

# The Provider NEWSLETTER

**PARTNERS**  
National Health Plans of North Carolina, Inc.

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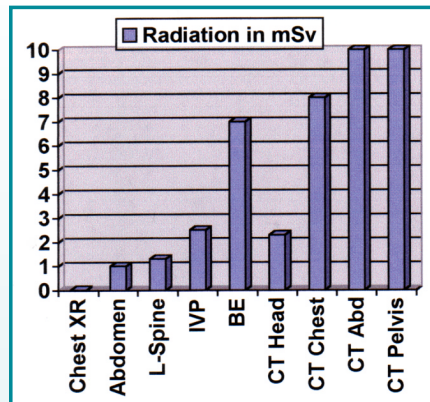


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## Patient Safety in Medical Imaging

Ionizing radiation has proved one of the most important diagnostic discoveries in the history of medicine. Without ionizing radiation, x-ray examinations, fluoroscopy, angiograms, and computed tomography (CT) would not be possible. The lack of these tools would disable a physician's ability to successfully diagnose and treat patients. Unquestionably, ionizing radiation saves lives.

Yet it also takes lives. Ionizing radiation's affect on molecules causes serious biological changes, such as cancer. Therefore, physicians should limit ionizing-radiation exams—especially CT scans, which produce a massive radiation dose. As indicated in the above graph, the radiation exposure for a single-body CT exam is typically 10 mSv (100mSv or more for specialized CTs). In contrast, a single, frontal-view chest x-ray exam



provides a radiation exposure of only 0.02 mSv. Nevertheless, CT exams are gaining popularity. Physicians ordered 33 million CT scans in 1998—a dramatic increase from 1998's 2.8 million exams.

Although physicians must limit their use of ionizing radiation in all patient cases, the affect of CT on children is of particular concern. A child's risk of cancer from ionizing radiation is much greater than an adult's, yet between 1996 and 1999, a major children's hospital increased pediatric body CT 92 percent. A somewhat controversial article by Dr. David Brenner of Columbia University predicted that of the estimated 600,000 patients under age fifteen who received a CT in 2001, 500 will die from radiation-induced cancer (Brenner, et al, Feb. 2001, American Journal of Roentgenology).

Physicians must consider the consequences of ionizing radiation in ordering radiology exams. While diagnostic imaging

is an important diagnostic tool, its immoderate use proves more harmful than beneficial to patients. Reducing the unnecessary use of all forms of ionizing radiation, especially CT in children, will result in fewer cancer deaths.

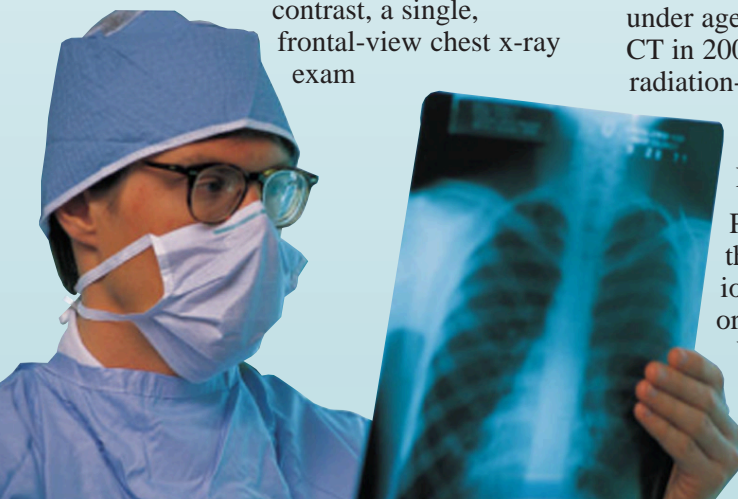
Dr. Neil Grossman

### IMPORTANT NOTICE REGARDING PRIOR APPROVAL REQUIREMENT

PARTNERS will no longer review clinical notes or otherwise make medical necessity determinations after the date of service on products and services that require prior approval. If prior approval is not obtained on products and services where it is required, coverage will be denied. And unless the patient has acknowledged non-coverage and agreed, in writing, to pay for the specific service, you will not be able to bill the member for the product or service. While in the past, PARTNERS has shown leniency on the prior approval requirement and sometimes reviewed for medical necessity after the fact when prior approval was not obtained, we will no longer do so. Be sure to check which products and services require prior approval.

### March 2002 Issue

- Patient Safety in Medical Imaging
- Medical Coverage Policies Updated
- PARTNERS Technology Assessment Review Policies



# The Pharmacy Connection

## March 2002

### Additions to the PARTNERS formulary effective January 2002:

- Amaryl
- Aranesp
- Benzaclin
- Novolog
- Rebetedol
- Zyrtec D

### Addition to the PARTNERS formulary which requires Prior Approval.

- Rebetedol (please call Express-Scripts at 1-800-417-8164 for authorization of this drug)

### Additions to the PARTNERS formulary which are considered Maintenance Medications:

- Amaryl
- Novolog

### MAC'd drugs

- Glucophage March 1, 2002

(only the generic version of Glucophage is covered; if members receive the brand, they will be responsible for either additional charges or a higher copayment amount)

### REMINDERS

Beginning February 1, 2002, PARTNERS requires prior authorization for Proton Pump Inhibitors. This will not affect members who are currently taking the medication or have taken the medication in the past 6 months. Prior authorization will only apply to new prescriptions for members who have not previously (within the last 6 months) been on a PPI and are not written by a gastroenterologist. As with other prior authorizations, the purpose is to promote appropriate therapy. Coverage of the formulary PPIs Aciphex, Prevacid, and Protonix, as well as the non-formulary agents Nexium and Prilosec, will require that you or a representative from your office call Express-Scripts at 1-800-417-8164 to request authorization prior to the member going to the pharmacy to have their prescription filled. Please remember that a formulary agent (Aciphex, Prevacid, and Protonix) will result in a lower copayment for most members.

## Editorial

This newsletter, unless otherwise stated, applies to both Commercial and Medicare Choice members.

PARTNERS is committed to offering its health plans on a non-discriminatory basis.

PARTNERS does not discriminate based on color, religion, national origin, age, race, disability, handicap, gender, or health status as defined by CMS.

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## PARTNERS Medical Coverage Policies Updated

The following Medical Coverage Policies and Technology Assessment Review Policies have been reviewed and approved by the Utilization Review/Quality Improvement Physician Advisory Committee. Please Contact your Network Management representative for additional information. Unless otherwise indicated, policies apply to all Commercial Certificates of Coverage.

### 1. CARDIAC/TELEMETRY CRITERIA FOR LOW RISK PATIENTS

Observation criteria for members with complaints of chest pain which may be of cardiac etiology and the member is considered to be of low risk.

### 2. ELECTRICAL STIMULATORS-BONE GROWTH

Eligible for coverage and require prior authorization before the stimulator is dispensed. The physician must submit a documented care plan indicating the stimulator use and expected outcome.

### 3. ELECTRICAL STIMULATORS-THALAMIC (DEEP BRAIN)

Eligible for coverage when medically necessary for a diagnosis of disabling, medically unresponsive tremor due to unilateral disease related to Essential Tremor or Parkinson's Disease. Prior authorization is required before the stimulator is dispensed.

### 4. ELECTRICAL STIMULATORS-PERCUTANEOUS ELECTRICAL NERVE STIMULATION (PENS)

Eligible for coverage and require prior authorization before the stimulator is dispensed. The physician must submit a documented care plan indicating the stimulator use and expected outcome.

### 5. ELECTRICAL STIMULATORS TRANCUTANEOUS ELECTRICAL NERVE STIMULATION (TENS)

Eligible for coverage and require prior authorization before the stimulator is dispensed. The physician must submit a documented care plan indicating the stimulator use and expected outcome.

## 6. ELECTRICAL STIMULATORS- VAGUS NERVE:

Eligible for coverage and require prior authorization before the stimulator is dispensed. The physician must submit a documented care plan indicating the stimulator use and expected outcome. Coverage will be considered by the Medical Director on a case-by-case basis for those patients with partial onset seizures.

## 7. ELECTRICAL STIMULATORS- SPINAL CORD:

Eligible for coverage and require prior authorization before the stimulator is dispensed. The physician must submit a documented care plan indicating the stimulator use and expected outcome. The Medical Director on a case-by-case basis will consider coverage for patients with chronic intractable pain.

## 8. NONEMERGENT TRANSPORTATION:

Non-emergent ambulance transportation may be covered when other methods of transportation would endanger a member's health. This type of transportation must be certified by a Plan physician and prior approved by the health plan.

## 9. TEMPOROMANDIBULAR JOINT SURGERY AND/OR OCCLUSAL SPLINTS:

Precertification by the Health Plan and Medical Director review is required for TMJ/TMD surgery. Documentation of a treatment plan by the participating physician, participating oral surgeon or licensed dentist (when under the direction of a plan MD) that will

perform the TMJ/TMD surgery or occlusal splinting should be submitted with the initial request.

## 10. TRANSPLANTS: STEM CELLS AND ORGAN:

Prior authorization and Medical Director approval for the transplant evaluation and transplant procedure is required. A physician must recommend organ or stem cell transplant and documentation of organ failure and transplantation candidacy as per transplant facility guidelines/protocol is required. The harvesting or banking of autologous bone marrow or stem cells for future use, when myeloablative high-dose chemotherapy may be a necessary treatment option, is eligible for coverage when criteria are met.

## 11. TREATMENTS FOR OBSTRUCTIVE SLEEP APNEA AND BREATHING RELATED SLEEP DISORDERS:

CPAP and BiPAP Requests require precertification by the Health Plan and documentation of a recent polysomnogram including evidence of CPAP or BIPAP titration in the sleep lab showing effectiveness at a documented pressure. In addition, the patient and either the sleep medicine physician or the vendor is willing to undertake a good faith effort at CPAP/BIPAP compliance. Failure of a good faith effort at conservative therapy will normally be required before a surgical request is approved. Sleep hygiene measures include weight loss where appropriate, avoidance of alcohol, sedatives, and caffeine in the pre-bedtime hours, allowing an adequate sleep time, and (where appropriate) alteration of the sleep position to reduce or eliminate position-specific events. CPAP or

BIPAP should be prescribed pursuant to a CPAP titration to obtain the most effective pressure compatible with patient comfort. The Plan expects that the CPAP vendor and the prescribing sleep medicine physician will undertake appropriate measures to maximize the chance of success of the CPAP/BIPAP effort. These measures to acclimate members to therapy include emotional support to overcome initial reluctance where appropriate, alternate mask fitting for effect and comfort, nasal pillows, ramping, etc. and must be documented in the medical record. Acclimation efforts are expected for a minimum of two months, and must be supported by proper documentation and compliance chip information before these modalities will be considered failed. The CPAP and BIPAP are considered Durable Medical Equipment (DME) and would be eligible for coverage under the DME section of the member's Certificate of Coverage (C.O.C.). BIPAP is utilized when a trial with CPAP is unsuccessful or not tolerated or when patient is five years of age or younger. Rental period of up to two months and/or purchase of the unit may be approved when the physician has evaluated the member after treatment and verified its effectiveness and compliance information indicates a minimum average nightly use of 6 hours as indicated by the compliance chip. Surgical treatments for obstructive sleep apnea and upper airway resistance syndrome are eligible for coverage when medically necessary. Precertification by the Health Plan and Medical Director review is required for all surgical procedures for sleep apnea. Hard copy documentation is required for medical director review.

# PARTNERS Technology Assessment Review Policies

## 1. INTRADISCAL ELECTROTHERMAL THERAPY (IDET):

(Revised policy) Intradiscal Electrothermal Therapy (IDET) is a minimally invasive surgical procedure that uses a catheter and flexible electrode to apply heat directly to intervertebral discs in order to treat lower back pain believed to be caused by internal disc disruption. The mechanism by which IDET works is still unproven and unknown. There is insufficient evidence of efficacy to warrant coverage of IDET at this time.

## 2. PORTABLE COAGULATION DEVICE FOR HOME MONITORING OF ORAL ANTICOAGULATION THERAPY:

Portable coagulation devices are portable monitoring devices intended for patients to use at home to monitor oral anticoagulant therapy. From a fingerstick, the device can calculate protime and INR within several minutes. The system includes the monitor, individually wrapped test strips, a code chip, a liquid quality control (QC) kit, an electronic QC device and optional capillary tubes and bulbs. There is insufficient evidence of efficacy to warrant coverage of portable coagulation devices at this time. The Plan will continue to monitor the progress of CMS's (formerly known as HCFA) policy, which would allow

limited coverage for selected patient groups. Medical Director review is required for all requests for the portable coagulation devices for home monitoring of oral anticoagulation therapy.

## 3. UTERINE ARTERY EMBOLIZATION:

Percutaneous transcatheter embolization of uterine arteries has been done since 1979, but is only now coming into more common usage. A catheter is inserted in the distal aorta from a common femoral artery. After an initial pelvic angiogram is obtained, selective internal iliac angiograms are done bilaterally (often in conjunction with digital road mapping, which greatly speeds up the process). When the bleeding vessel is identified, gel foam pledgets, metal coils, or polyvinyl alcohol is used to embolize the artery. Hemostasis can be obtained within three hours of consultation in prepared centers (ECRI, 1998). Uterine artery embolization is a same-day procedure requiring a surgical outpatient setting. There is insufficient evidence of efficacy to warrant coverage of uterine artery embolization at this time. Medical director review is required.

## 4. AUTOLOGOUS CHONDROCYTE IMPLANTATION (ACI) FOR KNEE CARTILAGE DEFECTS:

ACI is a surgical procedure involving the biopsy of healthy cartilage and implantation of chondrocytes extracted from the cartilage and cultivated in cell culture. This procedure is reserved for those patients who have clinically significant symptomatic defects or damage to the cartilage of the knee caused by acute or repetitive trauma. There is an initial arthroscopy and biopsy of normal cartilage. Carticel™ is an FDA approved biologic agent that is used to stimulate the growth of the patient's own cartilage cells. The chondrocyte cells are cultured and an arthrotomy is performed to create a periosteal flap and implant the chondrocytes. Post-surgical rehabilitation is recommended. Alternatives to ACI are debridement, subchondral drilling, microfraction and abrasion arthroplasty. Coverage will be approved based on outlined criteria.

Benefit payments are subject to the contractual obligations of the plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member's particular Certificate of Coverage (COC), the COC always governs the determination of benefits.