Uniform Medical Plan coverage limits

Updates effective 12/1/2019

The benefit coverage limits listed below apply to these UMP plans:

- Uniform Medical Plan (UMP) Classic (PEBB)
- UMP Consumer-Directed Health Plan (UMP CDHP) (PEBB)
- UMP Plus–Puget Sound High Value Network (UMP Plus–PSHVN) (PEBB)
- UMP Plus–UW Medicine Accountable Care Network (UMP Plus–UW Medicine ACN) (PEBB)

- UMP Achieve 1 (SEBB)
- UMP Achieve 2 (SEBB)
- UMP High Deductible Plan (SEBB)
- UMP Plus–Puget Sound High Value Network (UMP Plus–PSHVN) (SEBB)
- UMP Plus–UW Medicine Accountable Care Network (UMP Plus–UW Medicine ACN) (SEBB)

Some services listed under these benefits have coverage limits. These limits are either determined by a Health Technology Clinical Committee (HTCC) decision or a Regence BlueShield medical policy. **The table below does not include every limit or exclusion under this benefit. For more details, refer to your plan's Certificate of Coverage.**

Uniform Medical Plan Pre-authorization List

The Uniform Medical Plan (UMP) Pre-authorization List includes services and supplies that require pre-authorization or notification for UMP members.

Click to view important upcoming pre-authorization changes

- Pharmacy: Infusion Drug Site of Care – effective January 1, 2020
- Physical Medicine
    - Physical therapy, speech therapy, occupational therapy (PT/OT/ST) – effective March 1, 2020
        - PEBB: UMP Classic, UMP CDHP and UMP Plus – Limit 60 annual visits
        - SEBB: UMP Achieve 1, UMP Achieve 2, UMP High Deductible – Limit 80 annual visits
        - SEBB: UMP Plus – Limit 60 annual visits
    - Pain management – effective January 1, 2020
    - Joint management – effective January 1, 2020
    - Spine – effective January 1, 2020
- Radiology – effective January 1, 2020
- Sleep Medicine – effective January 1, 2020

Substance Use Disorder and Mental Health

Pre-authorization is required for the services listed below. **Emergency inpatient services do not require pre-authorization, but are subject to admission notification requirements.**

- **Inpatient: Psychiatric or ASAM 4.0 Detoxification**
    - Notification of admission must be received within 24 hours of admission or the next business day (whichever comes first). Medical necessity review will be conducted.
- **Sub-Acute Detoxification/ASAM Level 3.7**
    - Requires pre-authorization before the member is admitted for services. Under certain circumstances, pre-authorization requests can be made within 24 hours of admission or the next business day.
- **Residential treatment: Psychiatric or ASAM Level 3.5 for Substance Use Disorders**
    - Requires pre-authorization before the member is admitted for services. Under certain circumstances, pre-authorization requests can be made within 24 hours of admission or the next business day.
- **Partial hospitalization: Psychiatric or ASAM level 2.5 for Substance Use Disorders**
    - Request for authorization is required no later than the day of admission.
- **Intensive outpatient: Psychiatric or ASAM level 2.1 for Substance Use Disorders**
    - Request for authorization is required no later than the day of admission.

Medical necessity for behavioral health services is determined by:

- MCG's (https://www.mcg.com/care-guidelines/behavioral-healthcare/) criteria for mental health services
- The American Society of Addiction Medicine's (ASAM) criteria for chemical dependency services

Applied behavioral analysis (ABA) therapy

ABA Therapy is for the treatment of Autism Spectrum Disorders (ASD) when medically necessary.

- Procedure codes 0362T, 0373T, 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158
- Procedure codes 97151, 97152, and 0362T: Pre-authorization is not required when 97151, 97152, and 0362T are used for **initial** ABA assessments, but pre-authorization is required when 97151, 97152, and 0362T are used for ABA **reassessments**.

The following clinical providers, with expertise in using evidenced-based tools to establish or confirm the diagnosis of autism and experience in developing multidisciplinary autism treatment plans, can provide the diagnostic assessment, comprehensive evaluation report, and recommend treatment approach:

- Psychiatrist
- Neurologist
- Pediatric Neurologist
- Developmental Pediatrician
- Doctorate level psychologist
- Advanced registered nurse practitioner

Initial pre-authorizations must contain the following information; View specific details on what each of these items need to contain.

- Pre-authorization request form (or equivalent information)
- Clinical evaluation, which includes confirmation of an ASD diagnosis, and recommended treatment approach from a clinician meeting the criteria above (clinical evaluation needs to have been completed within the 12 months prior to the initial pre-authorization request)
- Written Clinical Order, Directive, or Prescription for ABA Therapy services from a clinician meeting the criteria above
- ABA initial report that includes an ABA assessment treatment plan (to be completed by the Lead Behavior Therapist). This sample ABA assessment and treatment plan form can be filled out and submitted or used as a reference tool.

A cover letter may be submitted; however it is not required. A sample cover letter template is provided for your reference. Other documentation may be submitted.

View ABA therapy clinical considerations for information about hours of service and documentation requirements.

Concurrent Review

The following document should be submitted within 5 business days prior to the end of a current authorization:

- Updated ABA assessment treatment plan (to be completed by the Lead Behavior Therapist). This sample ABA assessment and treatment plan form can be filled out and submitted or used as a reference tool.
- A new Pre-authorization request form (or equivalent information)

Following the submission of the concurrent review documentation, the plan may request additional information prepared and submitted by a clinician meeting the above clinical criteria. The plan will specify what must be included in this report which is intended to assess progress and prospective treatment in further detail and may include a written Clinical Order, Directive or Prescription for ABA Therapy services.

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ABA Assessment and Treatment Plan

This report is confidential and for professional use only. The content may not be divulged to any person or agency without consent of the parent, legal guardian, or patient, as appropriate. Fax to Regence BlueShield **1-888-496-1540** *or by mail to: Regence BlueShield PO Box 1271 MS E9H, Portland, OR 97207-1271*

Patient Name:	**Treatment Agency Name:**
Patient Birth Date:	**Lead Behavior Therapist Name:**
UMP ID Number (Include Alpha Characters):	**Therapist Assistant Name(s):**

RECOMMENDED TREATMENT HOURS/SESSIONS

	Direct Patient Support - hours (weekly)	**Caregiver/Parent Training - 1 session per day (monthly)**
Recommended Hours and Setting (indicate # of Sessions for Caregiver/Parent Training)	*e.g., 10 hours in home* *2 hours in community*	

	Program Supervision - **includes observation of the treatment being delivered, observation of the child in his/her natural setting, and communication with BCBAs/Techs delivering ABA services.** **(weekly)**	**ABA treatment day program in a clinic or outpatient hospital setting (weekly)**
Recommended Hours and Setting	*e.g., 10 hours in home* *2 hours in community*	

Rationale for this treatment plan should be reflected in the body of the report below, as well as the severity ratings on the Applied Behavior Analysis Authorization Request Form submitted with this treatment plan.

BACKGROUND AND HISTORY *Indicate at least the following or indicate NA.*

Past psychiatric history:

For diagnosis of autism spectrum disorder, include date of diagnosis and diagnosing provider name. Also include initial diagnosis documentation and comorbid diagnoses if this is an initial preauthorization request.

Chief Complaint and History of Present Illness (HPI): *Include all core deficit areas of autism, challenging behaviors, adaptive, motor, vocational, and cognitive skills, and any other related relevant areas. In addition to addressing the chief complaint, one should be able to understand the patient's level of functioning by reading this section. Please provide a detailed summary of information below for both Preauthorization and Concurrent review requests.*

Social Communication: *includes persistent deficits in social communication and social interaction, as outlined in DSM-5*

Behavior: *includes restricted interests and repetitive behaviors, as well as related challenging behaviors (e.g., tantrums, aggression, etc.)*

Adaptive skills:

Motor:

Vocational:

Cognitive:

Family history: *Focus on relevant family psychiatric history and related family training in support of performing ABA therapy*

Social history: *Information about where the patient lives, with whom, as well as any other relevant information about social context or stressors.*

Medical history:

Active medical problems:

Current medical providers:

Current medications, dose, purpose, and potential major side effects:

Allergies, special diets, etc.:

Past medical problems:

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Educational History: *Summarize past and current educational plan, including what services are being provided in the educational setting. Discuss whether functional behavior assessments, behavior plans, and/or aversive plans have been used in the school setting. State where the information was obtained (e.g., review of records, interview, etc.).*

History:

Current:

Past and Current Services: *Outline all additional services being provided outside school through any other agency or funding source. Include frequency, provider, and funding source.*

Ensure there is not redundancy with recommended ABA treatment plan.

Outline previous courses of ABA therapy; including dates, setting, and the outcome.

ASSESSMENTS COMPLETED FOR EVALUATION

Measures used: *Discuss all sources of information used in evaluating the patient, including standardized (norm-referenced) and curriculum-based measures, interviews (e.g., parent, caregivers, teacher), direct observation at home/school/community, etc. Please complete the Applied Behavior Analysis Authorization Form and attach to this treatment plan.*

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Evaluation Findings: *Briefly summarize findings, including test scores if available. Summary can be brief; a couple sentences per measure. E.g., Vineland-II results demonstrated delays in communication and socialization are present. Tables and score reports can be used if easier to present information. Present in appendices if desired. Briefly summarize findings derived from observations in natural settings (e.g., home, school).*

Functional behavior assessment/analysis findings: *Functional assessment or analysis results should be included here. The following components should be included:*

1) *Operational definition of behavior*

2) *Hypotheses or analysis about functions supported by indirect and direct assessment results*

3) *Functional assessment or analysis data to support function hypotheses or analyses*

4) *Baseline data, including frequency, duration, and intensity data, as appropriate to behavior.*

Include assessment of risk (e.g., due to elopement or other unsafe behavior) as appropriate.

Goal domains derived from assessment: *Include statement about how the information obtained supports goals in specific areas. E.g., Assessment information suggests CHILD needs treatment goals in the areas of Social Communication, Behavior, Adaptive skills, Motor skills, Vocational skills, and Cognitive skills.*

TREATMENT PLAN IMPLEMENTATION

Treatment Plan: *This section should include a brief overview of the treatment plan, including:*

1) *How ABA will be applied to the patient (e.g., ABA as applied to CHILD will include home and community based 1-1 intervention for (x) hours per week to target social, communication, and adaptive goals)*

2) *Whether a positive behavior support plan is required to address challenging behaviors*

3) *The parent/caregiver training plan*

4) *How the treatment plan will be coordinated with other providers, including school (e.g., speech pathologist, medical providers, outpatient psychologist, teachers, etc.).*

Goals and objectives can be found in Appendices A, B and C of this report.

Maintenance/Generalization/Discharge Plan: *This section should include a statement about how maintenance and generalization will be addressed, how services will be reduced or transitioned to the parents and/or how the patient will be transitioned into other less intensive services (e.g., school, outpatient, etc.). This should be more specific as the patient progresses in therapy. The transition or discharge plan should be specific, data driven, and include criterion for discharge.*

Goals and objectives can be found in Appendix D of this report.

ABA Agency or ABA Service Coordinator: _____

_____	_____
Print Name of Lead Behavior Therapist	Signature of Lead Behavior Therapist
_____	_____
Print Name of Therapist Assistant	Signature of Therapist Assistant
_____	_____
Print Name of Therapist Assistant	Signature of Therapist Assistant
_____	_____
Print Name of parent/caregiver	Signature of parent/caregiver

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Appendix A: Goals and Objectives for Skill Acquisition

Include goals and objectives in all relevant areas. Goals should be worded in such a way that they can be measured to track progress. Objectives should be clear steps toward a goal. Goals and objectives should be worded in such a way that they are easily interpretable to readers who are not familiar with behavioral terminology (i.e., parents, case managers, etc). The specified domains were decided upon by the HCA and include social communication, behavior (restricted interests, repetitive behaviors, other challenging behaviors), adaptive, motor, vocational, and cognitive. Broadly defined, all relevant goals (e.g., play skills, self-help, etc.) should fit into one of these categories. Goals for reduction of problem behavior should be outlined in Appendix B: Positive Behavior Support Plan.

Skill Acquisition Goals: *All skill acquisition goals and their corresponding objectives should be outlined here. Goals should be organized by skill area (e.g., social communication), should be titled with a short 2-3 word title, should include a broad goal that demonstrates the expected outcome, and then be broken down into specific objectives(also titled) that clearly outline target skills to be taught (e.g., within communication, expressive labels and requesting might be two specific objectives). Objectives should be measurable and measurement strategies, including mastery criteria, should be clearly stated (e.g., mastery criteria are met when a correct response occurs on 9 out of 10 opportunities across three sessions). Goals should be written in a manner that is consistent with how the therapists are taking data so data can easily be reported back for utilization review of progress. If progress will be documented by using a formal assessment tool (e.g., a measure associated with a curriculum), this should be stated in how the goal is written (e.g., patient will show improvement according to the ____ assessment).*

If the patient is receiving ABA therapy services primarily to address reduction of challenging behaviors, this section may be marked NA and the Positive Behavior Support Plan should be outlined in Appendix B.

DOMAIN: Social Communication

Goal 1:	
	Baseline:
	Treatment Approaches to be Used:
	Progress:
Objective 1A	
	Baseline:
	Progress:

Goal 2:	
	Baseline:
	Treatment Approaches to be Used:
	Progress:
Objective 2A	
	Baseline:
	Progress:

DOMAIN: Adaptive

Goal 1:	
	Baseline:
	Treatment Approaches to be Used:
	Progress:
Objective 1A	
	Baseline:
	Progress:
Goal 2:	
	Baseline:
	Treatment Approaches to be Used:
	Progress:
Objective 2A	
	Baseline:
	Progress:

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DOMAIN: Motor

Goal 1:	
	Baseline:
	Treatment Approaches to be Used:
	Progress:
Objective 1A	
	Baseline:
	Progress:
Goal 2:	
	Baseline:
	Treatment Approaches to be Used:
	Progress:
Objective 2A	
	Baseline:
	Progress:

DOMAIN: Vocational

Goal 1:	
	Baseline:
	Treatment Approaches to be Used:
	Progress:
Objective 1A	
	Baseline:
	Progress:

Goal 2:	
	Baseline:
	Treatment Approaches to be Used:
	Progress:
Objective 2A	
	Baseline:
	Progress:

DOMAIN: Cognitive

Goal 1:	
	Baseline:
	Treatment Approaches to be Used:
	Progress:
Objective 1A	
	Baseline:
	Progress:
Goal 2:	
	Baseline:
	Treatment Approaches to be Used:
	Progress:
Objective 2A	
	Baseline:
	Progress:

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Appendix B: Positive Behavior Support Plan

Positive Behavior Support (PBS) Plan for Reducing Challenging Behaviors: *Should follow from functional assessment/analysis results discussed above and include, 1)operational definitions of behaviors, 2) a brief statement of identified functions of behavior, 3) suggested parent/caregiver/staff response to behaviors when they occur, 4) recommended antecedent interventions to prevent behaviors, 5) plan for teaching replacement behaviors with clear goals, 6) statement about how the proposed interventions were derived from the functional assessment/analysis, 7) plan for coordinating PBS Plan across settings.*

If the patient has minimal challenging behaviors and the primary focus of their ABA treatment plan is on skill acquisition, this section may be marked NA and the skill acquisition goals should be outlined in Appendix A.

DOMAIN: Behavior

Goal 1:	
	Baseline:
	Treatment Approaches to be Used:
	Progress:
Objective 1A	
	Baseline:
	Progress:
Goal 2:	
	Baseline:
	Treatment Approaches to be Used:
	Progress:
Objective 2A	
	Baseline:
	Progress:

Appendix C: Parent/Caregiver Training Goals

This section should address caregiver goals for skill acquisition (e.g., parents will learn to implement the PBS Plan). It should include clear goals and objectives, written in the same format as the patient's skill acquisition goals.

All children should have parent/caregiver training goals in their treatment plan, regardless of the nature of the child's goals/objectives. If the treatment plan is for an adult or an individual living in a group setting, this portion of the plan should focus on training caregivers. This section may not be marked NA.

Goal 1:	
	Baseline:
	Treatment Approaches to be Used:
	Progress:
Objective 1A	
	Baseline:
	Progress:
Goal 2:	
	Baseline:
	Treatment Approaches to be Used:
	Progress:
Objective 2A	
	Baseline:
	Progress:

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Appendix D: Maintenance/Generalization/Discharge Plan

This section should include a statement about how maintenance and generalization will be addressed, how services will be faded and/or how the patient will be transitioned into other less intensive services (e.g., school, outpatient, etc.). This should be more specific as the patient progresses in therapy. The fading plan should be specific, data driven, and include criterion for discharge.

Statement about how maintenance and generalization will be addressed, etc.

DOMAIN: Social Communication

Goal 1:	
	Criterion for Discharge:
	Referral Program:
Objective 1A	
	Criterion for Discharge:
	Referral Program:
Goal 2:	
	Criterion for Discharge:
	Referral Program:
Objective 2A	
	Criterion for Discharge:
	Referral Program:

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DOMAIN: Adaptive

Goal 1:	
	Criterion for Discharge:
	Referral Program:
Objective 1A	
	Criterion for Discharge:
	Referral Program:
Goal 2:	
	Criterion for Discharge:
	Referral Program:
Objective 2A	
	Criterion for Discharge:
	Referral Program:

DOMAIN: Motor

Goal 1:	
	Criterion for Discharge:
	Referral Program:
Objective 1A	
	Criterion for Discharge:
	Referral Program:

Goal 2:	
	Criterion for Discharge:
	Referral Program:
Objective 2A	
	Criterion for Discharge:
	Referral Program:

DOMAIN: Vocational

Goal 1:	
	Criterion for Discharge:
	Referral Program:
Objective 1A	
	Criterion for Discharge:
	Referral Program:
Goal 2:	
	Criterion for Discharge:
	Referral Program:
Objective 2A	
	Criterion for Discharge:
	Referral Program:

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DOMAIN: Cognitive

Goal 1:	
	Criterion for Discharge:
	Referral Program:
Objective 1A	
	Criterion for Discharge:
	Referral Program:
Goal 2:	
	Criterion for Discharge:
	Referral Program:
Objective 2A	
	Criterion for Discharge:
	Referral Program:

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ASD DOCUMENTATION REQUIREMENTS

Documentation of the diagnosis of an Autism Spectrum Disorder will be based on criteria defined by the most current DSM version (such as DSM-5 299.00). The diagnosis must be made by a neurologist, pediatric neurologist, developmental pediatrician, psychiatrist, or doctorate level psychologist for an Autism Spectrum Disorder (ASD).

For a diagnosis to be accepted there must be:

- Documentation of the confirmed presence of the core symptoms of autism: communication, behavioral, and social impairments; AND
- Documentation of the tool **and/or** observations used to make/confirm the diagnosis.

To determine eligibility for services, there must be a report documenting a diagnostic assessment, comprehensive evaluation, and treatment plan with recommendations. The report must include these elements:

Specific to Diagnostic Assessment & Comprehensive Evaluation Report (cannot be more than a year old)
For children who are current patients, it is acceptable to send the initial evaluation, most current notes or recent evaluation, as well as a letter certifying the diagnosis and providing any other required elements below that are not in other documentation being submitted. The letter should serve as an addendum and refer to the documentation being submitted, rather than reiterate this content. The following documentation is required:

a. Documentation of routine developmental surveillance performed by providers at well child visits; Examples of source documentation are: IEP, primary care practitioner or health care provider who referred the child, e.g. Occupational therapist, etc. if available;

b. Audiology and vision assessment results if available; or that vision and hearing were determined to be within normal limits during assessment and not a barrier to completing a valid evaluation;

c. If applicable, name of screening questionnaire, date completed, and significant results;

d. If applicable, documentation of formal diagnostic procedures performed by an experienced clinician, including name of measure, date and results, including scores. Examples of diagnostic measures are:
    - Autism Diagnostic Observation Schedule (ADOS);
    - Autism Diagnostic Interview (ADI);

e. Documentation of formal cognitive and/or developmental assessment performed by a qualified clinician, including name of measure, dates, results, and standardized scores providing verbal, nonverbal, and full scale scores, as available. Examples are:
    - Mullen;
    - Weschler; or
    - Bayley;

01/22/2014

f. Documentation of formal adaptive behavior assessment performed by a qualified clinician, including name of measure, dates, results, and standardized scores providing scores for each domain as available. Examples are:

- Vineland Adaptive Behavior Scales; or
- Adaptive Behavior Assessment System (ABAS);

e. Documentation of the observed or family reported behaviors having an adverse impact on development, communication and of the injurious behavior, as applicable;

f. Expanded laboratory evaluation, if clinically indicated;

g. Documentation of less intrusive or less intensive behavioral interventions have been tried and not been successful; **OR** that there is no equally effective and substantially less costly alternative available for reducing interfering behaviors, increasing pro-social behaviors, or maintaining desired behaviors, if ABA is included on the treatment plan;

Specific to Treatment Plan with Recommendations:
(If child not a new patient, can be in prescription.)

A multi-disciplinary Individualized Treatment Plan (ITP) with recommendations that consider the full range of autism treatments with ABA as one treatment component, if clinically indicated;

The Prescription must include these elements:

a. The order or prescription for ABA for the child, without specifying hours or how services are to be provided;

b. Documentation that the child's behaviors are having an adverse impact on development and/or communication, and/or demonstrating injurious behavior, such that

- The child cannot adequately participate in home, school, or community activities because behavior interferes; OR
- The child presents a safety risk to self or others;

c. A statement that the requested ABA services will result in measurable improvement in the child's behavior and/or skills.

Regence

Regence BlueShield serves select counties in the state of Washington and is an Independent Licensee of the Blue Cross and Blue Shield Association

Pre-authorization Request Form
Behavioral Health
Fax: 1 (888) 496-1540
Mail to: PO Box 1271, WW5-53
Portland, OR 97207-1271

Instructions: This form should be completed and filled out by the requesting provider. Prior to completing this form, please confirm the patient's benefits, eligibility and whether pre-authorization is required.

Is this for a Medicare Preservice Benefit Organization Determination Request? ☐ Yes ☐ No

Expedited request. I attest that this request meets the definition indicated below by checking the expedited request box. ☐ Fax to 1 (855) 240-6498.

Expedited is defined as: When the member or his/her provider believes that waiting for a decision within the standard timeframe could place the member's life, health or ability to regain maximum function in serious jeopardy.

SECTION 1 – PATIENT INFORMATION

Patient Name (Last)	First	MI	Patient's Phone #

Patient's Regence Member ID #	Group #	Date of Birth

SECTION 2 – PROVIDER INFORMATION

Please check one: ☐ Requesting/Prescribing Provider ☐ Rendering/Treating Provider

Provider Name		Tax ID #	
NPI #	Office Phone #	Confidential Voice Mail ☐ Yes ☐ No	Fax #
Mailing Address		City	State / ZIP Code
Provider Specialty		Email Address	

Who should we contact if we require additional information?

Name	Phone # Ext.	Confidential Voice Mail ☐ Yes ☐ No	Fax #

If a physician reviewer needs a peer to peer discussion before a determination, please provide the treating provider's direct phone number and availability for the next 3 to 5 days.

Phone #: Ext:	Date: Time:	Date: Time:	Date: Time:

Facility Name		Tax ID #	NPI #
Mailing Address		Fax #	
City	State / ZIP Code	Phone # Ext.	Confidential Voice Mail ☐ Yes ☐ No
Facility Type: ☐ Freestanding ☐ Acute		Email Address	

SECTION 3 – PREAUTHORIZATION REQUEST

Date of Services/Anticipated Admission _____

Substance Use Disorders: ASAM Level of Care Requested: ☐ 2.0/2.1 ☐ 2.5 ☐ 3.5 ☐ 3.7 ☐ 4.0

Mental Health Care Requested:

☐ Inpatient ☐ Residential Treatment ☐ Partial Hospitalization
☐ Intensive Outpatient ☐ Other, please specify _____

Note: This form does not serve as a notification of admission. Please reference our provider website for instructions about how to notify us of an admission.

Please provide all diagnosis, CPT or HCPCS codes and their descriptions.

Diagnosis code(s) and description(s)	CPT or HCPCS code(s) and description(s)
Primary:	
Second:	
Third:	

SECTION 4 – DOCUMENTATION SUBMISSION

Please submit the following documentation, as appropriate for this request:

Psychiatric or substance use disorder evaluation or intake assessment including:

- Family history
- Medical, psychiatric and substance use history
- Mental status exam
- Personal and social history (psychosocial)
- History of current complaint/clinical status
- Member's current complaint/clinical status

History and physical/nursing assessment (if available) including:

- Current vitals
- Current medical concerns/risks

Substance use disorders only:

- Clinical Institute Withdrawal Assessment (CIWA) or
- Clinical Opiate Withdrawal Scale (COWS) score or
- Description of active withdrawal symptoms

Any other supporting documents you would like considered, such as letters from outpatient providers, etc.

SAMPLE COVER LETTER

CHILD was formally evaluated on DATE at SITE OF EXAM by PROVIDER. CHILD demonstrated impairments in social interaction, social communication and atypical behavior consistent with an Autism Spectrum Disorder. CHILD's behaviors and/or impairments are having an adverse impact on development and/or communication as documented on DATE by the presence of severe behaviors and/or functional impairments that interfere with CHILD's ability to participate adequately in their home, school or community environments and/or the health and safety of CHILD or others are at significant safety risk. Please see the attached report/COE report/treatment plan and DSM-IV-TR checklist for details.

Applied behavioral analysis services are recommended given the adverse impact of CHILD's behaviors and/or core impairments. CHOOSE HERE [Less intensive behavioral treatment or other therapy has been tried and not been successful, or it is not accessible, or there is no equally effective alternative available for reducing severe interfering or disruptive behaviors, increasing pro-social behaviors, or achieving desired behaviors]; and Applied Behavioral analysis services are reasonably expected to result in a measureable improvement in CHILD's skills and behaviors.

Effective November 21, 2016

Uniform Medical Plan ABA Therapy Clinical Considerations

ABA Therapy hours of service should reflect the number of and type of behavioral targets and key functional skills to be addressed and include a clinical summary justifying the hours requested for each behavioral target. The total hours of ABA Therapy requested should be comprised of fewer than 40 hours per week.

Any requests for greater than 40 hours per week should show documentation as to why more than 40 hours of therapy is medically necessary.

ABA therapy documentation should show the following:

- The client‘s response to ABA therapy services and progress being made
- Meaningful, measurable, and functional improvement, changes, or progress
    - Meaningful changes should be demonstrated by:
        - Data confirming the changes or progress
        - Documentation in charts and graphs
        - Durability over time beyond the end of the actual treatment session
        - Generalizable outside the treatment setting to the client’s residence or the community within which the client resides
- Compliance with treatment plan, including keeping appointments, attending and participating in treatment and family training sessions, completion of homework assignments, and family application of training techniques as directed by the therapy assistant or LBAT.

Important upcoming pre-authorization changes

- Pharmacy: Infusion Drug Site of Care - effective January 1, 2020
- Physical Medicine
    - Physical therapy, speech therapy, occupational therapy (PT/OT/ST) - effective March 1, 2020
        - PEBB: UMP Classic, UMP CDHP and UMP Plus - Limit 60 annual visits
        - SEBB: UMP Achieve 1, UMP Achieve 2, UMP High Deductible - Limit 80 annual visits
        - SEBB: UMP Plus - Limit 60 annual visits
    - Pain management - effective January 1, 2020
    - Joint management - effective January 1, 2020
    - Spine - effective January 1, 2020
- Radiology - effective January 1, 2020
- Sleep Medicine - effective January 1, 2020

Pharmacy

UMP has a separate vendor – Washington State Rx Services – for their prescription drug benefit. Pre-authorization is necessary for certain injectable drugs that are not normally approved for self-administration when obtained through a retail pharmacy, a network mail-order pharmacy, or a network specialty pharmacy. These drugs are indicated on the UMP Preferred Drug List.

Drugs usually payable under the member's medical benefit and pre-authorized will continue with the same Regence process.

Infusion Drug Site of Care

Effective January 1, 2020: Certain provider administered infusion medications covered on the medical benefit are subject to the Site of Care Program (dru408) medication policy (PDF). This policy does not apply to members covered under UMP Plus plans.

Physical Medicine

We partner with eviCore healthcare to administer our Physical Medicine program.

Providers obtain or verify an authorization with eviCore:

1. Sign in to eviCore's portal
2. Phone (855) 252-1115
3. Fax (855) 774-1319

If HTCC criteria is used for authorization – see below for links to that criteria

Effective March 1, 2020: Physical therapy, speech therapy, occupational therapy (PT/ST/OT)

- Members aged 17 and younger: Select pediatric diagnosis codes are excluded from the program (PDF).
- **We require authorization from eviCore for these codes: 92507, 92508, 92521, 92522, 92523, 92524, 92526, 92597, 92607, 92608, 92609, 92610, 92626, 92627, 92630, 92633, 95831, 95832, 95833, 95834, 95851, 95852, 96105, 97012, 97014, 97016, 97018, 97022, 97024, 97026, 97028, 97032, 97033, 97034, 97035, 97036, 97039, 97110, 97112, 97113, 97116, 97127, 97139, 97150, 97161, 97162, 97163, 97164, 97165, 97166, 97167, 97168, 97530, 97533, 97542, 97750, 97755, 97760, 97761, 97763, 97799, G0151, G0152, G0157, G0158, G0159, G0160, G0283, G0515, S8950, S9128, S9129, S9131, S9152**

Effective March 1, 2020: HTCC decisions administered by eviCore related to physical therapy, speech therapy, occupational therapy

- **Treatment of chronic migraine and chronic tension-type headache**
    - **UMP is subject to HTCC Decision (PDF): 97140**

Effective January 1, 2020: Pain management

- **We require authorization from eviCore for these codes: 00640, 27096, 61790, 61791, 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327, 62350, 62351, 62360, 62361, 62362, 64405, 64510, 64520, 72275, G0259, G0260**

Effective January 1, 2020: HTCC decisions administered by eviCore related to pain management

- **Discography**
  - **UMP is subject to HTCC Decision (PDF): 62290, 62291, 72285, 72295**
- **Facet Neurotomy**
  - **UMP is subject to HTCC Decision (PDF): 64633, 64634, 64635, 64636**
- **Spinal Injections**
  - **UMP is subject to HTCC Decision (PDF): 62320, 62321, 62322, 62323, 64479, 64480, 64483, 64484, 64490, 64491, 64492, 64493, 64494, 64495**
  - **This coverage policy does not apply to those with systemic inflammatory disease such as ankylosing spondylitis, psoriatic arthritis or enteropathic arthritis**

Effective January 1, 2020: Joint management

- **We require authorization from eviCore for these codes: 23470, 23472, 23473, 23474, 27125, 27130, 27132, 27134, 27137, 27138, 27442, 27443, 27486, 27487, 27488, 27580, 29805, 29806, 29807, 29819, 29820, 29821, 29822, 29823, 29824, 29825, 29826, 29827, 29828, 29860, 29861, 29862, 29863, 29868, 29870, 29871, 29873, 29875, 29876, 29879, 29880, 29881, 29882, 29883, 29884, 29885, 29886, 29887, 29888, 29889, 29891, 29892, 29893, 29894, 29895, 29897, 29898, 29899, 29904, 29905, 29906, 29907**

Effective January 1, 2020: HTCC decisions administered by eviCore related to joint management

- **Hip Surgery for Femoroacetabular Impingement Syndrome (FAI)**
  - **UMP is subject to HTCC Decision (PDF): 29914, 29915, 29916**
- **Knee Arthroscopy for Osteoarthritis of the Knee**
  - **UMP is subject to HTCC Decision (PDF): 29874, 29877**
- **Total Knee Arthroplasty**
  - **UMP is subject to HTCC Decision (PDF): 27437, 27438, 27440, 27441, 27445, 27446, 27447**

Effective January 1, 2020: Spine

- **We require authorization from eviCore for these codes: 20931, 20937, 20938, 22100, 22101, 22102, 22103, 22110, 22112, 22114, 22116,**

22206, 22207, 22208, 22210, 22212, 22214, 22216, 22220, 22222, 22224, 22226, 22325, 22326, 22327, 22328, 22532, 22534, 22548, 22556, 22585, 22590, 22595, 22600, 22610, 22614, 22632, , 22634, 22800, 22802, 22804, 22808, 22810, 22812, 22818, 22819, 22830, 22840, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 22850, 22852, 22855, 62380, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63040, 63043, 63045, 63046, 63050, 63051, 63055, 63064, 63066, 63075, 63076, 63077, 63078, 63081, 63082, 63085, 63086, 63087, 63088, 63101, 63102, 63103, 63170, 63172, 63173, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 63200, 63250, 63251, 63252, 63265, 63266, 63267, 63268, 63270, 63271, 63272, 63273, 63275, 63276, 63277, 63278, 63280, 63281, 63282, 63283, 63285, 63286, 63287, 63290, 63295, 63300, 63301, 63302, 63303, 63304, 63305, 63306, 63307, 63308, S2350, S2351

Effective January 1, 2020: HTCC decisions administered by eviCore related to spine

- **Cervical Fusion for Degenerative Disc Disease**
  - **UMP is subject to HTCC Decision (PDF): 22551, 22552, 22554, 22853, 22854, 22859, 22600**
- **Lumbar Fusion for Degenerative Disc Disease**
  - **UMP is subject to HTCC Decision (PDF): 22533, 22558, 22612, 22630, 22633, 22853, 22854, 22859**
  - **Lumbar Fusion for degenerative disc disease uncomplicated by comorbidities is not a covered benefit per HTCC Decision**
  - **Note: This decision does not apply to patients with the following conditions: radiculopathy, spondylolisthesis (>grade 1), severe spinal stenosis, acute trauma or systemic disease affecting spine, e.g., malignancy**
  - **UMP is subject to HTCC Decision (PDF) for Bone Morphogenic Protein: 22533, 22558, 22612, 22630, 22633**
  - **Bone morphogenetic protein-7 (rhBMP-7) is not a covered benefit**
  - **HTCC for bone morphogenetic protein does not apply to those under age 18**
- **Surgery for Lumbar Radiculopathy**
  - **UMP is subject to HTCC Decision (PDF): 62380, 63030, 63035, 63042, 63044, 63047, 63048, 63056, 63057, 63090, 63091**

Radiology

AIM Specialty Health

We partner with AIM to administer our Advanced Imaging Authorization radiology program. Providers:

- Login to AIM's ProviderPortal
- Phone 1 (877) 291-0509

NOTE: If HTCC criteria is used for pre-authorization, see below for links to that criteria. If there are no HTCC criteria, AIM criteria will apply.

Effective January 1, 2020: Contact AIM to obtain an order number for the following codes: 70336, 70480, 70481, 70482, 70490, 70491, 70492, 70496, 70498, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 71250, 71260, 71270, 71275, 71550, 71551, 71552, 71555, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72141, 72142, 72146, 72147, 72148, 72149, 72156, 72157, 72158, 72159, 72191, 72192, 72193, 72194, 72195, 72196, 72197, 72198, 73200, 73201, 73202, 73206, 73218, 73219, 73220, 73221, 73222, 73223, 73225, 73700, 73701, 73702, 73706, 73718, 73719, 73720, 73721, 73722, 73723, 73725, 74150, 74160, 74170, 74174, 74175, 74176, 74177, 74178, 74181, 74182, 74183, 74185, 74712, 75557, 75559, 75561, 75563, 75572, 75573, 75635, 77078, 77084, 78472, 78473, 78481, 78483, 78494, 93303, 93304, 93306, 93307, 93308, 93312, 93313, 93314, 93315, 93316, 93317, 93350, 93351, G0297, 0501T, 0502T, 0503T, 0504T

Effective January 1, 2020: HTCC decisions administered by AIM

- **Breast MRI**
  - **UMP is subject to HTCC Decision (PDF): 77046, 77047, 77048, 77049**
  - **HTCC criteria applies to all member requests regardless of gender**
- **Cardiac Nuclear Imagining**
  - **UMP is subject to HTCC Decision (PDF): 78451, 78452, 78453, 78454, 78459, 78466, 78468, 78469, 78491, 78492**
- **Coronary Computed Tomographic Angiography (CTA)**
  - **UMP is subject to HTCC Decision (PDF): 75574**
- **Functional Neuroimaging for Primary Degenerative Dementia or Mild Cognitive Impairment**
  - **UMP is subject to HTCC Decision (PDF): 70554, 70555, 78608, 78609**

    - **Please see AIM criteria for pre-authorization requirements for indications other than primary degenerative dementia or mild cognitive impairment**
- **Imaging for Rhinosinusitis**
    - **UMP is subject to HTCC Decision (PDF): 70450, 70460, 70470, 70486, 70487, 70488, 70540, 70542, 70543**
    - **Please see AIM criteria for pre-authorization requirements for indications other than Rhinosinusitis**
- **Positron Emission Tomography (PET) Scans for Lymphoma**
    - **UMP is subject to HTCC Decision (PDF): 78811, 78812, 78813, 78814, 78815, 78816**

Sleep Medicine

We partner with AIM to administer our Sleep Medicine program. Providers:

- Login to AIM's ProviderPortal
- Phone 1 (877) 291-0509

Effective January 1, 2020: contact AIM to obtain an order number for the following codes: 95782, 95783, 95805, E0470, E0471

AIM uses HTCC to pre-authorize sleep medicine diagnosis and equipment. Also refer to the Surgery section for additional information about Sleep Apnea Diagnosis and Treatment.

Effective January 1, 2020: HTCC decisions administered by AIM:

- **Sleep Apnea – Diagnosis and Equipment**
    - **UMP is subject to HTCC Decisions (PDF): 95800, 95801, 95806, 95807, 95808, 95810, 95811, E0561, E0562, E0601, G0398, G0399, G0400**
    - Please see AIM criteria for indications other than Sleep Apnea

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Medication Policy Manual

Policy No: dru408

Topic: Site of Care Review

Date of Origin: July 10, 2015

Committee Approval Date: July 24, 2019

Next Review Date: July 2020

Effective Date: October 1, 2019

Description

This policy is to review the requested site of care (SOC) for provider-administered medications. Many medications historically infused in hospital-based infusion centers have been evaluated and determined to be safe for infusion outside of hospital-based settings. Use of non-hospital-based infusion centers and home infusion services is an accepted standard medical practice and sometimes referred to as an "alternate site of care." These settings offer high-quality services for patients and reduce the overall cost of care, as compared to costly hospital-based infusion centers.

This policy applies to fully-insured commercial plans, exchange plans, and select self-insured groups [a.k.a. administrative-services only (ASO)] based in Washington, Oregon, Idaho, and Utah. This policy does **not** apply to Medicare plans.

IMPORTANT REMINDER

This Medication Policy has been developed through consideration of medical necessity, generally accepted standards of medical practice, and review of medical literature and government approval status.

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

Description

The purpose of medication policy is to provide a guide to coverage. Medication Policy is not intended to dictate to providers how to practice medicine. Providers are expected to exercise their medical judgment in providing the most appropriate care.

Policy/Criteria

I. Under most contracts, medications included in the infusion drug site of care program (see *Appendix 1*) may be considered medically necessary when individual medication policy criteria are met **AND** one of the following criteria (A. or B.) below are met**:**

A. The medication is administered in an approved site of care. (No formal "Site of Care" review is required)

OR

B. The medication is administered in an unapproved site of care (see Appendix 2), such as an unapproved hospital-based infusion center, when at least one of the criteria below (1. or 2.) are met:

NOTE: Site of care review criteria will be waived for payment of the first dose of a medication, to allow for adequate transition time to an approved site of care for subsequent infusions.

1. There is no nearby approved site of care **AND** home infusion is not an option, as documented by criteria a. **AND** b. being met:

a. All approved sites of care are greater than 10 miles further from the member's home than from the unapproved site of care, such as an unapproved hospital-based infusion center (example: the member's house is 41 miles from an approved site of care, but 30 miles to the unapproved site of care).

AND

b. The member's home is not eligible for home infusion services for reasons including, but not limited to: the home is not within the service area of the home infusion provider or is deemed unsuitable for care by the home infusion provider, unless the medication is not eligible for home infusion services (see *Appendix 1*)

OR

2. Clinical documentation of at least one medical reason why an approved site of care is not an option, including, but not limited to:

i. The member is 13 years of age or younger.

ii. Significant behavioral issues and/or cognitive impairment including, but not limited to, those associated with developmental delay, down syndrome, dementia, or excessive anxiety such as severe needle phobia.

iii. Prior severe infusion reactions, despite standard pre-medications.

iv. Presence of circulating antibodies which may increase risk of infusion reactions.

v. Treatment within 100 days after hematopoietic stem cell transplantation (HSCT, a.k.a. bone marrow transplant).

vi. Concurrent treatment with medications that require a higher level of monitoring (such as CAR T-cell therapy, intravenous cytotoxic chemotherapy, or blood products).
vii. Treatment of antibody-mediated rejection (a.k.a. vascular rejection, acute humoral rejection) following a solid organ transplant.
viii. Treatment of Kawasaki disease.

II. Limitations and Authorization Period – Authorization **shall** be reviewed at least annually to confirm that current medical necessity criteria are met, including that an approved site of care is still not a treatment option.

III. The medications in the infusion drug site of care program are considered not medically necessary if administered in an unapproved site of care, such as an unapproved hospital-based infusion center, when an approved site of care is a treatment option.

Position Statement

- New technologies and pharmaceuticals allow therapeutic services, such as infusion therapy, to be administered safely, effectively, and much less costly outside of hospital-based infusion centers (a.k.a. hospital outpatient settings). Sites of care such as doctor's offices, infusion centers, home infusion, and approved hospital-based infusion centers are well-established, accepted by physicians, and provide the best value to patients to reduce the overall cost of care.

Site of Care Review:

- Use of non-hospital-based infusion centers and home infusion services is an accepted standard medical practice. These sites offer high-quality services for patients and reduce the overall cost of care, as compared to costly hospital-based infusion centers. [1-8]
- All medications infused outside of a hospital setting have undergone an evaluation for safe infusion and development of infusion standards, including adverse drug reaction management and reporting algorithms.
- At all sites of care, every patient undergoes an assessment during the intake process by the infusion provider, which includes evaluation of individual clinical assessment parameters. These parameters may include, but are not limited to, previous tolerance of products (such as IVIG), assessment of kidney function, risk factors for developing thromboembolic events, and venous access. [9-10]
- For use of home infusion services, an assessment is conducted to determine if the home is a safe, appropriate site of care, with adequate support for infusion in the home.
- Because providers need time to arrange for assessment and coordination of care, the first dose of provider-administered medications may be covered in a hospital-based infusion center, if needed, to allow adequate time for a seamless transition of care. This may include arranging for delivery of medications and/or patient education, such as for self-administration of medications such as subcutaneous immune globulin (SCIG).

- Claims submitted for infusion services performed at an unapproved site of care, such as an unapproved hospital-based infusion center (such as on campus or off campus hospital outpatient settings, denoted by place of service codes 22 or 19; see *Appendix 3*), are considered not medically necessary when an approved site of care is a treatment option.
- Pediatric patients often differ from adult patients in physiology, development, and cognitive and emotional function. They may also require doses, infusion rates, and equipment that vary and differ compared to adult patients. Special infusion training and expertise is needed. Therefore, this policy allows for patients aged 13 years and younger to obtain infusion services in approved sites of care or unapproved sites of care, such as unapproved hospital-based infusion centers.

Appendix 1: Medications Included in the Infusion Drug Site of Care Program

Medication [a]	Effective Date	Policy Number	Home infusion eligible [b]	HCPCS Code
Actemra, tocilizumab [a]	3/1/2015	dru444	Yes	J3262
Adagen, pegademase bovine	4/1/2016	dru426	Yes	J2504
Aldurazyme, laronidase	4/1/2016	dru426	Yes	J1931
Benlysta, belimumab	9/1/2015	dru248	Yes	J0490
Cerezyme, imiglucerase	4/1/2017	dru002	Yes	J1786
Cimzia, certolizumab pegol [a]	3/1/2018	dru444	Yes	J0717
Crysvita, burosumab	11/1/2019	dru547	Yes	J0584
Elaprase, idursulfase	4/1/2017	dru426	Yes	J1743
Elelyso, taliglucerase alfa	9/1/2018	dru002	Yes	J3060
Entyvio, vedolizumab	3/1/2015	dru444	Yes	J3380
Evenity, romosozumab	10/1/2019	dru594	Yes	J3590
Fabrazyme, agalsidase beta	7/1/2015	dru575	Yes	J0180
Inflectra, infliximab-dyyb	1/1/2017	dru444	Yes	Q5103
Immune globulin	3/1/2015	dru020	Yes	J1459, J1555, J1556, J1557, J1559, J1561, J1566, J1568, J1569, J1572, J1575, J1599
Ixifi, infliximab-qbtx	10/1/2018	dru444	Yes	Q5109
Kanuma, sebelipase alfa	6/10/2016	dru426	Yes	J2840
Lumizyme, alglucosidase alfa	7/1/2015	dru426	Yes	J0221
Myozyme, alglucosidase alfa	7/1/2015	dru426	Yes	J0220
Naglazyme, galsulfase	4/1/2016	dru426	Yes	J1458
Ocrevus, ocrelizumab	9/1/2018	dru479	Yes	J2350
Onpattro, patisiran	4/1/2019	dru577	Yes	C9036
Orencia, abatacept [a]	3/1/2015	dru444	Yes	J0129
Prolia, denosumab	7/1/2015	dru223	Yes	J0897
Radicava, edaravone	8/11/2017	dru510	Yes	J1301
Remicade, infliximab	3/1/2015	dru444	Yes	J1745
Renflexis, infliximab-abda	8/11/2017	dru444	Yes	Q5104
Revcovi, elapegademase	4/1/2019	dru426	Yes	J3590
Simponi Aria, golimumab [a]	3/1/2015	dru444	Yes	J1602
Soliris, eculizumab	5/1/2015	dru385	Yes	J1300
Trogarzo, ibalizumab-uiyk	6/1/2018	dru542	Yes	J1746

Medication [a]	Effective Date	Policy Number	Home infusion eligible [b]	HCPCS Code
Tysabri, natalizumab	5/1/2015	dru111	No	J2323
Ultomiris, ravulizumab	7/1/2019	dru385	Yes	J3590
Vimizim, elosulfase alfa	4/1/2016	dru426	Yes	J1322
VPRIV, velaglucerase alfa	4/1/2017	dru002	Yes	J3385

[a] This policy only applies to the formulations of these medications covered under the medical benefit. Formulations for self-administration may be available through the pharmacy benefit for most members.

[b] As of the date of the policy publication

Appendix 2: Glossary	
Term	**Description**
Approved site of care	Location where medications are safely and effectively administered by a health care professional. Approved sites of care include: • Doctor's offices • Standalone ambulatory infusion centers • Home infusion • Approved hospital-based infusion centers
Unapproved site of care	Location where medications are administered by a professional and the facility is reimbursed for the medication and services at a much higher rate than approved sites of care. Unapproved sites of care include: • Unapproved hospital-based infusion centers

Appendix 3: Place of Service Codes and Descriptions [11]		
Place of Service Code	**Place of Service Name**	**Description**
11	Office	Location, other than a hospital, skilled nursing facility (SNF), military treatment facility, community health center, State or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.
12	Home	Location, other than a hospital or other facility, where the patient receives care in a private residence.
19	Off Campus-Outpatient Hospital	A portion of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.
22	On Campus-Outpatient Hospital	A portion of a hospital's main campus which provides diagnostic, therapeutic (both surgical and nonsurgical), and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization.

References

1. Home Infusion Therapy, CMT: CMT-0009(SR). MCG Care Guidelines, 20th edition, 2016.
2. ASHP Guidelines on Home Infusion Pharmacy Services, 2013. http://www.ashp.org/doclibrary/bestpractices/settingsgdlhomeinfusion.aspx.
3. Polinski JM, Kowal MK, Gagnon M, et al. Home infusion: safe clinically effective, patient preferred, and cost saving. Healthcare. 2016.
4. Condino AA, Fidanza S, Hoffenberg EJ. A home infliximab infusion program. J Pediatr Gastroenterol Nutr. 2005 Jan;40(1):67-9. PMID: 15625429
5. Ducharme J, Pelletier C, Zacharias R. The safety of infliximab infusions in the community setting. Can J Gastroenterol. 2010 May;24(5):307-11. PMID: 20485705
6. Foley JF, Dunne AM. Successful management of a neurology infusion practice. Int J MS Care. 2011 Summer;13(2):95-104. PMID: 24453711
7. Ratko TA, Marbella A, Godfrey S, Aronson N. Enzyme-Replacement Therapies for Lysosomal Storage Diseases. Agency for Healthcare Research and Quality Comparative Effectiveness Technical Briefs. 2013 Jan. Report No. 12(13)-EHC154-EF. PMID: 23390670
8. Scarpa M, Alamássy Z, Beck M, et al. Mucopolysaccharidosis type II: European recommendations for the diagnosis and multidisciplinary management of a rare disease. Orphanet J Rare Dis. 2011 Nov 7;6:72. PMID: 22059643
9. American Academy of Allergy Asthma and Immunology. Guidelines for the site of care for administration of IGIV therapy. 2011 Dec.
10. Souayah N, Hasan A, Khan HM, et al. The safety profile of home infusion of intravenous immunoglobulin in patients with neuroimmunologic disorders. J Clin Neuromuscul Dis. 2011 Jun;12 Suppl 4:S1-10. PMID: 22361589
11. Centers for Medicare & Medicaid Services Place of Service Code Set. https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

Revision History

Revision Date	Revision Summary
7/24/2019	• Added Crysvita (burosumab) and Evenity (romosozumab) to the policy.
4/25/2019	• Added Revcovi (elapegademase) and Ultomiris (ravulizumab) to the policy.
1/31/2019	• Added Onpattro (patisiran) to the policy, effective 4/1/2019. • Updated Appendix 1 HCPCS codes.
8/17/2018	• No criteria changes on this annual review.
6/15/2018	• Clarify home infusion criteria I.B.1.b only applies to medications eligible for home infusion. • Updated Appendix 1, to include home infusion eligibility.
5/18/2018	• No change to intent of coverage criteria. Clarification of description, policy language, and addition of applicable J-codes. Defined approved and unapproved sites of care. • Added the following medications to the policy: o Effective 6/1/2018: Trogarzo (ibalizumab-uiyk) o Effective 9/1/2018: Elelyso (taliglucerase alfa), Ocrevus (ocrelizumab) o Effective 10/1/2018: Ixifi (infliximab-qbtx) • Clarified medical exception criteria for concurrent cancer immunotherapy, including CAR T-cell therapy, and age less than 13 years old.
8/11/2017	Updated Appendix 1.
1/17/2017	Removed Lemtrada and Exondys from site of care program
12/16/2016	Updated Appendix 1.
11/11/2016	Updated Appendix 1.
9/23/2016	Updated Appendix 1.
9/9/2016	Select Utah plans are now included in the site of care review.
7/15/2016	Updated formatting of policy, added additional medical rationale for potential waivers to policy, noted distinction between approved and unapproved hospital outpatient settings, clarified affected members, and updated references.

Drug names identified in this policy are the trademarks of their respective owners.

Code	Description	Code	Description
E75.24	Niemann-Pick disease	G82.51	Quadriplegia, C1-C4 complete
E75.240	Niemann-Pick disease type A	G91.0	Communicating hydrocephalus
E75.241	Niemann-Pick disease type B	G91.1	Obstructive hydrocephalus
E75.242	Niemann-Pick disease type C	G91.3	Post-traumatic hydrocephalus, unspecified
E75.243	Niemann-Pick disease type D	G91.4	Hydrocephalus in diseases classified elsewhere
E75.248	Other Niemann-Pick disease	G91.8	Other hydrocephalus
E75.249	Niemann-Pick disease, unspecified	G91.9	Hydrocephalus, unspecified
E75.3	Sphingolipidosis, unspecified	G93.1	Anoxic brain damage, not elsewhere classified
E75.5	Other lipid storage disorders	G93.40	Encephalopathy, unspecified
E75.6	Lipid storage disorder, unspecified	G93.5	Compression of brain
E76	Disorders of glycosaminoglycan metabolism	G93.6	Cerebral edema
E76.0	Mucopolysaccharidosis, Type I	G93.7	Reye's syndrome
E76.01	Hurler's syndrome	G93.89	Other specified disorders of brain
E76.02	Hurler-Scheie syndrome	G93.9	Disorder of brain, unspecified
E76.03	Scheie's syndrome	G96.9	Disorder of central nervous system, unspecified
P07.30	Preterm newborn, unspecified weeks of gestation	G98.8	Other disorders of nervous system
P07.31	Preterm newborn, gestational age 28 completed weeks	P07.3	Preterm [premature] newborn [other]
P07.32	Preterm newborn, gestational age 29 completed weeks	P83.2	Hydrops fetalis not due to hemolytic disease
P07.33	Preterm newborn, gestational age 30 completed weeks	Q01.0	Feeding problems of newborn
P07.34	Preterm newborn, gestational age 31 completed weeks	Q01.1	Frontal encephalocele
P07.35	Preterm newborn, gestational age 32	Q01.2	Nasofrontal encephalocele

	completed weeks		
P07.36	Preterm newborn, gestational age 33 completed weeks	Q01.8	Occipital encephalocele
P07.37	Preterm newborn, gestational age 34 completed weeks	Q01.9	Encephalocele of other sites
P07.38	Preterm newborn, gestational age 35 completed weeks	Q02	Encephalocele, unspecified
P07.39	Preterm newborn, gestational age 36 completed weeks	Q03.0	Microcephaly
Q06	Other congenital malformations of spinal cord	Q03.1	Malformations of aqueduct of Sylvius
Q06.0	Amyelia	Q03.8	Atresia of foramina of Magendie and Luschka
Q06.1	Hypoplasia and dysplasia of spinal cord	Q03.9	Other congenital hydrocephalus
Q06.2	Diastematomyelia	Q04.0	Congenital hydrocephalus, unspecified
Q06.3	Other congenital cauda equina malformations	Q04.1	Arhinencephaly
Q06.4	Hydromyelia	Q04.2	Holoprosencephaly
Q06.8	Other specified congenital malformations of spinal cord	Q04.3	Other reduction deformities of brain
Q92.6	Marker chromosomes	Q04.4	Septo-optic dysplasia of brain
Q93	Monosomies and deletions from the autosomes, not elsewhere classified	Q04.5	Megalencephaly
Q93.51	Angelman syndrome	Q04.6	Congenital cerebral cysts
Q93.59	Other deletions of part of a chromosome	Q04.8	Other specified congenital malformations of brain
Q93.8	Other deletions from the autosomes	Q04.9	Congenital malformation of brain, unspecified
Q93.82	Williams syndrome	Q05.0	Cervical spina bifida with hydrocephalus
D82.1	Di George's syndrome	Q05.1	Thoracic spina bifida with hydrocephalus
E75.0	GM2 gangliosidosis	Q05.2	Lumbar spina bifida with hydrocephalus
E75.00	GM2 gangliosidosis, unspecified	Q05.3	Sacral spina bifida with hydrocephalus

E75.01	Sandhoff disease	Q05.4	Unspecified spina bifida with hydrocephalus
E75.02	Tay-Sachs disease	Q05.5	Cervical spina bifida without hydrocephalus
E75.09	Other GM2 gangliosidosis	Q05.6	Thoracic spina bifida without hydrocephalus
E75.1	Other and unspecified gangliosidosis	Q05.7	Lumbar spina bifida without hydrocephalus
E75.10	Unspecified gangliosidosis	Q05.8	Sacral spina bifida without hydrocephalus
E75.11	Mucolipidosis IV	Q05.9	Spina bifida, unspecified
E75.19	Other gangliosidosis	Q06.9	Congenital malformation of spinal cord, unspecified
E75.2	Other sphingolipidosis	Q07.00	Arnold-Chiari syndrome without spina bifida or hydrocephalus
E75.21	Fabry (-Anderson) disease	Q07.01	Arnold-Chiari syndrome with spina bifida
E75.22	Gaucher disease	Q07.02	Arnold-Chiari syndrome with hydrocephalus
E75.23	Krabbe disease	Q07.03	Arnold-Chiari syndrome with spina bifida and hydrocephalus
E75.25	Metachromatic leukodystrophy	Q07.8	Other specified congenital malformation of nervous system
E75.26	Sulfatase deficiency	Q07.9	Congenital malformation of nervous system, unspecified
E75.29	Other sphingolipidosis	Q90.0	Trisomy 21, nonmosaicism (meiotic nondisjunction)
E75.4	Neuronal ceroid lipofuscinosis	Q90.1	Trisomy 21, mosaicism (mitotic nondisjunction)
E78.71	Barth syndrome	Q90.2	Trisomy 21, translocation
E78.72	Smith-Lemli-Opitz syndrome	Q90.9	Down syndrome, unspecified
F70	Mild intellectual disabilities	Q91.0	Trisomy 18, nonmosaicism (meiotic nondisjunction)
F71	Moderate intellectual disabilities	Q91.1	Trisomy 18, mosaicism (mitotic nondisjunction)
F72	Severe intellectual disabilities	Q91.2	Trisomy 18, translocation
F73	Profound intellectual disabilities	Q91.3	Trisomy 18, unspecified
F78	Other intellectual disabilities	Q91.4	Trisomy 13, nonmosaicism (meiotic nondisjunction)
F79	Unspecified intellectual disabilities	Q91.5	Trisomy 13, mosaicism (mitotic nondisjunction)
F82	Specific developmental disorder of motor	Q91.6	Trisomy 13, translocation

	function		
F84	Pervasive development disorders	Q91.7	Trisomy 13, unspecified
F84.0	Autistic disorder	Q92.0	Whole chromosome trisomy, nonmosaicism (meiotic nondisjunction)
F84.2	Rett's syndrome	Q92.1	Whole chromosome trisomy, mosaicism (mitotic nondisjunction)
F84.3	Other childhood disintegrative disorder	Q92.2	Partial trisomy
F84.5	Asperger's syndrome	Q92.5	Duplications with other complex rearrangements
F84.8	Other pervasive developmental disorders	Q92.61	Marker chromosomes in normal individual
F84.9	Pervasive developmental disorder, unspecified	Q92.62	Marker chromosomes in abnormal individual
F88	Other disorders of psychological development	Q92.7	Triploidy and polyploidy
F89	Unspecified disorder of psychological development	Q92.8	Other specified trisomies and partial trisomies of autosomes
F90	Attention-deficit hyperactivity disorders	Q92.9	Trisomy and partial trisomy of autosomes, unspecified
F98.2	Other feeding disorders of infancy and childhood	Q93.0	Whole chromosome monosomy, nonmosaicism (meiotic nondisjunction)
F98.9	Unspecified behavioral and emotional disorders with onset usually occurring in childhood and adolescence	Q93.1	Whole chromosome monosomy, mosaicism (mitotic nondisjunction)
G11.1	Early-onset cerebellar ataxia	Q93.2	Chromosome replaced with ring, dicentric or isochromosome
G12.0	Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]	Q93.3	Deletion of short arm of chromosome 4
G12.1	Other inherited spinal muscular atrophy	Q93.4	Deletion of short arm of chromosome 5
G31.84	Mild cognitive impairment, so stated	Q93.5	Other deletions of part of a chromosome
G71.0	Muscular Dystrophy	Q93.7	Deletions with other complex rearrangements
G71.00	Muscular dystrophy, unspecified	Q93.81	Velo-cardio-facial syndrome

G71.01	Duchenne or Becker muscular dystrophy	Q93.88	Other microdeletions
G71.02	Facioscapulohumeral muscular dystrophy	Q93.89	Other deletions from the autosomes
G71.09	Other specified muscular dystrophies	Q93.9	Deletion from autosomes, unspecified
G71.11	Myotonic muscular dystrophy	Q95.2	Balanced autosomal rearrangement in abnormal individual
G71.12	Myotonia congenita	Q95.3	Balanced sex/autosomal rearrangement in abnormal individual
G71.13	Myotonic chondrodystrophy	Q99.2	Fragile X chromosome
G71.14	Drug induced myotonia	Q99.8	Other specified chromosome abnormalities
G71.19	Other specified myotonic disorders	Q99.9	Chromosomal abnormality, unspecified
G71.2	Congenital myopathies	R27.9	Unspecified lack of coordination
G80.0	Spastic quadriplegic cerebral palsy	R62.0	Delayed milestone in childhood
G80.1	Spastic diplegic cerebral palsy	R62.50	Unspecified lack of expected normal physiological development in childhood
G80.2	Spastic hemiplegic cerebral palsy	R62.51	Failure to thrive (child)
G80.3	Athetoid cerebral palsy	R62.59	Other lack of expected normal physiological development in childhood
G80.4	Ataxic cerebral palsy	R63.3	Feeding difficulties
G80.8	Other cerebral palsy	T74.4XXA	Shaken infant syndrome, initial encounter
G80.9	Cerebral palsy, unspecified	T74.4XXD	Shaken infant syndrome, subsequent encounter
		T74.4XXS	Shaken infant syndrome, sequela