

# Coding Guidelines and Policy Update

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[www.amerihhealth.com/medpolicy](http://www.amerihhealth.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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**View Full Policies Online** —Full descriptions of these policies are available online at [www.amerihhealth.com/medpolicy](http://www.amerihhealth.com/medpolicy) under the Medical section.

# About Coding Guidelines and Policy Update

## What Are the Primary Reasons That AmeriHealth Develops Claim Payment and Medical Policies?

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

- Comply with legislation (e.g., federal, state, and local legislative 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 policy functions as an informational resource that describes the Company’s requirements for claims submission, processing, and reimbursement. The Company relies substantially 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.

# Medical Policies

## Cervicography

**NOT COVERED: CONSIDERED  
EXPERIMENTAL/INVESTIGATIONAL**

Cervicography is an adjunctive cervical screening procedure. After the Papanicolaou (Pap) smear is obtained, the cervix is swabbed with an acetic acid solution and the outside of the cervix is photographed with a special macrolens strobe-flash camera. The photographs, referred to as “cervigrams,” are static photographic images of the cervix similar to those seen during low-level magnification colposcopy.

Cervicography is intended to increase the sensitivity of the Pap smear in screening for cervical abnormalities and is also used as a triage tool to determine which patients need further evaluation with colposcopy and biopsy.

Cervicography 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.

## Cold Laser Therapy

**NOT COVERED: CONSIDERED  
EXPERIMENTAL/INVESTIGATIONAL**

Cold laser therapy, also referred to as low-energy laser therapy or low-level laser therapy, uses a laser (light amplification by stimulated emission of radiation) device that emits minimal heat (0.1-0.5 C). This treatment has been investigated for use as adjunct therapy for wound healing and pain relief.

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

## Artificial Hearts

**NOT COVERED: CONSIDERED  
EXPERIMENTAL/INVESTIGATIONAL**

Artificial hearts are being studied for use as permanent heart replacements, or as temporary life-support system until a donor heart becomes available. Only one artificial heart, AbioCor® (ABIOMED, Inc., Danvers, Mass.) has received clearance for human trials by the U.S. Food and

Drug Administration (FDA). ABIOMED, Inc. received an investigational device exemption (IDE) from the FDA in January 2001.

Implantation of an artificial heart is considered experimental/investigational because the safety and/or efficacy of this service cannot be established. The FDA has not issued its final regulatory approval and labeling of this product. Therefore, this service is not covered. If FDA approval is granted, further review regarding the safety and efficacy of this service will be undertaken.

## Fluorescence Endoscopy

**NOT COVERED: CONSIDERED  
EXPERIMENTAL/INVESTIGATIONAL**

The available bronchoscopy technology includes the Lung ImmunoFluorescent Endoscopy (LIFE) System (Xillix Technologies Corp., Richmond, BC, Canada), which is U.S. Food and Drug Administration (FDA)-approved for use in conjunction with conventional white light bronchoscopy (WLB) in identifying and locating suspicious bronchial tissue for biopsy and histologic evaluation. Preliminary research has shown that the LIFE-Lung Fluorescence Endoscopy System is more sensitive than the WLB in identifying preinvasive cancers of the tracheobronchial tree in patients with known or suspected lung cancer. However, it also has been shown that LIFE has low positive predictive value, resulting in numerous negative biopsy results.

The LIFE-Lung Fluorescence Endoscopy System is considered experimental/investigational because the safety and/or efficacy of this service cannot be established by review of the available published literature.

There is no specific code for this service. When billing for this service, providers should use a code describing an unlisted surgical trachea/bronchi procedure. However, this code will be denied as experimental/investigational for this service.

**Speculoscopy****NOT COVERED: CONSIDERED****EXPERIMENTAL/INVESTIGATIONAL**

Speculoscopy (PapSure®, Watson Diagnostics, Inc., Corona, Calif.) is a procedure used in conjunction with the conventional Papanicolaou (Pap) smear. After insertion of the speculum, specimens are obtained and the cervix is washed with a 3% to 4% acetic acid (mild vinegar) solution. A blue-white chemiluminescent disposable light (Speculite®, Trylon Corp., Torrance, Calif.) that can be attached to the upper speculum blade is projected onto the cervix. This light, in conjunction with a hand held optic device, is used to visualize abnormalities (white lesions) of the cervix. Advocates of speculoscopy claim that it will identify at first visit a higher percentage of women with cervical dysplasia than will a Pap smear alone.

Speculoscopy 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.

**Pulsed Magnetic Neuromodulation for Incontinence****NOT COVERED: CONSIDERED****EXPERIMENTAL/INVESTIGATIONAL**

Extracorporeal magnetic innervation (ExMI™) technology is purported to deliver nerve impulses to the pelvic floor area, which results in muscular contractions and increased circulation. The NeoControl® Pelvic Floor Therapy System is one marketed device that employs this method for the treatment of urinary incontinence in women. The system consists of a control unit and treatment chair. The company's marketing literature states that pulsing magnetic fields generated by the chair's therapy head penetrate the perineal tissues, nerves, and muscles, reportedly increasing contractions and improving circulation.

Pulsed magnetic neuromodulation 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.

**Therapeutic Use of Transcranial Magnetic Stimulation****NOT COVERED: CONSIDERED****EXPERIMENTAL/INVESTIGATIONAL**

Transcranial magnetic stimulation (TMS) is a noninvasive method to stimulate the cortical neurons and thus alter brain activity. TMS was originally developed to study motor systems in the brain. However, this course of study was abandoned in order to further pursue noted stimulation occurring over the front part of the brain that could cause changes in mood. Therefore, because TMS can deliver rapid, repetitive stimulation, it is now being investigated as an alternative to electroconvulsive therapy (ECT) in the treatment of depression. In addition, TMS is also being investigated in the treatment of epilepsy, Alzheimer's disease, and other neurological disorders.

Therapeutic use of TMS 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.

**Transanal Radiofrequency Treatment of Fecal Incontinence****NOT COVERED: CONSIDERED****EXPERIMENTAL/INVESTIGATIONAL**

On March 21, 2002, the Secca® System from Curon Medical, Inc., (Sunnyvale, Calif.) a radiofrequency device, received 510(k) approval from the U.S. Food and Drug Administration (FDA) for use in the electrosurgical coagulation of tissue and specifically in the treatment of fecal incontinence in those individuals who are incontinent to solid or liquid stool at least once per week and whose condition has failed more conservative therapy.

Transanal radiofrequency treatment of fecal incontinence 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.

## Thermography

**NOT COVERED: CONSIDERED  
EXPERIMENTAL/INVESTIGATIONAL**

Thermography is the measurement of self-emanating infrared radiation that reveals temperature variations at the surface of the body. The thermographic device senses body temperature and demonstrates areas of differing heat emission by producing brightly colored patterns on a liquid crystal display. Each color represents a specific temperature level. Interpretation of these color patterns according to designated anatomic distribution is thought to aid in diagnosing a vast array of diseases, such as breast cancer, Raynaud's phenomenon, headache, reflex sympathetic dystrophy, and others.

Thermography is considered experimental/investigational because the available published literature does not support this test as a useful aid in the diagnosis or treatment of illness or injury. Therefore, this service is not covered.

## Sensory Stimulation for Coma Patients

**NOT COVERED: CONSIDERED NOT MEDICALLY  
NECESSARY**

Utilizing the senses of vision, hearing, smell, taste, touch, or bodily movements with tensions, sensory stimulation is aimed at arousing a comatose patient. The goal is to heighten rehabilitative potential.

Due to the lack of concrete evidence, despite more than 50 years of research, sensory stimulation for the comatose patient appears to lack any medical value or benefit. Also, medical necessity, if any at all, has yet to be validated by the literature. Therefore, sensory stimulation for coma patients is considered not medically necessary and is not covered.

The appropriate code for this service is S9056: Coma stimulation per diem. This code will be denied as not medically necessary.

## Cornea Transplant

**COVERED ACCORDING TO CERTAIN CRITERIA**

Cornea transplantation is intended to improve sight in individuals with irreversible tissue damage of the cornea. Cornea transplantation is a process that involves implanting cadaveric donor tissue into a recipient.

Cornea transplantation is medically necessary for the treatment of impaired vision from irreversible tissue damage of the cornea.

The appropriate diagnosis codes to report this service are as follows: Herpes simplex disciform keratitis (054.43), Vitamin A deficiency with xerophthalmic scars of cornea (264.6), Mucopolysaccharidosis (277.5), Disorders of the eye and adnexa (370.00-370.07, 370.20-370.9, 371.00-371.9, 379.31), Congenital Anomalies (743.30-743.43), Open wound of eyeball (871.0-871.9), Superficial injury of cornea (918.1), Contusion of eyeball (921.3), Burn confined to eye and adnexa (940.2-940.9), Mechanical complication due to corneal graft (996.51), Complications of transplanted organ (996.80, 996.89), Keratolytics, keratoplastics, other hair treatment drugs and preparations causing adverse effect in therapeutic use (E946.4), Eye anti-infectives and other eye drugs causing adverse effect in therapeutic use (E946.5), Cornea replaced by transplant (V42.5), Lens replaced by other means (V43.1).

## Ventricular Assist Devices

**COVERED ACCORDING TO CERTAIN CRITERIA**

Ventricular assist devices (LVADs) are considered medically necessary as a bridge (temporary means of maintaining heart function) for patients waiting for a heart transplant.

Heart transplant candidates who are unlikely to survive the waiting period until a heart is available are candidates for an LVAD as a bridge. These patients might have either a left atrial pressure of 20 mm Hg or a cardiac index (CI) of less than 2 L/min/m<sup>2</sup> while receiving maximal medical support. Patients on the heart transplant list with LVADs are considered the highest priority and are classified as status 1 by the United Network for Organ Sharing (UNOS).

LVADs are considered medically necessary postcardiotomy for patients unable to be weaned off cardiopulmonary bypass.

LVADs are considered medically necessary as destination (permanent implantation) therapy for patients with end-stage heart failure who are ineligible for heart transplant and who meet the following criteria:

- New York Heart Association (NYHA) class IV heart failure for 60 days or more

OR

- Patients in NYHA class III/IV for 28 days who have received 14 days or more support with intra-aortic

balloon pump or are dependent on intravenous inotropic agents, with two failed weaning attempts

AND

- Peak O<sub>2</sub> consumption of 14 ml/kg or less.

Additionally, patients must be ineligible for a heart transplant for one or more of the following reasons:

- Insulin-dependent diabetes mellitus with end-organ damage

OR

- Chronic renal failure (serum creatinine > 2.5 mg/dL for ≥ 90 days)

OR

- Presence of other clinically significant condition.

The appropriate diagnosis codes to report this service are as follows: Rheumatic heart failure (congestive) (398.91), Hypertensive disease (402.01, 402.11, 402.91, 404.01, 404.03, 404.11, 404.13, 404.91, 404.93) Cardiomyopathy (425.0-425.9), Heart Failure (428.0-428.9), Functional disturbances following cardiac surgery (429.4), Cardiogenic shock (785.51), Complications of Surgical and Medical Care, not elsewhere classified (996.00, 996.09, 996.61, 996.62, 996.72, 996.83, 997.1).

The PTVA system (TandemHeart) is considered experimental/investigational because the safety and/or efficacy of this device cannot be established by review of the available published literature. Therefore, this device is not covered.

## Continuous Video Monitoring for Seizures

### COVERED ACCORDING TO CERTAIN CRITERIA

Continuous video monitoring for seizures is medically necessary to confirm the following:

- True seizure activity when a neurological examination and EEG are inconclusive.
- Breakthrough seizure activity despite anticonvulsive therapy.
- Type of seizure and clinical correlation in order to determine the appropriate method of treatment.

The appropriate diagnosis codes to report this service are as follows: Epilepsy (345.00-345.91) and Other convulsions (780.39).

## Cryoablation of Renal Tumors

### COVERED ACCORDING TO CERTAIN CRITERIA

Cryoablation of renal tumors is considered medically necessary for the following:

- When used as an adjunct to other surgical treatments.
- When used alone to treat tumors that cannot be otherwise safely or effectively treated using traditional methods.

Cryosurgical ablation of renal tumors is also medically necessary in patients with predicted postsurgical and/or measured presurgical marginal renal function, or in patients with significant comorbidities that would eliminate surgical resection as a viable treatment option.

The appropriate diagnosis codes to report this service are as follows: Malignant neoplasm of kidney, except pelvis (189.0), Secondary malignant neoplasm of kidney (198.0), Benign neoplasm of kidney, except pelvis (223.0), Neoplasm of uncertain behavior of kidney and ureter (236.91).

## Functional Electrical Stimulation (FES) for Spinal Cord Injury

### COVERED ACCORDING TO CERTAIN CRITERIA

Functional electrical stimulation (FES) for spinal cord injury (344.1) is medically necessary for individuals who meet all of the following criteria:

- Intact lower motor units, (both muscle and peripheral nerve of L1 and below).
- Muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently.
- Demonstration of brisk muscle contraction to neuromuscular electrical stimulation (NMES) and the existence of sensory perception of electrical stimulation sufficient for muscle contraction.
- Possession of high motivation, commitment, and cognitive ability to use such devices for walking.
- Ability to transfer independently and demonstration of independent standing tolerance for at least three minutes.
- Demonstration of hand and finger function to manipulate controls.
- At least six-month post recovery spinal cord injury and restorative surgery.
- Lack of hip and knee degenerative disease and with no history of long bone fracture secondary to osteoporosis.

- Demonstration of a willingness to use the device on a long-term basis.

In addition to meeting all of the above criteria, individuals with spinal cord injury (SCI) must have completed physical therapy (PT) training with the device (benefit limits on PT apply).

FES for SCI is contraindicated in individuals with any of the following conditions:

- Cardiac pacemakers.
- Severe scoliosis or severe osteoporosis.
- Skin disease or cancer at area of stimulation.
- Irreversible contracture.
- Autonomic dysreflexia.

The appropriate code to report the device is K0600: Functional neuromuscular stimulator, transcutaneous stimulation of muscles of ambulation with computer control, used for walking by spinal cord injured, entire system, after completion of training program.

## **Chemonucleolysis with Chymopapain**

### **COVERED ACCORDING TO CERTAIN CRITERIA**

Chemonucleolysis with chymopapain is medically necessary for the treatment of documented lumbar disk disease (722.10) for individuals who meet the following criteria:

- Failed 6 to 12 weeks of conservative treatment.
- Neurologic symptoms in a dermatomal distribution in the lower extremity.
- Less than 50% of normal leg raise capacity and a minimum of two of the following:
  - Weakness.
  - Wasting.
  - Sensory loss.
  - Diminished reflexes.

Chemonucleolysis with chymopapain is experimental/investigational for the treatment of cervical and thoracic disk herniations. Chemonucleolysis with other substances is considered not medically necessary. Therefore, services in these instances are not covered.

Chemonucleolysis with chymopapain is contraindicated in individuals with lumbar disk disease who have any of the following:

- Papaya allergies.
- Pregnancy.

- Cauda equina syndrome.
- Sequestered disk fragmentation.
- Failed back surgery syndrome.
- Neurologic disease such as multiple sclerosis.
- Severe spondylolisthesis.
- Spinal cord tumor.
- Spinal instability.
- Severe spinal stenosis.

## **Cryosurgery of Liver Tumors**

### **COVERED ACCORDING TO CERTAIN CRITERIA**

Cryosurgery of liver tumors is medically necessary for the treatment of primary or secondary hepatic tumors (155.0, 155.1, 155.2, 197.7, 211.5, 235.3, 239.0) for patients:

- Whose disease may be deemed unresectable on the basis of location or number of tumors.
- Who have comorbid disease that makes them poor surgical candidates.
- Who refuse hepatic resection.

The codes for ablation may be reported only once per date of service, regardless of the number of tumors and number of cryoprobe passes to treat each tumor and achieve the tumor-free margin.

## **Pharmacogenetics and Metabolite Monitoring in 6-Mercaptopurine/Azathioprine Therapy**

### **COVERED ACCORDING TO CERTAIN CRITERIA**

Analysis of azathioprine/6-mercaptopurine (AZA/6-MP) metabolite markers is medically necessary:

- After initiation of therapy for individuals at increased risk of toxicity.
- To assess therapeutic response.
- To optimize pharmacological dosing (repeat testing may be necessary).

Determination of thiopurine methyltransferase (TPMT) enzyme status by genotyping or phenotyping is medically necessary as a one-time screening assay for individuals being considered for AZA/6-MP therapy.

AZA/6-MP therapy monitoring is available through some network providers.

**Nesiritide (Natrecor®)****COVERED ACCORDING TO CERTAIN CRITERIA**

Nesiritide (Natrecor®) is a recombinant form of human B-type natriuretic peptide (rhBNP), a naturally occurring protein secreted by the heart. Nesiritide (Natrecor®) has been utilized in the treatment of individuals with acutely decompensated congestive heart failure (CHF) who have dyspnea at rest or with minimal activity.

Nesiritide (Natrecor®) is medically necessary for the following FDA-approved indication:

- Individuals with acutely decompensated congestive heart failure (428.0) who have dyspnea at rest or with minimal activity.

All off-label indications for nesiritide (Natrecor®) are considered experimental/investigational and therefore are not covered.

The appropriate code to report this drug is J2324: Injection, nesiritide, 0.5 mg.

**Inpatient Administration of Dihydroergotamine Mesylate (D.H.E. 45®) Injection****COVERED ACCORDING TO CERTAIN CRITERIA**

An inpatient admission for the administration of dihydroergotamine mesylate (D.H.E. 45®) injection may be medically necessary for individuals with intractable cluster headaches and severe migraines (346.00-346.91, 784.0) when outpatient therapies, such as analgesics, antiemetics, and dihydroergotamine mesylate (D.H.E. 45®) injections, have been unsuccessful in relieving the headache cycle.

When an inpatient admission is required for the administration of dihydroergotamine mesylate (D.H.E. 45®) injection, the inpatient hospital stay is approximately 1-3 days.

The appropriate code to report this drug is J1110: injection, dihydroergotamine mesylate, per 1 mg.

**End-Diastolic Pneumatic Compression Therapy****COVERED ACCORDING TO CERTAIN CRITERIA***Treatment of Lower Extremity Ulcers*

End-diastolic pneumatic compression therapy is medically necessary for chronic venous insufficiency with venous stasis ulcers, diabetic ulcers of the lower extremity, and arterial ischemic ulcers of the lower extremity that are not clinically amenable to revascularization and/or skin grafting, or when skin grafting or surgical intervention is contraindicated or refused, when all of the following medical necessity criteria are met:

- The ulcer(s) has been treated with conventional therapy (e.g., moist wound dressings, compression bandage system, or a compression garment, exercise and elevation of the limb) for a minimum of 24 weeks.
- The ulcer(s) has failed to decrease in size with conventional therapy.
- The ulcer(s) has not shown any indication (e.g., granulation or progression towards closure) that improvement is likely with conventional therapy.
- The affected limb is free of osteomyelitis.

Treatment for conditions that meet the above criteria will be limited to 35 treatments per episode for venous stasis, diabetic ulcers, and arterial ischemic ulcers.

*Treatment of Claudication Pain and Lymphedema*

End-diastolic pneumatic compression therapy is medically necessary for individuals with claudication pain or chronic lymphedema. Treatment of these conditions is limited to six sessions per episode.

The appropriate diagnosis codes to report this service are as follows: Diabetes mellitus (250.70-250.83), Atherosclerosis (440.21-440.24), Diseases of veins and lymphatics and other diseases of the circulatory system (454.0, 454.2, 457.1, 459.31, 459.33), and Gangrene (785.4).

**Stereotactic Radiosurgery****COVERED ACCORDING TO CERTAIN CRITERIA**

Stereotactic radiosurgery is medically necessary for the following indications:

- Intracranial solitary metastases in patients having good performance status and no active systemic disease.
- High-grade gliomas.
- Arteriovenous malformations (AVMs).



- Acoustic neuromas.
- Nonresectable, residual, or recurrent meningiomas.
- Pituitary adenomas.
- Trigeminal neuralgia refractory to medical management (antidepressants, analgesics, and anticonvulsants such as phenytoin [Dilantin] and carbamazepine [Tegretol®]).

Stereotactic radiosurgery for the treatment of any other indications is considered experimental/investigational and therefore is not covered.

There are typically differences in coding between neurosurgeons and radiation oncologists for this surgical procedure. Stereotactic radiosurgery and stereotactic computer-assisted volumetric procedure are used by the neurosurgeon, whereas stereotactic radiation in the treatment management of cerebral lesion(s) is used by radiation oncologists.

The method of stereotactic radiosurgery selected may be dictated by local availability of the device. Linear accelerator surgery (linac) is the most common and may be an acceptable alternative for all but the largest lesions in which case the use of charged-particle beam may be required.

The appropriate diagnosis codes to report this service are as follows: Neoplasm of the brain, cerebral meninges, pituitary gland, and craniopharyngeal duct (191.1-191.9, 192.1, 194.3), Secondary malignant neoplasm of brain and spinal cord (198.3), Benign neoplasms (225.0-225.2, 227.3), Neoplasms of uncertain behavior (237.0 and 237.5), Neoplasm of unspecified nature of brain (239.6), Trigeminal neuralgia (350.1), Congenital anomaly of cerebrovascular system (747.81).

### **Gemtuzumab Ozogamicin (Mylotarg®)** **COVERED ACCORDING TO CERTAIN CRITERIA**

Gemtuzumab ozogamicin (Mylotarg®) is an intravenous chemotherapy agent composed of a recombinant humanized IgG4, Kappa antibody conjugated with a cytotoxic antitumor antibiotic isolated from fermentation of a bacterium.

The U.S. Food and Drug Administration (FDA) approved indications:

- Gemtuzumab ozogamicin (Mylotarg®) is medically necessary for the following FDA-approved indications:
  - Patients with CD33-positive acute myeloid leukemia (AML) (205.00-205.01) in first relapse who are 60 years of age or older and who are not considered

candidates for cytotoxic chemotherapy (i.e., experienced cardiotoxic effects after receiving cytarabine [ARA-C]).

Off-label indications:

- All off-label indications for gemtuzumab ozogamicin (Mylotarg®) are considered experimental/investigational and are not covered.

The appropriate code to report this drug is J9300: Gemtuzumab ozogamicin, 5 mg.

### **Surgical Treatment of Strabismus** **COVERED ACCORDING TO CERTAIN CRITERIA**

Surgical correction of strabismus is medically necessary for visually immature children ages ten years and younger.

Surgical correction of strabismus is medically necessary for visually mature individuals (older than ten years of age) who have vision in both eyes and who meet the following criteria:

- Are unable to maintain fusion and exhibit one of the following:
- Diplopia, or an abnormal head turn, or asthenopia, or have impairment of peripheral vision due to esotropia.

Surgery that is provided only for ocular alignment without expected functional benefit is not medically necessary and therefore is not covered.

The appropriate diagnosis codes to report this service are as follows: Disorders of the eye and adnexa (368.01, 378.00-378.9).

### **Diagnostic Breast Procedures** **(Mammography, Digital Mammography, and Scintimammography)**

#### **COVERED ACCORDING TO CERTAIN CRITERIA**

Coverage is provided for mammography services. Benefits may vary per Company product, and individual member benefits must be verified for all mammography services.

Screening mammography is medically necessary for the purpose of early detection of breast cancer. Benefits may vary per Company product.

Diagnostic mammography is medically necessary to evaluate breast abnormalities and/or breast complaints, to

further define an inconclusive screening mammogram, or as follow-up after an intervention.

Digital mammography is medically necessary as an alternative to standard screen film mammography, as either a screening or diagnostic modality.

Scintimammography is medically necessary as an adjunctive study for palpable breast masses when plain-film mammography is indeterminate or limited in patients with dense breasts or breast tissue, or patients with a history of previous surgery and/or radiotherapy. Scintimammography has not been scientifically proven as an appropriate primary screening test for breast cancer.

Certain radiology facilities, due to their own administrative procedures, may require a physician's written prescription. The ordering physician should provide a prescription for the mammography study if required by the radiology site.

In products and geographic locations with a capitated outpatient diagnostic radiology program, the member is not required to utilize the primary care physician's (PCP's) capitated radiology site for mammographies and may utilize any Company participating radiology site.

The appropriate diagnosis codes to report these services are as follows: Malignant neoplasm of the female and male breast (174.0-174.9, 175.0, 175.9), Malignant neoplasm of other and unspecified sites (196.3, 198.2, 198.81), Benign neoplasm (217), Carcinoma in situ, breast (233.0), Neoplasm of uncertain behavior of breast (238.3), Neoplasm of unspecified nature of breast (239.3), Disorders of breast (610.0-611.8), Nonspecific abnormal findings (793.80, 793.81), Factors influencing health status and contact with health services (V10.3, V16.3, V67.1, V67.2, V71.1, V76.10 -V76.19).

Ductal lavage is considered investigative and therefore is not covered.

## Claim Payment Policies

### Reimbursement of Autologous Blood Services (Collection, Storage, Transfusion, and Perioperative Salvage)

Autologous blood collection, storage, transfusion, and perioperative blood salvage associated with a scheduled elective surgical procedure that may necessitate blood transfusion are covered and eligible for reimbursement consideration under most Company products when the scheduled surgical procedure is covered.

- Individual member benefits must be verified, as some groups exclude coverage for this service.

When the transfusion occurs in a facility setting, the associated charges for the transfusion are included in the facility reimbursement.

Autologous blood collection, storage, and transfusion are not considered routine preadmission testing services.

### Acupuncture is a Benefit Contract Exclusion

According to the American Academy of Medical Acupuncture, acupuncture is a therapeutic and/or preventive medical procedure performed by the insertion of one or more specially manufactured solid metallic needle(s) into a specific location(s) on the body. The intent is to stimulate acupuncture points, with or without subsequent manual manipulation.

Acupuncture is a benefit contract exclusion for most Company products and groups, and, therefore, not covered and not eligible for reimbursement with the following exception:

- When purchased by a group as a benefit, acupuncture is covered and eligible for reimbursement consideration in accordance with the member's benefit contract.

# 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 coverage for technological advancements that are safe and clinically appropriate 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:

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	



## Photography in an Office Setting is Not Eligible for Separate Reimbursement

The Company does not consider the taking of photographs to be a distinct and separate service from an evaluation and management (E&M) service. The Company considers photography to be an integral part of E&M services, and therefore, reimbursement for this service is included in the E&M service reimbursement provided.

The most common methods of photography include Polaroids, digital, and 35mm cameras. When performed in the office setting, these methods are not eligible for separate reimbursement consideration.

## Coverage of Medical Devices

Coverage of a medical device is based on all of the following:

- The FDA approval/clearance.
- The setting in which the device is provided or used.
- The member's benefits.
- Medical necessity, as determined by the Company.
- Classification.

Medical devices that have received FDA classification are reviewed by the Company to determine medical necessity, coverage, and reimbursement. Medical devices that require FDA classification but have not been classified and/or have not received FDA clearance for marketing are considered experimental/investigational and are not covered by the Company's products.

In addition, a device that has FDA marketing clearance is considered experimental/investigational when Company review of available published literature determines that the safety and/or efficacy of the device cannot be established. Therefore, these devices are not covered.

## Reimbursement for Preadmission Testing

Preadmission testing (PAT) is covered and eligible for reimbursement consideration by the Company as follows:

The Company considers PAT to include any of the tests in the following all-inclusive list. However, the admitting physician determines which of the tests are appropriate for the member, as not all tests are required and/or appropriate in all cases.

- Routine chest x-ray.
- Urinalysis.
- Electrocardiogram (ECG).
- Complete blood count (CBC).
- Prothrombin time (PT).
- Partial thromboplastin time (PTT).
- Bleeding time (BT).
- Electrolyte levels.
- Glucose levels.
- Chemistry profiles.

PAT may be performed at the admitting facility or any participating facility designated by the admitting physician. Members enrolled in an HMO product may elect to have the physician-ordered PAT performed at their primary care physician's (PCP's) applicable capitated site (outpatient radiology or laboratory).

When PAT is performed at the admitting hospital and/or any participating facility, PAT is covered and eligible for reimbursement consideration in accordance with the facility contract.

In products and geographic regions with capitated programs, reimbursement for PAT performed for HMO members at the PCP's capitation site, is included in the monthly capitation fee. PAT in these circumstances is not eligible for separate additional reimbursement.

### *Canceled Surgery*

When a member has PATs and the procedure is canceled without being rescheduled or the procedure is rescheduled on a date beyond when the tests results are considered valid, the tests may be covered and are eligible for reimbursement consideration in accordance with the applicable contract.

When reporting a canceled procedure, use the primary diagnosis code in conjunction with the appropriate secondary diagnosis code: Surgical or, other procedure not carried out because of contraindication (V64.1) or Surgical or other procedure not carried out because of patient's decision (V64.2).