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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 CGPU. 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.

View Full Policies Online—When applicable, a list of codes and narratives is contained in the policy and is available online at: www.amerihealth.com.
Medical Policy

Airway Clearance Devices for Use in the Home Setting (05.00.53)

Covered: According to Certain Criteria

The use of nebulized medications followed by chest percussion, vibration, and postural drainage are interventions that are well documented as effective methods of chest physiotherapy (CPT). Pursed-lip breathing, a technique that creates a positive expiratory pressure (PEP), has long been used by individuals with chronic obstructive pulmonary disease (COPD). When performed consistently, the use of nebulized agents, followed by CPT, aids in keeping the airways open, thereby decreasing the work of breathing and reducing the incidence of airway obstruction and its sequelae. Airway clearance devices are considered medically necessary and, therefore, covered when the medical necessity criteria listed for each individual device are met:

Mechanical percussor devices (e.g., G5 Vibracare, G5 Flimm Fighter, G5 Neocussor, The Chest Clapper)

A four-week trial of the device for use daily or as prescribed is required, and the individual must meet all of the following criteria in order to qualify for the trial:

• A diagnosis of COPD, chronic bronchitis, or emphysema has been established.
• Manual therapy is unavailable or the caregiver is unable to administer it.
• The member’s care is managed by a pulmonologist/specialist.

After the required four-week trial, the following information is required in order to qualify for the continuing coverage of the device, which may be rented or purchased:

• Documentation that the use of the device has increased sputum production to at least 30 cc/day.

PEP devices (e.g., TheraPEP, PariPEP)

The individual must have both of the following:

• A diagnosis of cystic fibrosis or COPD.
• The ability to control breathing and cough.

Oscillating PEP devices (e.g., Flutter PEP, Acapella PEP)

The individual must have both of the following:

• A diagnosis of cystic fibrosis, COPD, or bronchiectasis.
• The ability to control breathing and cough.

Cough-stimulating devices (e.g., In-Exsufflator, CoughAssist)

The individual must meet all of the following criteria:

• The individual’s care is managed by a pulmonologist or specialist appropriate for the member’s diagnosis.
• The individual has inability to spontaneously cough.
• The individual has limited thoracic cage expansion (excursion) or is ventilator-dependent.

– Limited thoracic cage expansion can be a complication of diseases, injuries, or surgeries that prevents the lungs from fully expanding. Examples of this include, but are not limited to, the following: sequel of polio, high spinal cord injuries, scarring due to severe burns, scleroderma, neuropathies, myopathies, dystrophies, amyotrophic lateral sclerosis (ALS), and deformities of the chest wall.

The Intrapulmonary Percussive Ventilation System (IPV) (e.g., Pulmonaire)

This device is considered not medically necessary for use in the home setting. Therefore, this service is not covered. Use of this complex device is appropriate only in a facility setting.
Ankle-Foot/Knee-Ankle-Foot Orthosis (05.00.39)

Covered: According to Certain Criteria

Ankle-foot orthoses (AFOs) extend well above the ankle (usually to near the top of the calf) and are fastened around the lower leg above the ankle. These features distinguish AFOs from devices such as therapeutic shoes and supportive devices for the foot (i.e., shoe inserts and arch supports), which do not extend above the ankle. Knee–ankle–foot orthoses (KAFOs) support the knee as well as the ankle and foot.

Ambulatory Individuals

AFO
AFOs are considered medically necessary and, therefore, covered for ambulatory individuals with weakness or deformity of the foot and ankle, who require stabilization for medical reasons, and have the potential to benefit functionally.

KAFO
KAFOs are considered medically necessary and, therefore, covered for ambulatory individuals who meet the criteria for an ankle-foot orthosis and require additional knee stabilization.

Nonambulatory Individuals

AFO
AFOs are considered medically necessary and, therefore, covered for nonambulatory individuals to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body when all of the following medical necessity criteria are met:

• Plantar flexion contracture of the ankle with dorsiflexion on passive range of motion testing of at least ten degrees (e.g., a nonfixed contracture) exists.
• There is reasonable expectation that the device will correct the contracture.
• The contracture is interfering or expected to interfere significantly with the individual’s functional abilities.
• The AFO is a component of a therapy program that includes active stretching of the involved muscles and/or tendons.

KAFO
KAFOs are considered not medically necessary for a nonambulatory individual. Therefore, this service is not covered.

Custom-fabrication

Custom-fabricated, or molded-to-patient-model AFOs and KAFOs are considered medically necessary and, therefore, covered for ambulatory individuals when the coverage criteria for AFOs listed above are met and at least one of the following additional criteria is met:

• The individual could not be fitted with a prefabricated AFO.
• The condition necessitating the orthosis is expected to be permanent or of longstanding duration (more than six months).
• There is a need to control the knee, ankle, or foot on more than one plane.
• The individual has a documented neurological, circulatory, or orthopedic status that requires custom fabricating over a model to prevent tissue injury.
• The individual has a healing fracture that lacks normal anatomical integrity or anthropometric proportions.

Socks used in conjunction with orthoses are not covered, as they are not primarily medical in nature.

Not Medically Necessary

• When an AFO or KAFO for an ambulatory individual and any related component addition is used solely for the treatment of edema and/or for the prevention or treatment of a heel pressure ulcer, it is considered not medically necessary for these indications because it is not used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body (i.e., it does not meet the definition of an orthosis). Therefore, this service is not covered.
• If the medical necessity criteria for an AFO or KAFO are not met, the orthosis is considered not medically necessary. Therefore, this service is not covered.
• Additions to AFOs and KAFOs are considered not medically necessary if the base orthosis is considered not medically necessary. Therefore, this service is not covered.
 CODING GUIDELINES AND POLICY UPDATE

• A static AFO and replacement interface are considered not medically necessary if the contracture is fixed. Therefore, this service is not covered.

• A static AFO and replacement interface are considered not medically necessary for an individual who has foot drop but does not have an ankle flexion contracture. Therefore, this service is not covered.

• A component of a static AFO that is used to address positioning of the knee or hip is considered not medically necessary because the effectiveness of this type of component has not been established. Therefore, this service is not covered.

• Replacement interfaces in excess of one per six months are considered not medically necessary. Therefore, this service is not covered.

• Foot drop splints/recumbent positioning devices and related replacement interfaces are considered not medically necessary because there are other more appropriate treatment modalities. Therefore, this service is not covered.

If a static AFO is used for the treatment of a plantar flexion contracture, the pre-treatment passive range of motion should be measured with a goniometer and documented in the medical record. There should also be documentation that an appropriate stretching program is being carried out by professional staff (in a nursing facility) or caregiver (at home).

Evaluation and Fitting

Evaluation of the individual, measurement and/or casting, and fitting of the orthosis are included in the allowance for the orthosis. There is no separate reimbursement for these services.

Repairs

The reason for the repair must be documented in the supplier's record. If the expense for repairs exceeds the estimated expense of providing another entire orthosis, no reimbursement will be made for the excess amount.

Replacement

The reason for the replacement must be documented in the supplier’s record. The allowance for the labor involved in replacing an orthotic component that is coded with a specific HCPCS L code is included in the reimbursement for that component. The allowance for the labor involved in replacing an orthotic component that is coded with the miscellaneous HCPCS code L4210 is separately reimbursable in addition to the allowance for that component.

Automated External and Wearable Cardioverter Defibrillators (05.00.29)

COVERED: ACCORDING TO CERTAIN CRITERIA

An automated external defibrillator (AED) is a portable device used by someone other than the injured party to deliver an electrical shock to the heart for the treatment of sudden cardiac arrest. An AED is capable of monitoring cardiac rhythms, detecting dysrhythmias (i.e., ventricular tachycardia [VT], ventricular fibrillation [VF]) and delivering a defibrillation shock to the heart, thereby restoring a normal heart rhythm. The AED consists of a small computer (microprocessor), electrodes, and electrical circuitry. The electrodes collect information about the heart’s rhythm, which is immediately analyzed. If the rhythm is interpreted to be VF or VT, the rescuer is advised to deliver a shock by pushing a button.

An AED is only considered medically necessary and, therefore, covered when the member meets the medical criteria stated below, has a prescription from a physician for the device, and purchases the device from a durable medical equipment (DME) provider.

An AED is considered medically necessary and, therefore, covered when an implantable cardiac defibrillator (ICD) is contraindicated secondary to co-morbidities (e.g., infection, chest wall abnormalities), or the individual
refuses surgery and one or more of the following conditions are met:

- A documented episode of cardiac arrest due to VF that is not due to a transient or reversible cause.

- A sustained episode of ventricular tachyarrhythmia (30 seconds or longer), either spontaneous or induced during an electrophysiologic (EP) study, not associated with acute myocardial infarction (MI), and not due to a transient or reversible cause.

- A familial or inherited condition with a high risk of life-threatening ventricular tachyarrhythmias, such as long QT syndrome or hypertrophic cardiomyopathy.

- A diagnosis of coronary artery disease with a documented history of an MI, with a measured left ventricular ejection fraction less than or equal to 0.35 (35 percent), and inducible, sustained VT or VF during an EP study. To meet this criterion, the following must both be met:
  - The MI must have occurred more than four weeks prior to the external defibrillator prescription.
  - The EP study must have been performed more than four weeks after the qualifying MI.

- A documented history of an MI and left ventricular ejection fraction less than or equal to 0.30 (30 percent) and a QRS duration of greater than 120 milliseconds, providing that none of the following are present:
  - Symptoms occurring at rest (New York Heart Association classification IV).
  - Cardiogenic shock or symptomatic hypotension in a stable baseline rhythm.
  - A coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA) within the past three months.
  - An enzyme-positive MI within the past month.
  - Clinical symptoms or findings that would make the individual a candidate for coronary revascularization.
  - Irreversible brain damage from pre-existing cerebral disease.
  - A disease, other than cardiac disease (e.g., cancer, uremia, liver failure), associated with a likelihood of survival less than one year.

### Pediatric

A pediatric AED is specifically designed to be worn by a child. This device is considered medically necessary and, therefore, covered for children between one and eight years old or who weigh less than fifty-five pounds (25 kg) when they meet one or more of the above criteria. If a child is over the age of eight or weighs more than 55 pounds, an adult AED might be appropriate.

A wearable cardioverter defibrillator is considered not medically necessary for any individual under the age of 18. Therefore, this device is not covered.

### Not Medically Necessary

When the above criteria are not met, neither the AED (adult and pediatric) nor the wearable vest is considered medically necessary. Therefore, these devices are not covered.

Carrying cases or mounting hardware for the AED is considered not medically necessary. Therefore, these products are not covered.

More than one functioning defibrillator is considered not medically necessary. Therefore, these devices are not covered.
Intraoperative Neurophysiological Monitoring (07.03.14)

COVERED: ACCORDING TO CERTAIN CRITERIA

Intraoperative neurophysiological monitoring is the term used to describe a diversity of procedures used to monitor the integrity of neural pathways during high-risk surgeries. The primary objective of intraoperative neurophysiological monitoring is to identify and prevent complications to the nervous system (spinal cord or brain), its blood supply, or adjacent tissue with the expectation that prompt intervention will avert permanent deficits.

Intraoperative neurophysiological testing is considered medically necessary and, therefore, covered when performed during one of the following procedures:

- Surgery of the aortic arch, its branch vessels, or thoracic aorta, including carotid artery surgery, when there is risk of cerebral ischemia.
- Resection of epileptogenic brain tissue or tumor.
- Resection of brain tissue close to the primary motor cortex and requiring brain mapping.
- Correction of scoliosis or deformity of the spinal cord involving traction on the cord.
- Protection of the spinal cord where work is performed in close proximity to the cord, as in the placement or removal of old hardware or where there have been numerous interventions.
- Spinal instrumentation requiring pedicle screws or distraction.
- Decompressive procedures on the spinal cord or cauda equina carried out for myelopathy or claudication where function of the spinal cord or spinal nerves is at risk.
- Removal of spinal cord tumors.
- Removal of neuromas of the peripheral nerves of the brachial plexus, when there is risk to major sensory or motor nerves.
- Surgery for intracranial arteriovenous (AV) malformations.
- Surgery for AV malformation of the spinal cord.
- Repair of cerebral vascular aneurysms.
- Surgery for intractable movement disorders.
- Arteriography, during which there is a test occlusion of the carotid artery.
- Procedures requiring circulatory arrest with hypothermia (not including surgeries performed under circulatory bypass [e.g., coronary artery bypass, repair of ventricular aneurysms]).
- Distal aortic procedures, where there is risk of ischemia to the spinal cord.
- Leg lengthening procedures, where there is traction on the sciatic nerve or other nerve trunks.
- Treatment of basal ganglia movement disorders.
- Surgery as a result of traumatic injury to the spinal cord/brain.
- Deep brain stimulation (e.g., implantation of electrodes for the treatment of Parkinson’s disease).
- Surgery requiring protection of the cranial nerves:
  - Tumors that affect the optic, trigeminal, facial, or auditory nerves.
  - Cavernous sinus tumors.
  - Microvascular decompression of the cranial nerves.
  - Oval or round window graft.
  - Endolymphatic shunt for Meniere’s disease.
  - Vestibular section for vertigo.

Intraoperative neurophysiological monitoring must be requested by the operating surgeon and the monitoring has to be performed by a physician other than:

- The operating surgeon.
- A second physician acting as the technical/surgical assistant.
- The anesthesiologist rendering the anesthesia.

The physician billing the service must be performing the service concurrently with the surgery and be solely dedicated to performing this service. The physician may be in the operating room (OR) suite or at a remote site with the monitoring performed using digital transmission or closed circuit television. Additionally, when digital transmission or closed circuit television is used, the physician must be in continuous or immediate contact with the operating surgeon to ensure that the individual’s status can be immediately communicated during the procedure.
**Maze Procedure (11.02.20a)**

**COVERED: ACCORDING TO CERTAIN CRITERIA**

The Maze procedure is a surgical procedure intended to restore normal heart rhythm in individuals afflicted with atrial fibrillation or atrial flutter that does not respond to medical therapy. It can be performed alone or in conjunction with other cardiac surgeries for restoring the normal electrical impulses of the heart. The procedure is done under general anesthesia while the individual is on cardiopulmonary bypass (a machine that performs the functions of the heart and lungs during the surgery). Access to the heart is obtained through a sternal incision. The cardiothoracic surgeon then makes several incisions in the right and left atria of the heart to create a pathway (maze) for the electrical impulses to flow, thus restoring the normal rhythm of the heart. These incisions create a direction for the impulse to flow from the sinoatrial (SA) node to the atrioventricular (AV) node and block the re-entry of impulses that result in atrial fibrillation or atrial flutter. Results may not be evident immediately due to cardiac swelling, and some individuals may experience temporary fibrillation up to three months following the procedure. The fibrillation normally stops after the heart has had time to heal completely.

The Maze procedure is considered medically necessary and, therefore, covered for the treatment of atrial fibrillation or atrial flutter in individuals with any one of the following clinical indications:

- Resistance to drug therapy.
- Intolerance of drug therapy.
- Atrial fibrillation or atrial flutter for more than six months with an enlarged left atrium.
- High risk for thromboembolism (i.e., previous thromboembolism or long-standing atrial fibrillation with mitral valve disease).

**Pharmacogenetics and Metabolite Monitoring in 6-Mercaptopurine/Azathioprine Therapy (06.02.18a)**

**COVERED: ACCORDING TO CERTAIN CRITERIA**

The thiopurine drugs, 6-mercaptopurine (6-MP) and azathioprine (AZA), are cytotoxic and immunosuppressant agents used for the treatment of leukemia, rheumatological and autoimmune disorders, solid organ transplants, and for second-line therapy of steroid-dependent/steroid-refractory inflammatory bowel disease. AZA is a prodrug, or derivative, of 6-MP. Clinical use of AZA and 6-MP is limited by the long onset of action (about three months) and toxic side effects including hepatotoxicity and myelosuppression associated with these agents.

Analysis of AZA/6-MP metabolite markers is considered medically necessary and, therefore, covered for individuals at increased risk for toxicity following initiation of therapy when used to:

- Assess therapeutic response.
- Optimize pharmacological dosing (repeat testing may be necessary).

Determination of thiopurine methyltransferase (TPMT) enzyme status by genotyping or phenotyping is considered medically necessary and, therefore, covered as a one-time screening assay for individuals being considered for AZA/6-MP therapy.
Modifier 24: Unrelated Evaluation and Management Service by Same Physician during a Postoperative Period (03.00.15)

A physician may need to indicate that an evaluation and management (E&M) service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding Modifier 24 to the appropriate level of E&M service.

The following are appropriate uses of Modifier 24 when it is appended to an appropriate Current Procedural Terminology (CPT) and/or Healthcare Common Procedure Coding System (HCPCS) procedure code:

• The E&M service is performed by the same physician who performed the original procedure.

• The E&M service is unrelated to the condition for which the original surgical procedure was performed, regardless of the place of service.

• The Modifier 24 is appended to the E&M code for unrelated services for either major or minor surgery.

• The individual is admitted to a skilled nursing facility (SNF) for an unrelated condition during the global surgical period.

The following are inappropriate uses of Modifier 24:

• The E&M service is related to the standard postoperative management of the original surgical procedure.

• The E&M service is related to complications following the original surgical procedure.

• The subsequent procedure or service performed is more accurately described by a different procedure code and/or modifier.

• The E&M service is not associated with the global surgical period.

The medical management of an individual provided by the surgeon following surgery is not reportable with Modifier 24, with the following exceptions:

• The care is for immunotherapy management furnished by the transplant surgeon.

• The care is for critical care services unrelated to the surgery for a seriously injured or burned individual who is considered critically ill or injured and requiring constant physician attendance.

• The member’s medical record includes documentation that the care provided during the inpatient visits following surgery is not related to the initial surgery.
**Modifier 25: Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service (03.00.06)**

On the same day that a procedure or other service was performed, an individual’s condition or symptom may require a significant, separately identifiable evaluation and management (E&M) service above and beyond the other service provided, or beyond the usual pre-operative and postoperative care associated with the procedure that was performed.

These circumstances may be reported by appending Modifier 25 to the appropriate level of E&M service provided.

The following are appropriate circumstances for appending Modifier 25 to the Current Procedural Terminology (CPT) and/or Healthcare Common Procedure Coding System (HCPCS) codes representing an E&M service:

- The E&M service is a distinct and separately identifiable service performed by the same physician on the same day of the procedure or other service.
- The E&M service is performed by the same physician on the day of a minor surgical procedure.
  - A minor surgery (as defined in this policy) is one with a zero or 10-day postoperative period.
- The E&M service is beyond the usual pre-operative and postoperative care associated with the procedure.
- The E&M service is performed at the same time as a preventive care visit.
- The E&M service is reported with preoperative critical care codes within a global surgical period.

The following are inappropriate uses of Modifier 25:

- The E&M service is reported by a physician other than the physician who performed the procedure.
- The E&M service is performed on a different day than the procedure.
- The modifier is reported with an E&M service that is within the usual pre-operative or postoperative care associated with the procedure.
- The modifier is reported with non-E&M codes.
- The patient’s trip to the office was strictly for the minor procedure since reimbursement for the procedure includes the related pre-service work.
- The physician performs ventilation management in addition to an E&M service.

For additional information regarding the reporting of E&M services that resulted in a decision for major surgery, refer to the policy that addresses Modifier 57: Decision for Surgery.

Additional Modifier 25 reporting information:

- Different diagnoses are not required for reporting E&M services on the same day as a procedure.
- To appropriately report Modifier 25 with an E&M code, the service provided must be a clearly documented, distinct, and separately identifiable service.

Supporting medical necessity documentation is maintained in the medical record describing the circumstances precipitating the performance of the subsequent procedure or service.

- The member’s medical records must be available to the Company upon request.
Modifier 50: Bilateral Procedures (03.00.05)

Modifier 50 (bilateral procedure) is appended to the procedure code to indicate that the procedure was performed on both sides of the body or body part during the same operative session or on the same day.

The Company applies the Centers for Medicare & Medicaid Services’ (CMS) Physician Fee Schedule Database bilateral indicators to procedure codes to determine reimbursement consideration:

- 0 – Procedure codes with this indicator should not be reported with Modifier 50. It is inappropriate to report these codes with Modifier 50: a) because of physiology or anatomy or b) because the code specifically states that it is a unilateral procedure and another code for bilateral procedures exists.
  - When reported with Modifier 50, procedure codes with an indicator of 0 will be denied as an invalid procedure code/modifier combination.

- 1 – Procedure codes with this indicator are appropriate to be reported with Modifier 50. These are unilateral services that can be performed on paired organs or body parts.
  - When performed bilaterally and reported with Modifier 50, procedure codes with an indicator of 1 will be considered for reimbursement at 150 percent of the Fee Schedule allowance, which accounts for multiple surgery reductions when bilateral surgical procedures are performed.
  - When bilateral surgical procedures are performed in conjunction with other surgical procedures, multiple surgery reduction logic will be applied.
  - Procedure codes appended with Modifier 50 should be reported with 1 in the Number of Services field. It is inappropriate to report bilateral services with more than one unit of service.

- 2 – Procedure codes with this indicator should not be reported with Modifier 50. These codes by their terminology description state that the procedure may be performed unilaterally or bilaterally. The bilateral payment allowance has been precalculated for the code.
  - When reported with Modifier 50, procedure codes with an indicator of 2 will be denied as an invalid procedure code/modifier combination.

- 3 – Procedure codes with this indicator are appropriate to be reported with Modifier 50. These are typically nonsurgical services that can be performed on paired organs or body parts but are not subject to the standard payment rule for bilateral surgical procedures. Payment is based on 100 percent for each procedure performed.
  - When performed bilaterally and reported with Modifier 50, procedure codes with an indicator of 3 will be considered for reimbursement at 200 percent of the Fee Schedule allowance, as these are typically nonsurgical in nature and, therefore, would not be subject to multiple surgery reductions when performed bilaterally.
  - Procedure codes appended with Modifier 50 should be reported with 1 in the Number of Services field.

- 9 – Procedure codes with this indicator should not be reported with Modifier 50. The concept of bilateral does not apply to these procedure codes.
  - When reported with Modifier 50, procedure codes with an indicator of 9 will be denied as an invalid procedure code/modifier combination.

To report a bilateral service or procedure, the appropriate procedure code and/or modifier should be used.

Multiple surgery reduction logic will be applied when appropriate.

The medical records must clearly support the reporting of Modifier 50 (bilateral procedure).

- Medical records, operative notes, or other supporting documentation should not be submitted with the claim unless specifically requested by the Company.
Modifier 79: Unrelated Procedure or Service by the Same Physician during the Postoperative Period (03.00.28)

During the postoperative period of a procedure, it may be necessary for the same physician (or a physician from the same group practice) to perform an additional procedure or service that is both unrelated to the initial procedure or service and requires a return to the operating room (OR). Modifier 79 is appended to the procedure code representing the subsequent procedure or service to indicate that the procedure or service performed is unrelated to the initial procedure.

The Company has established the following guidelines for the appropriate reporting of Modifier 79 with the appropriate procedure codes:

• The subsequent procedure or service is performed by the same provider or a provider in the same provider group.

• The subsequent procedure or service is performed during the postoperative period applied to the initial procedure.

• The subsequent procedure or service is unrelated to the initial procedure as evidenced by all of the following:
  – The subsequent procedure or service is not a treatment for a complication of the initial procedure or service.
  – The subsequent procedure or service is not a repeat of the initial procedure (same procedure; on the same body part, system, or organ).
  – The diagnosis reported for the subsequent procedure or service is either:
    o Different from the diagnosis reported for the initial procedure.
    OR
    o Similar to or the same as the diagnosis reported for the initial procedure and any one or more of the following applies to the subsequent procedure or service:
      It is caused by different events or external causes (e.g., a fall from chair and a bicycle accident).
      It occurs on a different body part (e.g., pathological fractures of both a wrist and an ankle), system, or organ.

Additional Policy Information:

The following rules are applied when medical claims are received with procedure codes appended with Modifier 79 and such services meet all policy requirements:

• The postoperative period of the initial procedure remains intact.

• Procedure codes appended with Modifier 79 are not subject to the Global Surgery/Postoperative Period rules applied to the initial procedure.

• An independent postoperative period is applied to the subsequent procedure.

Additional Claims and Reporting Information:

• In order to determine if it is appropriate to report a procedure code with Modifier 79, the provider should verify the number of days representing the postoperative period applied to the initial procedure.

• The physician should report the diagnosis code that provides the highest degree of specificity, using the fourth and fifth digits where applicable.

• If multiple procedures are subsequently performed, append Modifier 79 to each of the corresponding procedure codes.

• Multiple surgical procedures appended with Modifier 79 are subject to standard multiple surgical reduction guidelines.

• It is not appropriate to report both Modifier 79 and Modifier 78 (return to the operating room [OR] for a related procedure during the postoperative period) appended to the same procedure code.

• Medical records, notes, or other supporting documentation should not be submitted unless specifically required and/or requested by the Company.
Modifiers LT/RT: Left Side/Right side Procedures (03.00.10)

Modifiers LT/RT are used to indicate the side of the body on which a service or procedure is performed. Modifiers LT/RT do not indicate a bilateral service and should not be used to report a service or procedure that is performed bilaterally. Modifier 50 should be used to report bilateral services or procedures.

The Company has established the following guidelines for the appropriate reporting of Modifiers LT/RT with the appropriate procedure codes:

- Modifiers LT/RT should be used to identify procedures that can be performed on contralateral anatomic sites (e.g., bones, joints), paired organs (e.g., ears, eyes, nasal passages, kidneys, lungs, ovaries), or extremities (e.g., arms, legs).
- Modifiers LT/RT should be used to indicate that the procedure is performed on only one side of the body.

It is inappropriate to use Modifiers LT/RT to identify bilateral services or procedures because a more appropriate modifier exists.

To report a bilateral service or procedure, the appropriate procedure code and/or modifier should be used.

Multiple surgery reduction logic will be applied when appropriate.

Associated Services Performed in Conjunction with Dental Services Considered Eligible for Reimbursement When Certain Criteria are Met (00.01.18a)

Dental services include procedures and/or surgery that relate to the teeth, jaw, and/or mouth (e.g., routine cleanings, fillings).

The Company covers and considers for reimbursement charges that are associated with noncovered dental procedures or surgery, including anesthesia, when any of the following conditions are met:

- The individual has a comorbid condition that would potentially increase the risk of the procedure being performed.
- The individual is severely disabled.
- The individual is a child.
- The individual’s admission to the Ambulatory Surgery Center (ASC), Short Procedure Unit (SPU), or hospital setting is appropriate/necessary to ensure and safeguard the individual’s health.

This policy applies to services that are performed in the following settings: ASC, SPU, hospital outpatient, or inpatient.

This policy applies whether or not the dental service is eligible under the medical benefits.

For information on dental services that are covered under the medical benefits, refer to the individual and/or group benefit contract.

Additional reporting requirements for Modifiers LT/RT:

- The medical records must clearly support the appropriate use of Modifiers LT/RT.
- Medical records, notes, and/or other documentation should not be attached to the claim unless specifically required and/or requested by the Company.
- Claims submitted with Modifiers LT/RT are subject to post-reimbursement clinical review and potential retractions for inappropriate use.
Experimental/Investigational Policies

Cryosurgical Ablation of Breast Tumors (11.08.27a)

**NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL**

Cryosurgery involves the freezing of a designated tissue (e.g., tumor) with a coolant (e.g., liquid nitrogen) through a probe inserted in the tissue. Cryosurgery is performed as an open technique or as a laparoscopic procedure utilizing ultrasound guidance. The hypothesized advantages of cryosurgery include the use of local anesthetic versus general anesthetic, a smaller incision with improved cosmetic appearance, and reduction of postoperative scarring.

Cryosurgical ablation of breast tumors 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.

Dual-Energy X-ray Absorptiometry (DEXA) Body Composition Study (09.00.20a)

**NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL**

A full-body DEXA is a noninvasive method for assessing body fat and composition. It can also be combined with an additional measurement of total body water and contribute to a body composition assessment that is based on a four-compartment mode: bone, fat, dry fat-free soft tissue, and water.

DEXA body composition study 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.

Genetic Testing for Alzheimer’s Disease (06.02.19a)

**NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL**

Of all the individuals with Alzheimer’s disease (AD), only two percent to 10 percent are affected with early onset of the disease. Furthermore, of these individuals, only 30 percent to 50 percent have been identified to have a genetic mutation. Therefore, identifiable genetic mutations are rare causes of AD overall.

Genetic testing for AD 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.

Infrared Heating Pad Systems (07.00.18a)

**NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL**

Monochromatic infrared energy (MIRE), applied via an infrared heating pad system, has been used to treat various conditions related to circulation and pain. An infrared heating pad system consists of a pad or pads containing mechanisms that generate infrared, or near-infrared, light (e.g., luminous gallium aluminum arsenide diodes) and a power source. The pads are placed on the skin for 30 to 45 minutes, three times weekly, as a treatment program for diabetic neuropathy, ischemic ulcers, and/or musculoskeletal conditions such as back, foot, or myofascial pain. No randomized, controlled studies have been conducted to assess the efficacy of the technique or its long-term effects.

Treatment of wounds, diabetic neuropathy, and/or musculoskeletal conditions with infrared heating pad systems 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.
Microwave Thermotherapy for Primary Breast Cancer (11.08.26a)

**NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL**

The thermotherapy system works by placing microwave applicators on either side of the compressed breast. The applicators then illuminate (heat) a large area of breast tissue. A probe is also placed within the breast to monitor the interstitial temperature. The technique is based on the microwave heating that occurs in high-water-content breast carcinoma compared with the surrounding low-water-content of healthy breast tissue. It is theorized that, if successful, microwave therapy could function similarly to whole-breast irradiation following breast-conserving surgery (i.e., destroying microscopic residual cancer cells). For individuals with locally advanced primary breast cancer, microwave thermotherapy may shrink the size of the tumor, thus allowing a less invasive breast surgery.

Microwave thermotherapy for primary breast cancer 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.

Salivary Estriol as Risk Predictor for Preterm Labor (07.09.02a)

**NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL**

Estrogen is released by the fetal adrenal gland and converted into estriol by the placenta. Estriol is normally present in plasma early in gestation, with accelerated increases occurring several weeks prior to term or preterm labor and delivery. This increase in estriol is also reflected in maternal saliva levels. It is proposed that monitoring salivary estriol levels may be used as a component of the clinician’s assessment of risk for preterm labor and delivery. Advocates suggest that if an initial test is positive, further monitoring for other risk factors for preterm birth, including a repeat salivary estriol test, may be performed. If a repeat test is also positive, high-risk care should be followed. A negative test predicts a low likelihood of delivering within the ensuing two weeks.

Salivary estriol as a risk predictor for preterm labor 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 (07.02.13a)

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 disease, such as, but not limited to, breast cancer, Raynaud’s phenomenon, headache, and reflex sympathetic dystrophy.

The American College of Radiology, the American Medical Association, and the American Academy of Neurology have all issued documents that do not recommend or endorse thermography as a diagnostic technology.

Thermography 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.

Transytympanic Micropressure Applications as a Treatment of Meniere’s Disease (05.00.64)

NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL

Meniere’s disease is a chronic, incurable disorder of the inner ear that is characterized by episodes of vertigo, tinnitus (ringing in the ears), fluctuating hearing loss, and a feeling of fullness or pressure in the ear.

The traditional and conservative therapy for managing Meniere’s disease includes pharmacological therapy to lessen vestibular symptoms and a low-sodium diet and diuretics to reduce the fluid accumulation in the inner ear. The Meniett is a transtympanic micropressure application device that applies low-pressure pulses to the external ear canal, restoring the balance in the hydrodynamic system of the inner ear. The device consists of a portable air pressure generator that delivers intermittent low-pressure pulses.

Transytympanic micropressure applications as a treatment of Meniere’s disease are considered experimental/investigational because the safety and/or efficacy of these services cannot be established by review of the available published literature. Therefore, these services are not covered.
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 the 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.

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 abide by our conflict of interest statement (available upon request prior to participation, and reviewed and reaffirmed annually upon becoming a member of the Committee).
• 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.

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

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