologic Tumors - Interim Update
Policy Number: 7.01.92

- Added new Medically Necessary Statement:
  - Cryosurgical ablation may be considered medically necessary to treat lung cancer when either of the following criteria is met:
    - The patient has early-stage non-small cell lung cancer and is a poor surgical candidate; or
    - The patient requires palliation for a central airway obstructing lesion.

Genetic Testing for Hereditary Breast/Ovarian Cancer Syndrome (*BRCA1*/*BRCA2*)
Policy Number: 2.04.02

- Updated first medically necessary statement title:
  - Patients with Cancer or With Personal History of Cancer
- Updated medically necessary indications for Patients with Cancer or With Personal History of Cancer :
  - Added "pancreatic cancer or prostate cancer" indication to Personal history of breast cancer and Diagnosed age ≤50 years

- Added to medically necessary criteria for Patients with Cancer or With Personal History of Cancer:
    - Personal history of pancreatic cancer or prostate cancer[b] at any age AND 2 or more 1st-, 2nd-, or 3rd-degree relatives[a] with breast, pancreatic or prostate cancer[b] at any age.
    - For pancreatic cancer, if Ashkenazi Jewish ancestry (no additional affected relative is needed).
- Reworded familial assessment criteria for medically necessary statement Patients Without Cancer or Without History of Cancer with no change to intent.

Changes to existing policies effective February 1, 2018

Adoptive Immunotherapy – Interim Update
Policy Number: 8.01.01
Recommendations:

- Policy changed from Investigational to Medically Necessary.
- Added Medically Necessary statements:
  - Tisagenlecleucel intravenous infusion is considered **medically necessary** for relapsed[a] or refractory[b] patients if they meet all of the following criteria:
    - Confirmed diagnosis of CD19-positive B-cell acute lymphoblastic leukemia with morphologic bone marrow tumor involvement (≥5% lymphoblasts)
    - Are up to 25 years old at the time of infusion
    - Have not received prior treatment with tisagenlecleucel or any other gene therapy or are being considered for treatment with any other gene therapy
    - Have adequate organ function with no significant deterioration in organ function expected within 4 weeks after apheresis
  - Do not have any of the following:
    - Burkitt lymphoma
    - Active hepatitis B, C, or any uncontrolled infection
    - Grade 2 to 4 graft-versus-host disease
    - Concomitant genetic syndrome with the exception of Down syndrome
    - Received allogeneic cellular therapy, such as donor lymphocyte infusion, within 6 weeks prior to tisagenlecleucel infusion
    - Patient has active central nervous system 2 or 3 acute lymphoblastic leukemia (i.e., white blood cell count ≥5 cells/μL in cerebrospinal fluid with presence of lymphoblasts).

[a] Relapsed disease describes the reappearance of leukemia cells in the bone marrow or peripheral blood after the attainment of a complete remission with chemotherapy and/or allogeneic cell transplant.
[b] Refractory (resistant) disease is defined as those patients who fail to obtain complete response with induction therapy, i.e., failure to eradicate all detectable leukemia cells (<5% blasts) from the bone marrow and blood with subsequent restoration of normal hematopoiesis (>25% marrow cellularity and normal peripheral blood counts).

- Axicabtagene ciloleucel intravenous infusion is considered **medically necessary** for relapsed or refractory[a] patients if they meet all of the following criteria:
  - Are adults (age ≥18) at the time of infusion

    - Histologically confirmed diagnosis of diffuse large B-cell lymphoma, not otherwise specified; or primary mediastinal large B-cell lymphoma or high-grade B-cell lymphoma or diffuse large B-cell lymphoma arising from follicular lymphoma.
    - Received adequate prior therapy including all of the following
        - Anti-CD20 monoclonal antibody for CD20-positive tumor
        - Anthracycline-containing chemotherapy regimen
        - For subjects with transformed follicular lymphoma, prior chemotherapy for follicular lymphoma and subsequently have chemorefractory disease after transformation to diffuse large B-cell lymphoma
- Documentation of all of the following:
    - Absolute neutrophil count ≥1000/μL
    - Absolute lymphocyte count >100/μL
    - Platelet count ≥75,000/μL
- Have adequate organ function with no significant deterioration in organ function expected within 4 weeks after apheresis
- Have not received prior treatment with axicabtagene ciloleucel or any other gene therapy or are being considered for treatment with any other gene therapy.

[a] Relapsed or refractory disease, defined as progression after 2 or more lines of systemic therapy (which may or may not include therapy supported by autologous cell transplant).

- Removed Investigational Statement:
    - Adoptive immunotherapy, using adoptive cellular therapy for the administration of cytotoxic T lymphocytes, cytokine-induced killer cells, tumor-infiltrating lymphocytes, antigen-loaded autologous dendritic cells, or genetically engineered T cells is considered **investigational**.

Diagnosis and Treatment of Sacroiliac Joint Pain – Interim Update
Policy Number: 6.01.23

- Added new Medically Necessary Statement:
    - Minimally invasive fusion/stabilization of the sacroiliac joint using a titanium triangular implant may be considered medically necessary when ALL of the following criteria have been met:
        - Pain is at least 5 on a 0 to 10 rating scale that impacts quality of life or limits activities of daily living; AND
        - There is an absence of generalized pain behavior (e.g., somatoform disorder) or generalized pain disorders (e.g., fibromyalgia); AND

        - Patients have undergone and failed a minimum 6 months of intensive nonoperative treatment that must include medication optimization, activity modification, bracing, and active therapeutic exercise targeted at the lumbar spine, pelvis, sacroiliac joint, and hip, including a home exercise program; AND
        - Pain is caudal to the lumbar spine (L5 vertebra), localized over the posterior sacroiliac joint, and consistent with sacroiliac joint pain; AND
        - A thorough physical examination demonstrates localized tenderness with palpation over the sacral sulcus (Fortin's point) in the absence of tenderness of similar severity elsewhere; AND
        - There is a positive response to a cluster of 3 provocative tests (e.g., thigh thrust test, compression test, Gaenslen sign, distraction test, Patrick test, posterior provocation test); AND
    - Diagnostic imaging studies include ALL of the following:
        - Imaging (plain radiographs and computed tomography or magnetic resonance imaging) of the sacroiliac joint excludes the presence of destructive lesions (e.g., tumor, infection) or inflammatory arthropathy of the sacroiliac joint; AND
        - Imaging of the pelvis (anteroposterior plain radiograph) rules out concomitant hip pathology; AND
        - Imaging of the lumbar spine (computed tomography or magnetic resonance imaging) is performed to rule out neural compression or other degenerative condition that can be causing low back or buttock pain; AND
        - Imaging of the sacroiliac joint indicates evidence of injury and/or degeneration; AND
    - There is at least a 75% reduction in pain for the expected duration of the anesthetic used following an image-guided, contrast-enhanced intra-articular sacroiliac joint injection on 2 separate occasions; AND
    - A trial of a therapeutic sacroiliac joint injection (i.e., corticosteroid injection) has been performed on at least once.

Multimarker Serum Testing Related to Ovarian Cancer – Interim Update
Policy Number: 2.04.62

- Investigational statement updated to include addition of the Overa test.

Prostatic Urethral Lift – Interim Update
Policy Number: 7.01.151

- Policy intent changed to Medically Necessary.
- Added Medically Necessary indications:
    - Use of prostatic urethral lift in individuals with moderate-to-severe lower urinary tract obstruction due to benign prostatic hyperplasia may be considered medically necessary when all of the following criteria are met:
        - Patient is not an appropriate candidate for a surgical procedure using general anesthesia, such as transurethral resection of the prostate, due to a chronic medical condition including but not limited to cardiopulmonary disease or chronic anticoagulation therapy.
        - Patient has persistent or progressive lower urinary tract symptoms or is unable to tolerate medical therapy (α1-adrenergic antagonists maximally titrated, 5α-reductase inhibitors, or combination medication therapy maximally titrated) over a trial period of no less than 6 months.
        - Prostate gland volume is ≤80 mL.
        - Prostate anatomy demonstrates normal bladder neck without an obstructive or protruding median lobe.
        - Patient does not have urinary retention, urinary tract infection, or recent prostatitis (within past year).
        - Patient does not have prostate-specific antigen level ≥3 ng/mL, or has had appropriate testing to exclude diagnosis of prostate cancer.
        - Patient does not have a contact dermatitis nickel allergy.
- Reworded Investigational statement:
    - Use of prostatic urethral lift in other situations is considered **investigational**.

New policies effective March 1, 2018

Gene Therapy for Inherited Retinal Dystrophy
Policy Number: 2.04.144

- Inherited retinal dystrophy can be caused by recessive variants in the *RPE65* gene.
- Patients with biallelic variants have difficulty seeing in dim light and progressive loss of vision. These disorders are rare and have traditionally been considered untreatable.
- Gene therapy with an adeno-associated virus vector expressing RPE65 has been proposed as a treatment to improve visual function.
- Genetic testing is required to detect the presence of pathogenic(s) variants in the *RPE65* gene. (81406 MOLECULAR PATHOLOGY PROCEDURE LEVEL 7)
- Policy statements:
    - Voretigene neparvovec-rzyl adeno-associated virus vector-based gene therapy subretinal injection is considered **medically necessary** for patients with vision loss due to biallelic *RPE65* variant-associated retinal dystrophy if they meet all of the following criteria:
        - Are adults (age <65 years) or children (age ≥3 years)
        - Documentation of the following:
            - Genetic testing confirming presence of biallelic *RPE65* pathogenic variant(s) (see Considerations)
                - Single *RPE65* pathogenic variant found in the homozygous state
                - Two *RPE65* pathogenic variants found in the *trans* configuration (compound heterozygous state) by segregation analysis
            - Presence of viable retinal cells as determined by treating physicians as assessed by optical coherence tomography imaging and/or ophthalmoscopy:
                - An area of retina within the posterior pole of >100 µm thickness shown on optical coherence tomography, OR
                - ≥3 disc areas of retina without atrophy or pigmentary degeneration within the posterior pole, OR
                - remaining visual field within 30° of fixation as measured by III4e isopter or equivalent.
    - Do not have any of the following:
        - Pregnancy in females

        - Breastfeeding
        - Use of retinoid compounds or precursors that could potentially interact with the biochemical activity of the RPE65 enzyme; individuals who discontinue use of these compounds for 18 months may become eligible.
        - Prior intraocular surgery within 6 months.
        - Preexisting eye conditions or complicating systemic diseases that would preclude the planned surgery or interfere with the interpretation of study. Complicating systemic diseases would include those in which the disease itself, or the treatment for the disease, can alter ocular function. Examples are malignancies whose treatment could affect central nervous system function (e.g., radiotherapy of the orbit; leukemia with central nervous system/optic nerve involvement). Subjects with diabetes or sickle cell disease would be excluded if they had any manifestation of advanced retinopathy (e.g., macular edema, proliferative changes). Also excluded would be subjects with immunodeficiency (acquired or congenital) because they could be susceptible to opportunistic infection (e.g., cytomegalovirus retinitis).
    - Other applications of voretigene neparvovec-rzyl are considered **investigational**.

Peroral Endoscopic Myotomy for Treatment of Esophageal Achalasia
Policy Number: 2.01.91

- Policy statement:
    - Peroral endoscopic myotomy is considered **investigational** as a treatment for esophageal achalasia.

Synthetic Cartilage Implants for Joint Pain
Policy Number: 7.01.160

- Policy statement:
    - Synthetic cartilage implants are considered **investigational** for the treatment of articular cartilage damage.

Changes to existing policies effective March 1, 2018

Amniotic Membrane and Amniotic Fluid Injections
Policy Number: 7.01.149

- Added Medically Necessary statement:
  - Sutured human amniotic membrane grafts may be considered medically necessary for the treatment of the following ophthalmic indications:
    - Neurotrophic keratitis
    - Corneal ulcers and melts
    - Pterygium repair
    - Stevens-Johnson syndrome
    - Persistent epithelial defects.
- Added Investigational statements:
  - Sutured human amniotic membrane grafts are considered **investigational** for the treatment of all other ophthalmic conditions including but not limited to dry eye syndrome, burns, corneal perforation, bullous keratopathy, limbus stem cell deficiency, and after photorefractive keratectomy.

Human amniotic membrane without suture (e.g., Prokera®, AmbioDisk™) for ophthalmic indications is **investigational**.

Bio-Engineered Skin and Soft Tissue Substitutes
Policy Number: 7.01.113

- Removed from investigational statement:
  - CellerateRX®
  - DermACELL™
  - Integra™ Flowable Wound Matrix
  - Oasis® Wound Matrix
- Added to Medically necessary statement:
  - DermACELL™
  - FlexHD® Pliable™
  - Integra Flowable Wound Matrix

Miscellaneous Genetic and Molecular Diagnostic Tests
Policy Number: 2.04.121

- All of the tests listed in this policy are considered investigational, and are grouped according to the categories of genetic testing as outlined in a separate policy:
  - Testing of an affected (symptomatic) individual's germline to benefit the individual (excluding reproductive testing)
  - Diagnostic testing

  - Testing an asymptomatic individual to determine future risk of disease.
  - Prognostic testing
  - Therapeutic testing
  - Genetic variants that alter response to treatment or to an environmental factor

Miscellaneous Investigational Procedures – Interim Update
Policy Number: 10.01.528

- Removed codes:
  - Q4176 NeoPatch, per sq cm
  - Q4178 FlowerAmnioPatch, per sq cm
  - Q4180 Revita, per sq cm
  - Q4181 Amnio Wound, per sq cm

Molecular Analysis for Targeted Therapy of Non-Small-Cell Lung Cancer
Policy Number: 2.04.45

- Added alectinib [Alecensa®], or brigatinib [Alunbrig™]) to ALK Testing in medically necessary statement:
  - **ALK Gene**
    Analysis of somatic rearrangement mutations of the ALK gene may be considered **medically necessary** to predict treatment response to ALK inhibitor therapy (e.g., crizotinib [Xalkori®] or ceritinib [ZykadiaTM]), alectinib [Alecensa®], or brigatinib [Alunbrig™]) in patients with advanced lung adenocarcinoma or in whom an adenocarcinoma component cannot be excluded (see Considerations section).
- Added ROS1 and BRAF testing to medically necessary statement:
  - **BRAF V600E TESTING**
    Analysis of the BRAF V600E variant may be considered **medically necessary** to predict treatment response to BRAF or MEK inhibitor therapy (e.g., dabrafenib [Tafinlar®] and trametinib [Mekinist®]), in patients with advanced lung adenocarcinoma or in whom an adenocarcinoma component cannot be excluded (see Considerations).
  - **ROS1 TESTING**
    Analysis of somatic rearrangement variants of the ROS1 gene may be considered **medically necessary** to predict treatment response to ALK inhibitor therapy (crizotinib [Xalkori®]) in patients with advanced lung adenocarcinoma or in whom an adenocarcinoma component cannot be excluded (see Considerations).

Molecular Markers in Fine Needle Aspirates of the Thyroid
Policy Number: 2.04.78

- Policy revised with updated genetics nomenclature.
    - The use of either Afirma Gene Expression Classifier or ThyroSeq v2 in fine needle aspirates of thyroid nodules with indeterminate cytologic findings (i.e., Bethesda diagnostic category III [atypia/follicular lesion of undetermined significance] or Bethesda diagnostic category IV [follicular neoplasm/suspicion for a follicular neoplasm]) may be considered medically necessary in patients who have the following characteristics:
        - Thyroid nodules without strong clinical or radiologic findings suggestive of malignancy.
        - In whom surgical decision making would be affected by test results.
- Added new medically necessary policy statement:
    - The use of any of the following types of molecular marker testing or gene variant analysis in fine needle aspirates of thyroid nodules with indeterminate findings (Bethesda diagnostic category III [atypia/follicular lesion of undetermined significance] or Bethesda diagnostic category IV [follicular neoplasm/suspicion for a follicular neoplasm]) or suspicious findings (Bethesda diagnostic category V [suspicious for malignancy[) to rule in malignancy to guide surgical planning for initial resection rather than a 2-stage surgical biopsy followed by definitive surgery may be considered medically necessary:
        - ThyroSeq v2;
        - ThyraMIR microRNA/ThyGenX;
        - Afirma BRAF after Afirma Gene Expression Classifier; or
        - Afirma MTC after Afirma Gene Expression Classifier.
- Removed existing investigational statements and updated:
    - Gene expression classifiers, genetic variant analysis, and molecular marker testing in fine needle aspirates of the thyroid not meeting criteria outlined above, including but not limited to use of RosettaGX Reveal, are considered **investigational**.

2018 Benefit Expansion for Digital Breast Tomosynthesis (DBT)

Effective July 1, 2018, Blue Cross and Blue Shield of Kansas City (Blue KC) will begin providing coverage for Digital Breast Tomosynthesis (DBT), also known as 3D mammograms. Blue KC will no longer consider DBT to be "investigational" in the screening or diagnosis of breast cancer. 3D mammography services performed on dates July 1, 2018, or after will be covered for Blue KC members in accordance with their benefits.

Members' costs for these services will vary, based on their individual benefit plans. For all plans that are required to meet the ACA preventive care requirements, 3D mammography services are covered at no cost to the member when received from an in-network provider.

Members from other Blues plans may or may not have coverage for 3D mammography services. Providers should verify a member's individual eligibility and benefits before providing any non-emergency test, procedure or service.

We appreciate your partnership. Should you have questions about these changes, please contact your Provider Relations Representative or the Blue KC provider hotline at (816) 395-3929.

Blue KC's Preventive Care Benefits Now Include Diabetes Prevention

Beginning June 1, 2018, Blue Cross and Blue Shield of KC (Blue KC) expanded its' Affordable Healthcare Act (ACA) Routine Preventive Care Benefits to include coverage for Diabetes Prevention Programs (DPP).

More details will be available in the July 2018 BlueSpeak!

Blue KC Member Case Management Services

Are you aware Blue KC provides case management services for all eligible members? We are a highly-trained team consisting of Registered Nurses, a Registered Dietician (CDE certified), and a licensed Social Worker who are ready to assist your patients. Below is an example of the various member conditions you can refer to our programs.

- Chronic Disease
- Catastrophic Accident
- Pre and Post-Transplant
- High-Risk Pregnancy/Premature Birth
- Life-Threatening Illness
- Post-Discharge Follow Up
- Stroke
- Care Coordination while away from home/DME/Medication
- Advanced Illness Program (end-of-life care guidance)
- Integrated Care Management (Behavioral and medical diagnosis)
- Other medical conditions requiring case management support

Blue KC Case Management clinicians provide personalized, support by phone as needed to help:

- **Develop individualized treatment plans** that optimize the health benefits allowed in a member's Blue KC plan.
- **Understand the medical costs** associated with treatment and find available care resources.
- **Advocate for patients health** by coordinating with the member, and or their family, family physician and healthcare providers, finding and reviewing treatment alternatives, and helping with discharge planning (if hospitalized).

To refer a member to a care management program, please contact us at (816) 395-2060 or toll free at (866) 859-3813 Monday-Friday from 8 a.m. to 5 p.m., central time. You will be prompted to leave your name, phone number and your call will be returned by one of our clinicians.

Blue KC Commercial and Medicare Advantage Utilize the Healthcare Effectiveness Data and Information Set

Blue KC Commercial and Medicare Advantage teams use the Healthcare Effectiveness Data and Information Set (HEDIS), a tool developed by the National Committee for Quality Assurance (NCQA), to measure health plan performance on important domains of care. This process includes requesting medical records be sent to Blue KC to close gaps in care for the Performance Based Incentive Programs for Medical Homes, perform audits, and fulfill HEDIS requests.

Records can be submitted to Blue KC any time after the April, July, and October scorecards release, until January 15 , which is the due date for practices to submit medical records*. From February through May, Blue KC will have nurses available to retrieve charts from the practices for medical record review followed by a compliance audit of rate results conducted by an NCQA-certified HEDIS auditor.

Results of the data collection and assessment of defined performance measures are used to evaluate areas of opportunity to improve quality improvement efforts, as well as provide a unique opportunity to assess the care provided to the entire membership.

If you have questions regarding requests regarding the commercial line of business please reach out to Health_Statistical_Analysis_Team@BlueKC.com. For questions regarding Medicare Advantage, please contact Mark.Hillix@BlueKC.com.

Blue KC Requests	Start Date	Finish Date
*Records for Year-end Scorecard *Commercial (Non MA)*	October 2018	January 2019
HEDIS Season for both *Medicare Advantage and Commercial* lines of business	January 2019	May 2019
Enhanced Encounter Deadlines for *Medicare Advantage*	May 2018	February 2019
HHS RADV Audit for *Medicare Advantage*	May 2018	October 2018

HHS ACA Risk Adjustment for *Medicare Advantage*	August 2018	December 2018
CMS *Medicare Advantage* Risk Adjustment	Year round audit	
Scorecards for *Commercial* Year to date and Rolling 12	April, July, October	*Records can be send any time after the scorecard release

Questions?

For questions, comments or to refer a member directly to the Healthy Companion program, please call (816) 395-2076 or (866) 859-3813.

Contact Us

BlueSpeak is published three times a year as a service to Blue KC network providers.

Reader's comments are welcome. Please send an email to **Tasha James** at Tasha.James@BlueKC.com.

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