AmeriHealth

CODING GUIDELINES AND POLICY UPDATE

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www.amerihealth.com/medpolicy

Important Note:

The medical policies referenced in this document apply to all HMO, POS, and PPO products of AmeriHealth, including its affiliates.

This document was developed to assist AmeriHealth in administering the provisions of its benefits programs and does not constitute medical advice. Professional providers are responsible for providing medical advice and treatment. Even though this document may conclude that a particular service or item is medically necessary, such conclusion is NOT based upon the terms of a particular member's benefit plan. Members must refer to their specific benefit program for the terms, conditions, limitations and exclusions of coverage.

Please note that the Policy Bulletins which are referenced herein describe the status of a specific topic at the time the Policy Bulletin was created. Policy Bulletins are updated biennially and when new medical evidence becomes available, therefore, they are subject to change.

Please be aware that the actual Policy Bulletins which are discussed herein are used as a guide only. Coverage decisions are made on a case-by-case basis by applying Policy Bulletin criteria to the member's medical history, condition, and proposed course of treatment as well as the member's benefit program. Providers should review Policy Bulletins with Members as treatment options are discussed, as the Policy Bulletins are designed to be used by our professional staff in making coverage determinations and can be highly technical.

Information contained in this document and the actual Policy Bulletin does not constitute an offer of coverage, medical advice, or guarantee of payment. Please note that, if there is a conflict between the Policy Bulletin and a member's benefit program, the terms of the benefit program will govern. The inclusion of a code/modifier in this policy does not imply reimbursement. Eligibility, Benefits, Limitation, Exclusions, Precertification/ Referral Requirements, Provider Contracts, and Policy still apply.

Please note that providers who opted out of the class action settlement may not be entitled to certain claim payment policy changes. Therefore, any payments made pursuant to such policy changes to providers who opted out of the class action settlement are subject to retroactive adjustments.

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Special Note

Due to the frequent release of CPT®, HCPCS, and ICD-9-CM coding updates, code ranges will no longer be included in the *Coding Guidelines and Policy Update*. An up-to-date list of appropriate billing, diagnostic, and procedure codes, with their respective narratives, can be found in the individual policies at *www.amerihealth.com/medpolicy* under the Medical section. Please check the website frequently, as policies are updated often.

Medical Policies

Ambulatory Blood Pressure Monitoring (ABPM) (07.02.09)

Covered: According to Certain Criteria

Ambulatory blood pressure monitoring (ABPM) involves the use of a noninvasive device that measures blood pressure in 24-hour cycles. The device consists of a portable sphygmomanometer attached to a recording device. The information it provides can help a physician determine whether an individual is truly hypertensive or is exhibiting white coat hypertension (WCH).

The ABPM device is fitted to and removed from the individual by a trained technician. The sphygmomanometer inflates at predetermined times, generally every 30 minutes, and the blood pressure recorded at each inflation is stored. The individual performs normal activities while wearing the monitor. Automated ABPM is considered more accurate than individual self-monitoring. Therefore, it is generally thought that readings obtained at frequent intervals throughout the day and night would help the physician better manage the individual's care. These stored 24-hour measurements are later interpreted at the physician's office. A clinician is required to interpret the collected data by uploading it onto a computer where device-specific programs are used to categorize and analyze the measurements.

ABPM is considered medically necessary and, therefore, covered for individuals who meet the definition criteria of WCH and have no evidence of end-organ damage. ABPM is covered for individuals requiring 24-hour monitoring of their blood pressure to confirm the diagnosis.

Physician interpretation is medically necessary and required for reimbursement. Therefore, ABPM utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer, with recording only or scanning analysis with report only (no mention of physician interpretation), is not eligible for separate reimbursement when billed alone or in conjunction with another service.

When a primary care physician (PCP) is contracted to provide medically necessary and preventive care services on a monthly capitation basis, this service is included in the monthly capitation payment.

Cardiac Event Detection Monitoring (External Loop Monitoring) (07.02.12a)

Covered: According to Certain Criteria

Cardiac event detection monitoring involves long-term monitoring (30 days or more) of the heart rhythm of an individual with significant, but very infrequent, symptoms that are suggestive of arrhythmia (transient cardiac arrhythmia). Due to the infrequency of the arrhythmia, it is difficult to identify on a 24- or 48-hour continuous Holter monitor.

Cardiac event detection monitoring is initiated in either the office or home setting. The cardiac event device is an electrocardiogram (ECG)-recording device approximately the size of a pager that has a continuous loop and can be worn externally for up to a month or longer. When symptoms of an arrhythmia are felt, the individual activates the recording device by pressing a button on the front of the device. This activates the ECG recording starting from a time period prior to the event because looping memory is individually programmed to record 30 to 90 seconds before activation. Information is then transmitted over the phone from the device to a central processing unit that produces a hard copy of the ECG.

Cardiac event detection monitoring is considered medically necessary and, therefore, covered for the following situations:

- To regulate antiarrhythmic drug dosages
- To establish the diagnosis of symptomatic transient cardiac arrhythmias when the symptoms are obscure and suggestive of a cardiac arrhythmia but difficult to identify on a 24- or 48-hour continuous Holter monitor

The following are examples and/or clinical symptoms of symptomatic transient cardiac arrhythmias:

- Atrial fibrillation
- Atrial flutter
- Cardiac dysrhythmia
- Chest pain
- Dizziness
- Lightheadedness

- Near syncope, syncope
- Palpitations
- Paroxysmal supraventricular tachycardia
- Paroxysmal tachycardia, unspecified
- Paroxysmal ventricular tachycardia
- Premature beats
- Shortness of breath, dyspnea
- Transient ischemic episodes

In the majority of individuals, symptomatic transient cardiac arrhythmias are detected within two months. Therefore, reimbursement for the cardiac event recorder is made for two months within a twelve-month period. Additional payment may be made for the cardiac event recorder if medical necessity is established by documentation in the individual's medical record. Payment for cardiac event detection is allowed once in a 30-day period, regardless of the number of events or recordings that occurred.

Separate reimbursement is allowed for service set up (the technical component of the service) and the professional provider fees; however, if any of the above services are submitted with the global services, only the global fee is reimbursed.

Electronic Speech Aids (05.00.23a)

Covered: According to Certain Criteria

Electronic speech aids are prosthetic devices that produce speech as the individual mouths words. Electronic speech aids create a vibrating tone from a battery-powered electronic circuit. Once the tone is introduced into the mouth, the individual shapes the sound into words.

The two types of electronic speech aids are extra-oral (or neck-held) and intra-oral. The extra-oral type is a cylindrical hand-held box that has a vibrating electronic sound source that is activated by control buttons. The head of the device is placed against the neck to produce sound as the individual mouths words.

The intra-oral type generates sound directly in the oral cavity via a small tube that is connected to an electronic speech aid or is mounted into an upper denture or an orthodontic retainer. This device consists of a loudspeaker, control circuit, and a control unit. The control unit transmits radio waves to the radio circuit. The radio waves are converted into an electronic signal by the radio circuit. The loudspeaker is driven by the electronic signal to produce speech.

Electronic speech aids are considered medically necessary and, therefore, covered when an individual has had a laryngectomy or has a nonfunctional larynx.

Replacement batteries that are required for the devices described above can be purchased over the counter and are a benefit contract exclusion, as they do not meet the definition of durable medical equipment. Therefore, these items are not covered and not eligible for reimbursement consideration.

Home Phototherapy for Neonatal Jaundice (07.06.02)

Covered: According to Certain Criteria

Phototherapy is often used to treat neonatal jaundice and involves the continuous application of ultraviolet light via a lamp or a fiberoptic system to a newborn for a prescribed period of time. The fiberoptic system consists of a pad of woven fibers that transport light from a light source to the baby. This covered fiberoptic pad is placed directly against the baby to bathe the skin in light. Phototherapy uses blue wavelengths of light to convert the bilirubin to less toxic water-soluble photoisomers, which are then excreted in bile and urine. Phototherapy can be administered in a hospital or home setting (home phototherapy). It is important to note that the use of phototherapy in the home setting is contraindicated in the presence of risk factors.

Home phototherapy devices do not consistently provide the same degree of irradiance as those available in the hospital. Due to the questionable efficiency of home phototherapy for neonatal jaundice, the American Academy of Pediatrics states that home phototherapy is considered inappropriate for infants with higher bilirubin concentrations.

Home phototherapy is considered medically necessary and, therefore, covered for full-term newborns who are diagnosed with neonatal jaundice and have none of the

risk factors, major or minor, that have been identified by the American Academy of Pediatrics.*

The following are major risk factors that have been identified by the American Academy of Pediatrics for the development of severe hyperbilirubinemia in infants of 35 weeks or more gestation:

- Predischarge total serum bilirubin (TSB) or transcutaneous bilirubin (TcB) level in the high-risk zone
- Jaundice observed within the first 24 hours
- Blood group incompatibility with positive direct antiglobulin test, other known hemolytic disease (e.g., glucose-6-phosphate-dehydrogenase [G6PD] deficiency), elevated end tidal carbon monoxide (ETCOc)
- Gestational age 35-36 weeks
- Previous sibling received phototherapy
- Cephalohematoma or significant bruising
- Exclusive breastfeeding, particularly if nursing is not going well and weight loss is excessive
- East Asian race

The following are minor risk factors that have been identified by the American Academy of Pediatrics for the development of severe hyperbilirubinemia in infants of 35 weeks or more gestation:

- Predischarge TSB or TcB level in the high intermediate-risk zone
- Gestational age 37-38 weeks
- Jaundice observed before discharge
- Previous sibling with jaundice
- Macrosomic infant of a diabetic mother
- Maternal age of 25 years or more
- Male gender

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Islet Cell Transplantation (11.04.01)

Covered: According to Certain Criteria

Islet cell transplant tissue comes from either the patient themselves (autologous transplant) or from a cadaveric donor (allogeneic transplant). Islet cell transplantation may benefit an individual who is without a functioning pancreas. Currently, only individuals with either chronic pancreatitis or type 1 diabetes mellitus have been the subject of clinical investigations.

Autologous islet transplantation is a technique to prevent the serious morbidity of surgically induced diabetes due to the removal of the individual's pancreas. Although the pancreatectomy and transplant can be performed on two different days, the transplant is generally performed during the pancreatectomy procedure. During the pancreatectomy, a suspension is created by mixing plasma and the isolated islet cells collected from the individual's own resected pancreatic specimen. This suspension is then injected into the portal vein of the liver, where the cells function as a free graft. There is no risk of rejection because, unlike allogeneic organ/tissue transplants, the individual's own islet cells are used in the procedure.

Autologous islet cell transplantation is considered medically necessary and, therefore, covered as an adjunct to a total or near-total pancreatectomy in individuals with chronic pancreatitis.

Autologous islet cell transplantation is considered experimental/investigational for all other indications because the safety and/or efficacy of this service cannot be established by review of the available published literature. Therefore, this service is not covered.

Allogeneic islet cell transplantation is considered experimental/investigational for all indications because the safety and/or efficacy of this service cannot be established by review of the available published literature. Therefore, this service is not covered.

Spinal Cord Stimulation (SCS) (Dorsal Column Stimulation [DCS]) (11.15.01b)

Covered: According to Certain Criteria

Spinal cord stimulation (SCS), also known as dorsal column stimulation (DCS), is most commonly used for the management of chronic intractable pain (e.g., failed back syndrome, nerve root injuries). The use of SCS for controlling chronic lower back pain is a non-destructive, reversible procedure that provides low-voltage electrical stimulation to block sensations of pain in the dorsal column of the spinal cord. Although the stimulation blocks pain conduction pathways to the brain and may stimulate endorphins, it does not eliminate the source of pain.

The SCS device, which consists of a neurostimulator that transmits electrical impulses to the spinal cord through an implanted lead/wire, should be used as a late (if not last) resort for the treatment of individuals for whom other conservative treatment modalities (pharmacological, surgical, physical, or psychological therapies) have proven unsatisfactory, unsuitable, or contraindicated for the individual.

A trial period utilizing a temporary SCS/DCS device is considered medically necessary and, therefore, covered for the relief of chronic intractable pain when all of the following criteria are met:

- The individual has undergone careful screening including evaluation by a multidisciplinary team that confirms one of the following conditions:
  - Lumbosacral arachnoiditis that has not responded to medical management including physical therapy. (Presence of arachnoiditis is usually documented by presence of high levels of proteins in the cerebrospinal fluid [CSF] and/or by myelography or magnetic resonance imaging [MRI].)
  - Nerve root injuries, post-surgical or post-traumatic including post-laminectomy syndrome (failed back syndrome)
  - Complex regional pain syndrome I or II (previously called reflex sympathetic dystrophy syndrome/ causalgia)
    - Type I syndrome is associated with symptomatic tissue injury.
    - Type II syndrome involves symptoms associated with nerve injury.
  - Phantom limb syndrome that has not responded to medical management
  - End-stage peripheral vascular disease, when the individual cannot undergo revascularization or when revascularization has failed to relieve painful symptoms and the pain has not responded to medical management
  - Post-herpetic neuralgia
  - Plexopathy (a disorder affecting a network of nerves, blood vessels, or lymph vessels)
  - Intercostal neuralgia that has not responded to medical management and nerve blocks
  - Cauda equina injury
  - Incomplete spinal cord injury
- Other conservative treatment modalities (pharmacological, surgical, physical, or psychological therapies) have been tried and did not prove satisfactory, or are judged to be unsuitable or contraindicated for the individual.
- The implantation of the stimulator is used only as a late (if not last) resort.

The implantation of a permanent SCS/DCS device is considered medically necessary and, therefore, covered for the relief of chronic intractable pain when the following criterion is met:

- A successful trial period has proven a 50 percent or more reduction in pain.

The removal/revision of an SCS/DCS device or services and supplies related to such removal/revision are considered medically necessary and, therefore, covered for any of the following indications:

- Failure of equipment
- Loss of effectiveness
- Intolerance by patient
- Infection

Surgery for Gynecomastia (11.08.12c)

Covered: According to Certain Criteria

Gynecomastia is the benign condition of enlargement of the male breast due to overgrowth of the glandular component of the breast that is primarily due to an altered estrogen-androgen balance or a heightened breast sensitivity to a normal circulating estrogen level; it can be unilateral or bilateral. Additionally, any of the following can cause gynecomastia: congenital defects, testicular failure, increased estrogen production, testicular tumors, liver or adrenal disease, and carcinomas that produce human chorionic gonadotropin (hCG). Sometimes gynecomastia may present as a side effect of the use of certain drugs, including estrogens, digitalis, metronidazole, cimetidine, cisplatin, spironolactone, calcium-channel blockers, captopril, and tricyclic antidepressants. Gynecomastia is rarely idiopathic. It is critical in the male that cancer of the breast be ruled out since a breast nodule may resemble gynecomastia.

Surgical treatment of gynecomastia should be reserved for cases where medical treatment has failed and where the individual continues to experience persistent pain and tenderness. Surgical techniques include excision of excess breast tissue and the use of adjunctive liposuction when required.

Surgery for unilateral or bilateral gynecomastia is considered medically necessary and, therefore, covered when medical treatment of the underlying condition(s) has been unsuccessful and **all** of the following medical necessity criteria are met:

- Contributing factors have been treated or excluded for at least six months.
- Breast tissue is glandular tissue (gynecomastia) and not excess fatty tissue (lipomastia) as documented by physical examination.
- Radiographic studies (ultrasound or mammogram) are negative for tumor or cyst.
- Breast pain/tenderness is present.
- Male is 18 years of age or older.
  - Males who have not reached 18 years of age but who are a minimum of 17 years of age will be considered for surgery when the presence of significant glandular breast tissue is documented in the member's medical record to have been present for at least two years AND all required medical necessity criteria in the medical policy are met.

AND

One of the following must be met:

- The individual is not taking any prescribed medications.
- The individual is taking prescribed medications that are considered to be non-contributory.
- The individual is taking prescribed medications that are believed to be contributory but can be discontinued.
- The individual is taking prescribed medications that are believed to be contributory but cannot be discontinued because there are no alternative medications.
  - If clomiphene citrate (Clomid) or tamoxifen (Novaldex) is prescribed, symptoms of gynecomastia must be present for at least six months.

Liposuction is considered an adjunctive procedure for the treatment of gynecomastia. If liposuction is performed as the primary procedure, the service is considered cosmetic and, therefore, a benefit contract exclusion.

Any surgery to treat gynecomastia that does not meet medical necessity criteria is considered cosmetic and, therefore, a benefit contract exclusion.

The Boston® Scleral Lens (07.13.11)

Covered: According to Certain Criteria

A contact lens that covers the cornea and the adjacent portion of the white of the eye (sclera) is called a scleral contact lens and is sometimes referred to as a corneal liquid bandage.

The BOSTON® Scleral Lens (BSL), which is more specifically termed the BOSTON® Equalens II, is the only rigid gas-permeable scleral contact lens that is commercially available in the United States and that can be post-fabricated for the treatment of persistent corneal

epithelial defects (PEDs). Currently, it is only post-fabricated and distributed by the Boston Foundation for Sight in Needham, MA. The BSL, unlike a traditional rigid gas-permeable contact lens, is a specially designed, fluid-ventilated, gas-permeable scleral contact lens. It is designed to maintain a bubble-free reservoir of oxygenated aqueous fluid over the corneal surface at a neutral hydrostatic pressure. Due to the fact that air bubbles are avoided, the fluid reservoir functions as a liquid corneal bandage that offers unique therapeutic benefits for the management of severe ocular surface disease, in addition to its traditional role of masking irregular corneal astigmatism.

Although limited, compelling evidence exists that shows that the BSL is effective in alleviating pain and photophobia and improves the vision of individuals with PEDs. In the majority of studies, the most frequent specific indication for the BSL was Stevens-Johnson syndrome. The BSL has also been shown to be effective in preventing the recurrence of PEDs in anesthetic corneas.

The BSL is considered medically necessary and, therefore, covered to alleviate pain and photophobia for PEDs that have been documented as disabling and that have symptoms that are not significantly relieved with medical treatment. The BSL is also considered medically necessary and, therefore, covered to improve visual acuity in an individual for whom surgery is either undesirable and/or contraindicated due to any of the following conditions:

- Stevens-Johnson syndrome (a syndrome of systemic, as well as more severe, mucocutaneous lesions that results in corneal opacities, perforations, and/or blindness)
- Conditions that result from a chemical and/or traumatic injury
- Postradiotherapy complications
- Recurrent corneal erosion
- Congenital and/or postsurgical lid defect(s)
- Ocular cicatricial pemphigoid
- Exposure keratitis
- Toxic epidermal necrolysis
- Lacrimal and/or meibomian gland obliteration or deficiency
- Superior limbal keratoconjunctivitis
- Sjögren syndrome
- Inflammatory corneal degeneration
- Neurotrophic corneal disease (e.g., corneal denervation that is related to acoustic neuroma surgery, trigeminal ganglion obliteration, diabetes mellitus, herpetic syndrome, congenital dysautonomia [Reily-Day syndrome])
- Corneal edema

Claim Payment Policies

Mohs' Micrographic Surgery is Considered Eligible for Reimbursement (11.08.23a)

Mohs' micrographic surgery (MMS) is a precise tissue-sparing surgical technique used in the removal of selected malignant neoplasms of the skin. This surgery requires a single surgeon to act in two distinct roles — surgeon and pathologist.

MMS relies on the accuracy of a microscopic examination of skin cells to trace and ensure removal of skin cancer down to its roots.

The surgery is usually performed using local anesthesia as follows:

- The tumor is scraped to remove the majority of the visible skin cancer.
- A thin layer of tissue is then removed and analyzed microscopically for evidence of remaining cancer cells.
- If any cancer cells are detected, another thin layer of tissue is removed and analyzed microscopically.
- This procedure is repeated until the cancer is completely removed.

MMS is covered and eligible for reimbursement consideration by the Company.

Each stage of MMS is a distinct procedure and is reimbursed at 100 percent of the Company's contracted amount. Therefore, multiple surgery reduction guidelines do not apply.

The biopsy procedure, together with the anatomical pathology service, is eligible for separate reimbursement consideration when a presurgical biopsy is performed on the same day as MMS and the surgeon has no prior pathology confirmation of a diagnosis.

The appropriate modifier should be used to report the biopsy procedure when it is performed on the same day as the MMS. The physician's documentation should include the applicable rationale for the service.

Preoperative Consultations Performed by Providers in Anesthesia Specialties are Considered Eligible for Reimbursement According to Certain Criteria (01.00.08)

As used in this policy, providers in anesthesia specialties refers to anesthesiologists and certified registered nurse anesthetists (CRNAs).

The preoperative consultation performed by providers in anesthesia specialties involves, at a minimum, the taking of an individual's medical and social history, an examination, and medical decision making, each at a varying level of complexity. A preoperative consultation performed by a provider in an anesthesia specialty is a type of evaluation and management (E&M) service that is provided by an anesthesiologist or CRNA whose opinion or advice is requested by a physician regarding the evaluation and/or management of an individual.

Preoperative consultations are frequently performed by providers in anesthesia specialties prior to surgery to determine the surgical candidate's fitness for surgery. Additionally, the preoperative consultation assists the provider in an anesthesia specialty in determining the type of anesthesia (e.g., regional, general) and which anesthetic(s) and dosage(s) would be most medically safe and appropriate for the individual.

Preoperative consultations performed by providers in anesthesia specialties differ in scope and depth from the final preanesthetic assessment and clearance of the surgical candidate, which is routinely performed immediately prior to anesthesia administration and surgery.

A preoperative consultation performed by a provider in an anesthesia specialty is covered and eligible for reimbursement consideration by the Company when all of the following requirements are met:

- The request is from an appropriate source (i.e., physician) and must be documented in the patient's medical record.
- The consultation must involve a face-to-face service between the consulting provider in an anesthesia specialty and the individual.

  - The date of service reported for the preoperative consultation is the date on which the face-to-face service occurs.
- The preoperative consultation is performed prior to and is significantly distinct and separate from the final preanesthetic assessment and clearance, which is performed immediately prior to induction or administration of anesthesia and surgery.
  - Reimbursement for the final preanesthetic assessment is reflected in the base units assigned to the specific anesthesia procedure code and is considered to be integral to the administration of anesthesia.
- The consulting provider in an anesthesia specialty prepares a written report of his/her findings, which is both documented in the individual's medical record and provided to the requesting physician.
  - The medical record documentation for the consultation must be separate and distinct from that of the final preanesthetic assessment.
- Documentation in the medical record must support the level of service reported in accordance with Current Procedural Terminology (CPT®) guidelines.

CRNAs who are employed by a facility or an anesthesiologist/anesthesiology group are not directly reimbursed by the Company for preoperative anesthesia consultations.

A preoperative consultation performed by a provider in an anesthesia specialty provided in association with a procedure that is subsequently cancelled or discontinued is covered and eligible for reimbursement consideration when the above requirements are met.

Experimental/Investigational Policies

Intraperitoneal Hyperthermic Chemotherapy (IPHC) (11.00.13)

Not Covered: Considered Experimental/ Investigational

Intraperitoneal hyperthermic chemotherapy (IPHC) is a procedure that includes a combination of cytoreductive surgery (debulking or macroscopically removing all visible tumors) with heated chemotherapy delivered intraperitoneally immediately following the surgery. The goal of IPHC is to eliminate microscopic metastases that are too small to be identified and removed during cytoreductive surgery. It is theorized that heated chemotherapy increases cytotoxicity and enhances penetration of chemotherapy into the tumor. In addition, hyperthermia itself has a cytotoxic effect on tumor tissue.

IPHC has been explored in a number of studies over the past 20 years. The majority of research evidence includes Phase II trials and case series. There are few Phase III trials. Also, the populations studied included only a small number of individuals with various locations of primary cancer, different stages of peritoneal carcinomatosis, and varying degrees of success with cytoreductive surgery. Additional research is needed to further define the criteria used to select which individuals should receive IPHC, and to identify the most effective drug combination for peritoneal administration. In addition, some of the technical aspects of the procedure such as the optimal temperature of the chemotherapeutic agents, the length of time for the IPHC perfusion, and the efficacy and safety of open and closed chemoperfusion need to be determined and standardized.

IPHC in conjunction with cytoreductive surgery is considered experimental/investigational because the safety and/or efficacy of this service cannot be established by review of the available published literature. Therefore, this service is not covered.

Ocular Photoscreening (07.13.12)

Not Covered: Considered Experimental/ Investigational

Ocular photoscreening has been investigated as an alternative screening method to detect the risk factors for amblyopia in children, which include strabismus (a misalignment of the eyes in any direction), media opacities (e.g., cataracts), and refractive errors (e.g., myopia, hyperopia, astigmatism, presbyopia). It is based on the principle of photorefraction, in which the refractive state of the eye is assessed via the pattern of light that is reflected through the pupil.

Ocular photoscreening involves the use of a camera or video system that is equipped for photoscreening to obtain images of the pupillary reflexes (autonomic reflex constrictions caused by light) and red reflex (a circular red light reflected from the retina of the eye). The images can then be analyzed based on the position of the corneal light reflex, as well as the overall reflection of light from the fundus, which provides information on the child's fixation pattern and the presence or absence of strabismus. Ocular photoscreening is performed in a darkened room and requires little cooperation from the child, other than fixating on a target for the duration of the photoscreening process. The photographs can then be analyzed by the evaluator or sent to a central laboratory for analysis by an ophthalmologist or specially-trained personnel. Test results are typically graded as pass, fail, or repeat photoscreening.

Ocular photoscreening is considered experimental/ investigational because the safety and/or efficacy of this service cannot be established by review of the current available published literature. Therefore, this service is not covered.

Surgical Ventricular Restoration (SVR) (11.02.24)

Not Covered: Considered Experimental/ Investigational

Surgical ventricular restoration (SVR) is a procedure that is designed to restore or remodel the left ventricle to its normal spherical shape and size in individuals who have akinetic (non-moving) segments of the heart. This condition may be secondary to either dilated cardiomyopathy or postinfarction left ventricular aneurysm. The SVR procedure is most commonly performed after coronary artery bypass grafting (CABG) and may also proceed or be followed by procedures such as mitral valve repair or replacement, endocardectomy, and cryoablation for the treatment of ventricular tachycardia.

The SVR procedure may also be referred to as ventricular remodeling or surgical anterior ventricular endocardial restoration (SAVER).

SVR is considered experimental/investigational because the safety and/or efficacy of this service cannot be established by a review of the available published literature. Therefore, this service is not covered.

More Information

Physician Volunteers Needed to Assist in Developing Medical Policies

AmeriHealth is currently recruiting physicians to join our Policy Committee Advisory Panel. This panel is responsible for evaluating the scientific evidence and local standards of care addressed in our medical policies.

Medical policies are research-based documents that allow AmeriHealth to evaluate the medical necessity of services, devices, biologics, and procedures for its members. In addition, medical policies provide guidelines for obtaining benefits and reimbursement in accordance with a member's plan. As a volunteer consultant on the Policy Committee Advisory Panel, you will evaluate proposed medical policies based on your area(s) of expertise. As such, your contributions will significantly impact the care of patients in your region.

At this time, AmeriHealth is seeking physician consultants in the following specialties:

- Neurosurgery
- Orthopedics
- Urology
- Vascular Surgery
- Physical Medicine and Rehabilitation
- Rheumatology
- Cardiology
- Gastroenterology
- Pain Medicine

To qualify as a member of the Policy Committee Advisory Panel, you must:

- Maintain board certification for each specialty or subspecialty for which you wish to consult.
- Maintain an active clinical practice in each specialty or subspecialty for which you wish to consult.
- Understand and agree to adhere to our confidentiality statement.
- Maintain a high ethical standard, evidenced by the absence of any AmeriHealth investigation into personal or group claims practices.
- Complete and sign a Conflict of Interest Statement and Confidentiality Agreement prior to becoming a member of the advisory panel.

If you meet the above criteria and have an interest in sharing your expertise as a member of the Policy Committee Advisory Panel, please submit your curriculum vitae to:

Gerald W. Peden, M.D., M.A.
Medical Director
Claim Payment Policy Department
AmeriHealth
1901 Market Street
Philadelphia, PA 19103-1480

Contact Provider Services

Provider Services	New Jersey	Delaware
HMO Policies/Procedures/Eligibility/Claims	(800) 821-9412	(800) 888-8211
PPO Policies/Procedures/Claims	(800) 595-3627	(800) 888-8211

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