Volume 2003, Issue 1
Fall 2003

AmeriHealth

Coding Guidelines and Policy Update

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.

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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INTRODUCING THE *CODING GUIDELINES AND POLICY UPDATE*

Simple, Convenient, and at Your Fingertips

As a service to our valued providers, AmeriHealth is pleased to present the *Coding Guidelines and Policy Update*.

Just the Facts

In each quarterly edition, you will find concise descriptions of new or updated policies that you can immediately adopt within your practice.

These brief overviews can simplify your information retrieval and claims submission processes. Keep them with your *Provider Manual* or *Billing Guide*—or anywhere that is handy. Full, expanded versions of each policy are available on our Web site, *www.amerihealth.com*.

From a Provider's Point of View

This new publication was designed for physicians to make coding guidelines and medical policies easy to read and implement.

Through a committee process, AmeriHealth reviews and recommends policies that represent accepted medical practice by recognized national and local medical organizations as well as accepted peer-review journals and research-based, peer-review literature.

Available When You Need Them

New and updated guidelines will be published on a regular basis, featuring the most timely and accurate information available.

What Are the Primary Reasons That AmeriHealth Develops Policy?

Some of the primary reasons that AmeriHealth develops policy are to:

- Comply with legislation (e.g. Federal, State, and/or Local mandates).
- Correspond to National or Local Medicare Carrier Coverage Policy.
- Allow consistent interpretation and application of benefits.
- Respond to requests for new, emerging technology or changes in existing technology.
- Ensure a relevant and timely scheduled review of existing policies.
- Provide Claims submission "policies and procedures."

What Is the Difference Between a Claim Payment Policy and a Medical Policy?

Claim Payment Policy

A claim payment policy is the description of an administrative process that is used to adjudicate a claim based on a defined set of circumstances. It may define a Company program or position, and it may be based on contractual agreements or special requirements of Company products. The document functions as an informational resource that describes the Company's requirements for claims submission, processing, and reimbursement. The Company relies heavily on nationally accepted standards when setting requirements for such claims submission, processing, and reimbursement.

Medical Policy

A medical policy is the written description of the Company's position concerning the use or application of a biologic, device, pharmaceutical, or procedure, based on Medicare guidelines, clinical practice guidelines, nationally accepted standards, and the findings and conclusions drawn from a complete Technology Assessment (TA). Additionally, a medical policy is an informational resource that establishes the medical necessity criteria for the biologic, device, pharmaceutical, or procedure. It also functions as an informational resource by describing any special requirements for claims processing.

How Does AmeriHealth Assess New Technology?

Routinely, new technology is evaluated with a thorough TA prior to determining a coverage position. A TA is an evaluation of available data from multiple sources to assess the medical efficacy, safety, and proposed effects on health outcomes of the procedure or product.

The following five criteria are used to assess whether a technology improves health outcomes. The term "health outcomes" generally refers to such considerations as length of life, quality of life, and functional ability.

1. The technology must have final approval from the appropriate government regulatory bodies.

- This criterion applies to drugs, biological products, devices, and diagnostics.

2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.

- The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence. Studies are primarily judged on their statistical power, overall design, and presence or absence of significant flaws or bias.
- The evidence should demonstrate that the technology could measure or alter the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence that such measurements or alteration affects health outcomes.
- Opinions and evaluations by national medical associations, consensus panels, or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale. Expert opinion from an individual or a panel of individuals based on limited study or empirical evidence is generally inadequate as a sole source of evidence to permit conclusions regarding efficacy.

3. The technology must improve the net health outcome.

- The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.

4. The technology must be as beneficial as any established alternatives.

- The technology should improve the net health outcome as much as, or more than, established alternatives. Comparison studies with existing technologies are the most reliable form of evidence.

5. The improvement must be attainable outside the investigative settings.

- The technology should be available to our members outside of a trial or research setting.

View Full Policies Online

Full descriptions of these policies are available online at *www.amerihealth.com/medpolicy* under the Medical section.

Medical Policies

Cardiac Resynchronization Using Implantable Biventricular Pacemakers for the Treatment of Heart Failure

Covered According to Certain Criteria

There are some patients with Congestive Heart Failure (CHF) that have intraventricular conduction disorders resulting in wide QRS intervals on an Electrocardiogram (EKG). The biventricular pacemaker, using three leads (one in the right atrium and one in each ventricle), has been investigated as a device for coordinating the contraction of the ventricles, thus improving the hemodynamic status of these patients.

FDA-approved implantable biventricular pacemakers, used to treat CHF and/or heart failure as a primary or secondary diagnosis, are medically necessary for patients who meet ALL of the following criteria:

- Diagnosis of moderate-to-severe heart failure (New York Heart Association Class III or IV) AND
- QRS duration of greater than or equal to 130 ms AND
- Left ventricular ejection fraction of less than or equal to 35% AND
- Symptomatic despite stable pharmacologic regimen, which may include ANY of the following:
  - –Angiotensin-converting enzyme inhibitor.
  - –Angiotensin receptor blocker.
  - –Beta blocker.
  - –Digoxin.
  - –Diuretic.

The implantation of biventricular pacemaker for the treatment of heart failure has the following contraindications:

- Asynchronous pacing is contraindicated in the presence (or likelihood) of competitive paced and intrinsic rhythms.
- Unipolar pacing is contraindicated in patients with an implanted defibrillator or cardioverter-defibrillator (ICD) because it may cause unwanted delivery or inhibition of defibrillator or ICD therapy.

Intensity Modulated Radiation Therapy

Covered According to Certain Criteria

Intensity Modulated Radiation Therapy (IMRT) is a new technology in radiation oncology. It is an advanced form of Three-Dimensional Conformal Radiation Therapy (3D CRT) and is a computer-based method of planning for, and delivery of, narrow, patient-specific, spatially and temporally modulated beams of radiation to solid tumors. Adding intensity modulation allows for more intense treatment of the tumor, while limiting the radiation dose to adjacent healthy tissue.

IMRT is medically necessary in instances in which sparing the surrounding normal tissue is essential for the following diagnoses:

- Malignant neoplasms: lip, oral cavity, and pharynx (140.0-149.9); digestive organs and peritoneum (150.0-159.9); respiratory and intrathoracic organs (160.0-165.9); connective tissue, skin, and breast (171.0-176.9); genitourinary organs (179-189.9); other and unspecified sites (190.0-194.1, 195.0-195.8, 198.0-199.1); lymphatic and hematopoietic tissue (200.00-203.81).
- Benign neoplasms (225.0-225.2, 227.3, 227.4, 227.6).
- Congenital anomaly of the cerebrovascular system (747.81).

In addition, the patient must meet at least one of the following criteria:

- Important dose-limiting structures adjacent to but outside the Planned Treatment Volume are sufficiently close and require IMRT to assure for safety and morbidity reduction.
- An immediately adjacent volume has been irradiated, and abutting portals must be established with high precision.
- Gross Tumor Volume margins are concave or convex, and in close proximity to critical structures that must be protected to avoid unacceptable morbidity.
- IMRT techniques decrease the probability of grade 2 or grade 3 radiation toxicity.
- The volume of interest is in a location such that its parameters are not assessed by simple two-dimensional imaging techniques but rather by three-dimensional reconstructions.

- The tumor tissue lies in areas associated with target motion caused by cardiac and pulmonary cycles, and IMRT is necessary in order to protect adjacent normal tissues.

IMRT is not a replacement for conventional radiation therapy methods and 3D CRT methods in every situation. Therefore, documented rationale regarding the advantage of the use of IMRT over other radiation therapy methods must be included in the medical record of the patient for whom IMRT is provided.

IMRT is excluded from the capitated radiology program and therefore is eligible for separate reimbursement consideration.

Photodynamic Therapy (PDT) Using Levulan® Kerastick® (Aminolevulinic Acid)

Covered According to Certain Criteria

In December 1999, the FDA approved Photodynamic Therapy (PDT) using Levulan® Kerastick® (aminolevulinic acid [ALA]) and the BLU-U™ light source (DUSA Pharmaceuticals, Inc., Valhalla, NY) for treating actinic keratoses of the face or scalp. PDT is a medical procedure that involves the administration of a photosensitive (light-activated) drug with a very specific absorption peak. This drug is chemically designed to have a unique affinity for the diseased tissue intended for treatment. Once introduced to the body topically, the drug accumulates and is retained in diseased tissue to a greater degree than in normal tissue. The administration of this photosensitive drug is followed by the targeted irradiation of this tissue with a nonthermal laser, calibrated to emit light at a wavelength that corresponds to the drug's absorption peak. This activates the drug enabling it to locally treat the diseased tissue.

PDT using Levulan Kerastick is medically necessary for the treatment of actinic keratoses (702.0) of the face or scalp.

PDT using Levulan Kerastick is administered over two physician office visits. During the first office visit, the Levulan Kerastick is topically applied directly to the actinic keratoses. Fourteen to eighteen hours after the application of the Levulan Kerastick, the second office visit occurs for treatment with the BLU-U light source.

The provider is eligible to be reimbursed for an Evaluation and Management (E&M) service in addition to reimbursement for the application of Levulan Kerastick during the first office visit. The provider is not eligible to be reimbursed for an E&M service in addition to reimbursement for the photodynamic therapy during the second office visit.

The appropriate code for Levulan Kerastick is J7308: Aminolevulinic acid HCL for topical administration, 20%, single-unit dosage form (354 mg).

Transcoronary Ablation of Septal Hypertrophy

Covered According to Certain Criteria

Transcoronary ablation of septal hypertrophy is a minimally invasive procedure using a catheter-based technique for the treatment of hypertrophic obstructive cardiomyopathy. It is aimed at selective destruction of the hypertrophied part of the left side of the intraventricular septum which induces septal infarction and subsequent thinning of the septum by injection of absolute ethanol. This approach is used for patients who have incapacitating symptoms despite maximal medical therapy.

Transcoronary ablation of septal hypertrophy is medically necessary for the treatment of typical hypertrophic obstructive cardiomyopathy (425.1) when drug therapy has failed or when surgical treatment is contraindicated.

Intradiscal Electrothermal Therapy

Not Covered: Considered Experimental/Investigational

Intradiscal Electrothermal Therapy (IDET), also known as intradiscal electrothermal annuloplasty, is a minimally invasive, catheter-based outpatient procedure intended to treat chronic low back pain.

Once identified with the use of discography, IDET involves inserting a navigable catheter, by posterolateral approach, into the annulus or nucleus of the affected disc and feeding it circumferentially. The catheter completes a circuit around the disc and is then returned posteriorly. Next, a thermal resistive coil in the catheter generates electrothermal heat, which heats the disc material for up to 20 minutes. Recovery time varies from 30 to 40 minutes.

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

The appropriate codes for reporting this service are S2370: Intradiscal electrothermal therapy; single interspace and S2371: Each additional interspace (list separately in addition to code for primary procedure). These codes will be denied as experimental/investigational services.

Protonics® Device

NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL

Protonics® (Empi, St. Paul, MN) is described by the manufacturer as a knee orthosis that helps reduce patellofemoral dysfunction by applying resistance to the hamstrings to restore proper biomechanics and improve muscle function. The brace has a patented, programmable module that allows resistance to be set at the appropriate level for each patient. The resistance varies, which enhances muscle recruitment throughout the range of motion. The resistance operates independently of gravity and velocity. This allows the patient to perform functional activities and exercise.

The Protonics device is considered experimental/investigational because the safety and/or efficacy of this service cannot be established by a review of the available published literature.

The appropriate code for reporting this device is L1885: Knee orthosis; single or double upright, thigh and calf, with functional active resistance, control, prefabricated, includes fitting and adjustment. This code will be denied as an experimental/investigational service.

Topical Oxygenation

NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL

Topical oxygenation, also referred to as topical hyperbaric oxygenation, is the use of 100% oxygen applied under pressure greater than atmospheric pressure to moist open wounds. The theory driving this therapy is that the increase in oxygen at the surface of the wound speeds healing. A device surrounds the wound area, often an extremity, and oxygen is delivered under pressure from a source that may be a conventional oxygen tank. This technology may be used by patients in the home setting. It has been promoted as a treatment for diabetic and venous stasis ulcers, pressure ulcers, burns, amputations, infected wounds, frostbite, and skin graft sites.

Topical oxygenation has sometimes been confused with hyperbaric oxygen therapy, which is a proven treatment for a number of conditions, including some types of wounds. Hyperbaric oxygen therapy, unlike topical oxygenation, involves whole-body pressurization and inhalation of 100% oxygen at a minimum of 1.4 (usually 1.4-2.5) atmospheres.

Topical oxygenation is considered experimental/investigational because the safety and/or efficacy of this service cannot be established by a review of the available published literature.

The appropriate code for reporting this service is A4575: Topical hyperbaric oxygen chamber, disposable. This code will be denied as an experimental/investigational service.

Mechanical Traction Tables (VAX-D System, DRS System, and 3D ActiveTrac)

NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL

Decompression therapy is marketed as nonsurgical decompression of intervertebral disc and reduced intradiscal pressure. Decompression devices employ adjustable tables that move in cycles to exert distraction force on the spine for treatment of discogenic pain and degenerative disc disease. According to advocates for the therapy, low back pain occurs because of loss of vertebral separation, which results in reduced blood supply and nutrients to the discs. The relief from compression allows oxygen and glucose to flow to the affected disc.

Decompression devices that have received FDA 510(K) notification include the VAX-D System (VAT-TECH, Inc., North Palm Harbor, FL), the DRS System (Professional Distribution Systems, Inc., Boca Raton, FL), and 3D ActiveTrac (Saunders Group, Inc., Chaska, MN).

The use of mechanical traction tables for decompression therapy is considered experimental/investigational because the safety and/or efficacy of this service cannot be established by a review of the available published literature.

The appropriate code for reporting this service is S9090: Vertebral axial decompression, per session. This code is to be used when billing for the use of all mechanical traction tables. This code will be denied as an experimental/investigational service.

Claim Payment Policies

Provider Reimbursement of Office Evaluation and Management (E&M) Services and Procedures Performed on the Same Day*

Professional providers are eligible for separate reimbursement consideration for evaluation and management (E&M) services performed in the office setting on the same date of service as a procedure when performed by the same physician.

The guidelines are as follows:

- When an E&M service for a new patient (initial visit) is reported on the same day as a procedure, the E&M service is eligible for separate reimbursement consideration.
- When an E&M service for an established patient (subsequent visit) is reported on the same day as a procedure, the E&M is eligible for separate reimbursement consideration when billed with the appropriate modifier indicating a separate condition.
- Only one E&M service in the office setting is reimbursed per date of service.

Office procedures are only eligible for reimbursement consideration when the procedure is an eligible service under the individual's benefit contract.

* This policy, in whole or in part, is part of the class action settlement with providers. 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.

Reimbursement Rules When Multiple Surgeries Are Performed

Multiple surgeries are separate procedures performed by a physician or associate on the same patient during the same operative session on the same day. Multiple surgeries are distinguished from procedures that are components of, or incidental to, a primary procedure.

When multiple surgeries are performed, those procedures eligible for multiple surgical reductions are reimbursed as follows:

- Reimbursement for the highest-valued procedure will be 100% of the allowance of the professional fee schedule amount.
- Reimbursement for the second, third, fourth, and fifth procedures is considered at 50% of the allowance of the professional fee schedule amount.
- Reimbursement for the sixth procedure, and each subsequent procedure, is given individual consideration.

More Information

Currently, the Technology Evaluation and Medical Policy Unit of AmeriHealth is seeking clinical input into the development of its Medical Policies.

We actively welcome and seek expert consultant opinion from our provider community to assist us with the evaluation of both the scientific evidence and the local standard of care related to a particular service. Our ultimate goal in this process is to provide access to technological advancements in a safe and clinically appropriate manner for our members.

Medical necessity/appropriateness decisions are based on these documents, which are used to interpret medical issues related to benefits and other terms of the member's plan. The consultants on the Advisory Panel for the Policy Committee evaluate proposed medical policy based on their area of expertise. As such, your contribution can significantly impact the care of patients in your region.

To qualify as a professional consultant, you must:

- Maintain an active clinical practice.
- Maintain board certification for each specialty and each subspecialty or designation for which you are a professional consultant.
- Understand and agree with our conflict of interest statement (available upon request prior to participation, and reviewed and reaffirmed annually once becoming a member of the committee).
- Maintain a high ethical standard, evidenced by the absence of any AmeriHealth investigation into personal or group claims practices.

If you have interest in providing your expertise as a member of the Policy Committee and making your voice heard in this important clinical area, please submit your curriculum vitae to:

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AmeriHealth
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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	

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