Blue Cross and Blue Shield of Nebraska Prior Authorization List

Effective Jan. 1, 2016

As part of Blue Cross and Blue Shield of Nebraska's (BCBSNE) prior authorization and utilization management programs, the following services and procedures will require prior authorization (also referred to as certification), effective Jan. 1, 2016:

- All inpatient admissions (acute hospital, skilled nursing, acute rehab, hospice)
- Home health care services (skilled nursing and hospice)
- Any treatment or service that is considered investigational per our medical policies. Please refer to MedPolicy Blue at **medicalpolicy.nebraskablue.com**.

- The following services or procedures, to determine medical necessity (includes, but is not limited to)*:
  - Brachytherapy
  - Cardiac event monitoring
  - Durable medical equipment: Please refer to the code-specific listing in Medical Policy Blue
  - Genetic testing
  - Intra-articular hyaluronate injections for osteoarthritis
  - Intensity-modulated radiation therapy (IMRT)
  - Neuropsychiatric testing
  - Radiofrequency and cryosurgical ablation of solid tumors
  - Transcranial magnetic stimulation

***Note**: Please refer by code for specific services that require prior authorization in MedPolicy Blue, available online at **medicalpolicy.nebraskablue.com**.

- The following services or procedures, to determine medical necessity – using InterQual criteria:
  - Biventricular pacemaker
  - Biventricular pacemaker with implantable cardioverter-defibrillator (ICD)
  - Carotid angioplasty/stenting
  - Deep brain stimulation
  - Endometrial ablation
  - Gastric stimulation
  - Hysterectomies
  - Hysteroscopies
  - Left ventricular assist device
  - Kyphoplasty/vertebroplasty
  - Radiofrequency ablation/cryoablation for renal
  - Radiofrequency ablation and transarterial chemoembolization for liver (TACE)
  - Sinus surgery
  - Sleep studies (adult/pediatric)
  - Spinal stimulation
  - Subcutaneous prophlylactic mastectomy (breast cancer)
  - Surgery for morbid obesity (adult/adolescent)
  - Vagal nerve stimulation
  - Varicose vein surgeries
  - Wireless capsule endoscopy (adult/pediatric)

- Lumbar and cervical fusions, microdiscectomies and lumbar decompression require prior authorization through NIA Magellan at **www1.radmd.com**.
- Interventional pain management (facet injections, epidural injections and facet neurolysis) require prior authorization through NIA Magellan at **www1.radmd.com**.
- CT, MRI, PET scans and SPECT scans require prior authorization through AIM **www.aimspecialtyhealth.com**.

Blue Cross and Blue Shield of Nebraska is an independent licensee of the Blue Cross and Blue Shield Association.

MEDICAL POLICIES REQUIRING PREAUTHORIZATION*

POLICY NUMBER	POLICY NAME
I.0	PROCEDURES RECOMMENDED FOR MEDICAL NECESSITY REVIEW
I.31	CHELATION THERAPY/CHEMICAL ENDARTERECTOMY
I.83	GENETIC ENGINEERING
I.91	MEASURING CARDIAC OUTPUT BY THORACIC ELECTRICAL BIOIMPEDANCE
I.101	PROLOTHERAPY
I.105	ELECTRICAL STIMULATION OF MUSCLES AND NERVES
I.121	PARASPINAL SURFACE ELECTROMYOGRAPHY (EMG) TO EVALUATE AND MONITOR BACK PAIN
I.129	VIRTUAL COLONOSCOPY / COMPUTED TOMOGRAPHY COLONOGRAPHY
I.133	DUCTAL LAVAGE OF THE MAMMARY DUCTS
I.134	DERMATOSCOPY
I.137	FECAL ANALYSIS IN THE DIAGNOSIS OF INTESTINAL DYSBIOSIS
I.145	ANALYSIS OF HUMAN DNA IN STOOL SAMPLES
I.146	THE CORCAP CARDIAC SUPPORT DEVICE
I.147	OPIOID ANTAGONISTS UNDER HEAVY SEDATION OR GENERAL ANESTHESIA AS A TECHNIQUE OF OPIOID DETOXIFICATION
I.149	ANALYSIS OF PROTEOMIC PATTERNS FOR EARLY DETECTION OF CANCER
I.155	CARDIAC EVENT MONITORS AND OUTPATIENT CARDIAC TELEMETRY
I.161	TRANSURETHRAL RADIOFREQUENCY ENERGY SYSTEM (RENESSA) FOR URINARY INCONTINENCE
I.167	TARGETED PHOTOTHERAPY FOR PSORIASIS
I.170	MANIPULATION UNDER ANESTHESIA FOR TREATMENT OF CHRONIC SPINAL OR PELVIC PAIN
I.171	INTRAVENOUS ANESTHETICS FOR THE MANAGEMENT OF CHRONIC PAIN
I.174	NEUROFEEDBACK
I.175	AUTOMATED POINT OF CARE NERVE CONDUCTION TESTING
I.178	AUTISM SPECTRUM DISORDERS
I.179	CATEGORY III CODES
III.105	PROCEDURES TO TREAT DYSMENORRHEA AND UTERINE FIBROIDS INCLUDING: UTERINE NERVE ABLATION, PRESACRALNEURECTOMY (LUNA), LAPAROSCOPIC AND PERCUTANEOUS TECHNIQUES FOR THE MYOLYSIS OF UTERINE FIBROIDS
III.109	TOTAL ARTIFICIAL HEARTS
III.118	TRANSMYOCARDIAL REVASCULARIZATION FOR THE TREATMENT OF CORONARY ARTERY DISEASE
III.125	MONITORING OF SENSORY EVOKED POTENTIALS
III.139	FETAL SURGERY FOR PRENATALLY DIAGNOSED MALFORMATIONS
III.142	PERCUTANEOUS DISC PROCEDURES, INCLUDING: PERCUTANEOUS LASER DISC DECOMPRESSION (PLDD), PERCUTANEOUS RADIOFREQUENCY DISC DECOMPRESSION, AND PERCUTANEOUS SPINAL DISCECTOMY
III.145	RADIOFREQUENCY AND CRYOSURGICAL ABLATION OF SOLID TUMORS
III.148	TRANSESOPHAGEAL ENDOSCOPIC THERAPIES FOR GASTROESOPHAGEAL REFLUX DISEASE
III.150	EXTRACORPOREAL SHOCK WAVE THERAPY (ESWT)

III.158	TOTAL ANKLE REPLACEMENT
III.159	TOTAL HIP RESURFACING
III.168	PERCUTANEOUS SACROPLASTY
III.170	LUMBAR ARTIFICIAL INTERVERTEBRAL DISCS
III.172	IMPLANTATION OF INTRASTROMAL CORNEAL RING SEGMENTS
III.175	LUNG VOLUME REDUCTION SURGERY / REDUCTION PNEUMOPLASTY AND THORACOSCOPIC LASER ABLATION
III.177	BALLOON SINUS OSTIAL DILATION
III.178	BRONCHIAL THERMOPLASTY
III.179	SEMI-IMPLANTABLE AND FULLY IMPLANTABLE MIDDLE EAR HEARING AIDS
III.180	SURGICAL DEACTIVATION OF MIGRAINE HEADACHE TRIGGER SITE
III.181	OVARIAN AND INTERNAL ILIAC VEIN EMBOLIZATION AS A TREATMENT OF PELVIC CONGESTION SYNDROME
III.182	COMPUTER ASSISTED MUSCULOSKELETAL SURGICAL NAVIGATIONAL ORTHOPEDIC PROCEDURE
III.183	MAGNETIC ESOPHAGEAL RING TO TREAT GASTROESOPHAGEAL REFLUX DISEASE (GERD)
III.185	INTERQUAL PRE-SERVICE REVIEW: Surgery for Morbid Obesity, Gastric Stimulation, Deep Brain stimulation, spinal stimulation, vagal nerve stimulation, biventricular pacemaker with and without ICD, wireless capsule endoscopy, sleep studies, subcutaneous prohplylactic mastectomy, left ventricular assist device, carotidi angioplasty/stenting, radiofrequncy ablation/cryoablation for rena, kypohoplasty, vertebroplasty ,varicose veins, radiofrquency albation and transarterial chemoembolization for liver.
III.187	NIA MAGELLAN-INTERVENTIONAL PAIN MANAGEMENT AND CERVICAL/LUMBAR SPINE SURGERY
III.188	AUTOLOGOUS CHONDROCYTE IMPLANTATION FOR FOCAL ARTICULAR CARTILAGE LESIONS
III.189	DIAGNOSIS AND TREATMENT OF SACROILIAC JOINT PAIN
III.24	ELECTRICAL BONE GROWTH STIMULATION OF THE APPENDICULAR SKELETON AND AS AN ADJUNCT TO A SPINAL FUSION
III.52	PERIURETHRAL INJECTION FOR THE TREATMENT OF URINARY INCONTINENCE
III.57	COSMETIC AND RECONSTRUCTIVE SURGERY
III.62	SURGERIES FOR OBSTRUCTIVE SLEEP APNEA: UVULOPALATOPHARYNGOPLASTY (UPPP),PALATOPHARYNGOPLASTY (PPP), UVULECTOMY, TONSILLECTOMY, ADENOIDECTOMY, NASAL SEPTOPLASTY, LASER-ASSISTED UVULOPALATOPLASTY (LAUP)
III.72	SUBCUTANEOUS OR PROPHYLACTIC MASTECTOMY (non cancer diagnosis)
III.78	TREATMENTS FOR PARKINSON'S DISEASE AND OTHER MOVEMENT DISORDERS
III.83	CHARGED-PARTICLE RADIATION, HELIUM ION OR PROTON, AND STEREOTACTIC RADIOSURGERY/ FRACTIONATED STEREOTACTIC RADIOTHERAPY (SRS)/(SRT) AND STEREOTACTIC BODY RADIATION (SBRT)
IV.0	AMERICAN IMAGING MANAGEMENT

IV.51	OPHTHALMOLOGIC TECHNIQUES OF EVALUATING GLAUCOMA
IV.54	MAGNETOENCEPHALOGRAPHY (MEG)/MAGNETIC SOURCE IMAGING (MSI)
IV.58	MAGNETIC RESONANCE IMAGING (MRI) OF THE BREAST
IV.62	COMPUTED TOMOGRAPHY ANGIOGRAPHY (CTA)
IV.64	MAGNETIC RESONANCE NEUROGRAPHY
IV.65	TOTAL BODY COMPUTED TOMOGRAPHIC (CT) SCREENING
IV.67	TRANSCRANIAL MAGNETIC STIMULATION AS A TREATMENT OF MENTAL ILLNESS AND OTHER BRAIN DISORDERS
IV.72	INTENSITY MODULATED RADIATION THERAPY (IMRT)
IV.73	ULTRASONOGRAPHIC MEASUREMENT OF INTIMAL-MEDIAL THICKNESS AS AN ASSESSMENT OF SUBCLINICAL ATHEROSCLEROSIS
IV.76	ACCELERATED IRRADIATION THERAPY, BRACHYTHERAPY, AND INTRAOPERATIVE RADIATION THERAPY (IORT)
IV.78	BONE MINERAL DENSITY MEASUREMENT (DEXA)
IV.79	3-DIMENSIONAL AND 4-DIMENSIONAL FETAL ULTRASOUND
IV.80	DIGITAL BREAST TOMOSYNTHESIS
V.10	KRAS AND BRAF MUTATION ANALYSIS
V.11	MULTIGENE EXPRESSION ASSAY FOR PREDICTING RECURRENCE IN COLON CANCER
V.13	MULTIANALYTE ASSAY WITH ALGORITHMIC ANALYSIS FOR THE PREDICTION OF TYPE 2 DIABETES
V.14	CYTOCHROME P450 GENOTYPING
V.15	GENETIC TESTING FOR NON-CANCEROUS INHERITABLE DISEASES
V.16	GENETIC TESTING FOR CANCER SUSCEPTIBILITY
V.18	CYTOGENETIC MICROARRAY ANALYSIS
V.19	CARDIOVASCULAR RISK PANELS
V.20	FECAL CALPROTECTIN TESTING
V.21	MEASUREMENT OF SERUM ANTIBODIES TO INFLIXIMAB AND ADALIMUMAB
V.22	GENERAL APPROACH TO EVALUATING THE UTILITY OF GENETIC PANELS
VI.16	HYPERBARIC OXYGEN PRESSURIZATION AND TOPICAL HYPERBARIC OXYGEN CHAMBER
VII.15	CONTINUOUS PASSIVE MOTION (CPM) DEVICES
VII.35	OSCILLATORY DEVICES FOR THE TREATMENT OF RESPIRATORY DISORDERS (THE VEST AIRWAY CLEARANCE SYSTEM)
VII.39	HEART DISEASE REVERSAL PROGRAMS (ORNISH PROGRAM)
VII.49	SENSORY INTEGRATION THERAPY
VII.51	CONTINUOUS MONITORING OF GLUCOSE IN THE INTERSTITIAL FLUID
VII.65	MICROPROCESSOR-CONTROLLED PROSTHETIC KNEES
VII.67	SPEECH GENERATING DEVICE
VIII.1	CHAIR, SEAT, LIFT
VIII.3	SPECIALTY HOSPITAL BEDS
VIII.5	ULTRAVIOLET CABINET
VIII.6	WHEELCHAIR
VIII.7	ADJUSTABLE CRANIAL ORTHOSES FOR POSITIONAL PLAGIOCEPHALY AND CRANIOSYNOSTOSIS
VIII.8	MEDICAL MANAGEMENT FOR OBSTRUCTIVE SLEEP APNEA (OSA)
X	ALL PHARMACY MEDICAL POLICIES

*This list is current as of 11/25/15. It is subject to change. For the most current information, check here regularly for updates.