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

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

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

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

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

View Full Policies Online—Full descriptions of these policies are available online at www.amerihealth.com/medpolicy under the Medical section.
CODING GUIDELINES AND POLICY UPDATE

Medical Policies

**Cryosurgical Ablation of Hepatic Tumors**

**COVERED: ACCORDING TO CERTAIN CRITERIA**

Cryosurgical ablation of hepatic tumors is a technique that exposes liver tumor tissue to extreme cold in order to produce cell injury and tissue destruction. A cryoprobe is guided into the center of a tumor with the aid of intraoperative ultrasound, and when the center of the tumor is located, cooled liquid nitrogen or argon gas is pumped into the probe. The tumor freezes from the center and expands outward resulting in cellular crystallization, cell shrinkage, and membrane damage. The freezing process is continued until the tissue is frozen to 1 cm beyond the confines of the tumor.

Although the most common treatment for hepatic tumors is surgical resection, cryosurgical ablation is a viable option for individuals with liver tumors that are nonresectable. Use of cryosurgical ablation to treat hepatic tumors makes it possible to preserve more of the normal liver tissue and to destroy liver tumors without major surgical resection and significant blood loss.

A variety of cryosurgery systems, components, and accessories have received approval by the U.S. Food and Drug Administration (FDA) for use in cryosurgical ablation of hepatic tumors.

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

Cryosurgical ablation of hepatic tumors is medically necessary for the treatment of primary or secondary hepatic tumors for individuals:

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

The appropriate diagnosis codes to report this service are: Malignant neoplasm of digestive organs and peritoneum (155.0-155.2); Secondary malignant neoplasm of liver, specified as secondary (197.7); Benign neoplasm of liver and biliary passages (211.5); Neoplasm of uncertain behavior of liver and biliary passages (235.3); Neoplasm of unspecified nature of digestive system (239.0).

**Dermabrasion**

**COVERED: ACCORDING TO CERTAIN CRITERIA**

Dermabrasion is a procedure used to treat dermal and epidermal irregularities (eg, scars) in which skin, particularly the epidermis and superficial dermis, is removed. Medical literature supports dermabrasion for the revision of scars that have resulted from trauma and reports consistent good functional outcomes.

Under most circumstances, dermabrasion is a cosmetic service and a benefit contract exclusion.

Dermabrasion is medically necessary when one of the following criteria is met:

- A scar causes functional impairment severe enough to interfere with the typical activities of daily living (e.g., eating, getting in and out of bed, dressing, bathing, walking).
- As part of a global reconstructive treatment plan that follows a burn, trauma, or surgery. (Reconstructive treatment is defined as any medical or surgical service designed to restore bodily function or to correct a deformity that has resulted from trauma or surgery.)

All requests for dermabrasion require review by the Company’s Cosmetic Review Team and must include color photographs and a letter of medical necessity.

Dermabrasion not meeting the medical necessity criteria is considered cosmetic and, therefore, a benefit contract exclusion that is not covered.
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 antibody portion of gemtuzumab ozogamicin (Mylotarg®) binds specifically to the CD33 antigen, a sialic acid-dependent adhesion protein found on the surface of leukemic myeloblasts and immature normal cells of myelomonocytic lineage, but not on normal hematopoietic stem cells.

Gemtuzumab ozogamicin (Mylotarg®) is medically necessary for the following U.S. Food and Drug Administration (FDA) approved indication: Individuals with CD33-positive acute myeloid leukemia (AML) in first relapse who are 60 years of age or older and who are not considered candidates for cytotoxic chemotherapy (i.e., cardiotoxic effects occurred after receiving cytarabine [ARA-C]).

All off-label indications for gemtuzumab ozogamicin (Mylotarg®) are considered experimental/investigational.

The appropriate diagnosis codes to report this agent are: Malignant neoplasm of lymphatic and hematopoietic tissue (205.00, 205.01).

The appropriate code to report this agent is: Gemtuzumab ozogamicin, 5 mg (J9300).

Intracoronary Atherectomy, Angioplasty, and Stenting  
**Covered: According to Certain Criteria**

Atherectomy, angioplasty, and stenting are transluminal intracoronary interventions that were developed to prevent or delay coronary artery bypass grafting. These percutaneous therapeutic options are used to manage patients with angina and/or evolving myocardial infarction caused by coronary artery stenosis. Atherectomy involves the removal of plaque from an artery using a rotating blade, extraction catheter, or studded burr. Angioplasty involves inflation of a balloon catheter in a narrow or occluded coronary vessel to recanalize and dilate the vessel. Stenting involves the insertion of stainless steel mesh tubing into an artery, where it acts as a scaffolding to assist in holding the vessel open. Angioplasty can be done with or without the insertion of stents.

Transluminal intracoronary interventions, including transluminal atherectomy, angioplasty, and the insertion of stents approved by the U.S. Food and Drug Administration (FDA), are medically necessary for the treatment of acute or chronic myocardial ischemia.

The appropriate diagnosis codes to report these services are: Ischemic heart disease (410.0, 410.01-410.92, 411.1, 411.81, 411.89, 413.0, 413.9, 414.00-414.07, 414.10, 414.11, 414.19, 414.8, 414.9).
Nesiritide (Natrecor®)

**Covered: According to Certain Criteria**

Nesiritide (Natrecor®) has been approved by the U.S. Food and Drug Administration (FDA) for the short-term intravenous treatment of individuals with acutely decompensated congestive heart failure (CHF) who have dyspnea at rest or with minimal activity. It has also been proven effective when used as a constant infusion for individuals needing a bridge to transplantation.

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

Individuals with acutely decompensated CHF who have dyspnea at rest or with minimal activity as evidenced by all of the following:

- Documented New York Heart Association (NYHA) Classification Class III or IV heart failure.
- Significantly elevated brain natriuretic peptide (BNP) results greater than 500 (in the absence of CHF symptoms) or 100-500 (with acute clinical findings and CHF symptoms).
- Recent hospitalization or more than one emergency department visit related to CHF symptoms/treatment within 60 days prior to nesiritide (Natrecor®) initiation.
- The individual receives optimal treatment with oral medications including an angiotensin-converting enzyme (ACE) inhibitor, beta blocker, diuretic(s), and digitalis, and all are administered at the maximum dosage tolerated by the patient, and not otherwise contraindicated.

Nesiritide (Natrecor®) infusions must be administered under the direct supervision of the treating physician. Direct supervision is defined as the physician being present in the suite during infusion and immediately available if needed or requested. Nesiritide (Natrecor®) must only be infused with appropriate staff and equipment present to resuscitate an individual in the event of cardiac arrest, pulmonary edema, or life-threatening arrhythmia. Nesiritide (Natrecor®) should not be administered in the home setting.

Nesiritide (Natrecor®) is contraindicated in individuals who are hypersensitive to any of its components. Nesiritide (Natrecor®) should not be used as primary therapy for patients with cardiogenic shock or in patients with a systolic blood pressure less than 90 mm Hg. Since hypotension is the most common side effect of nesiritide (Natrecor®), it is vitally important that this medication be administered in a setting where blood pressure can be closely monitored and the dose of nesiritide (Natrecor®) can be reduced or discontinued if this side effect occurs. Additionally, administration of nesiritide (Natrecor®) should be avoided in individuals suspected of having, or known to have, low cardiac filling pressures, valvular stenosis, restrictive or obstructive cardiomyopathy, or other conditions in which cardiac output is dependent on venous return.

All off-label indications for nesiritide (Natrecor®) are considered experimental/investigational because the safety and/or efficacy of this agent cannot be determined based on a review of the available published literature. Therefore, all off-label indications are not covered.

The appropriate diagnosis codes to report this agent are: Other forms of heart disease (428.0, 428.21, 428.23, 428.31, 428.33, 428.41, 428.43).

The appropriate code to report this agent is: Injection, nesiritide, 0.25 mg (J2324).
Procedures for the Treatment of Gastroesophageal Reflux Disease (GERD) in Adults

Covered: According to Certain Criteria

Gastroesophageal reflux disease (GERD) is associated with chronic symptoms of heartburn and/or regurgitation and mucosal damage of the esophagus, which are produced by the abnormal reflux of gastric contents. Treatment of GERD is aimed at relieving and preventing symptoms and preventing complications. Treatment is individualized to patient symptoms and severity, and can include lifestyle modification, increasing gastric pH, increasing esophageal clearance, decreasing gastric volume, increasing gastric emptying, and increasing the tone of the lower esophageal sphincter (LES).

If, after a reasonable period of medical management following current standards of practice (e.g., histamine-receptor blockers, proton pump inhibitors, and promotility agents), the patient’s condition has failed medical treatment or the patient has developed comorbidities, the next approach may be surgical intervention.

Surgical fundoplication and valvuloplasty of the LES are medically necessary for individuals with any of the following:

- Failed medical management of GERD.
- Complications of GERD such as Barrett’s esophagus or grade 3 or 4 esophagitis.
- Medical complications attributable to a large hiatal hernia, such as bleeding or dysphagia.
- Extraesophageal symptoms, such as asthma, hoarseness, cough, chest pain, or aspiration, and documented reflux on 24-hour intraesophageal pH monitoring.

Surgical implantation of an antigastroesophageal reflux device is medically necessary for individuals with documented severe or life-threatening GERD whose conditions have been resistant to medical treatment with histamine-receptor blockers, proton pump inhibitors, or promotility agents, and who also have any of the following:

- Esophageal involvement with progressive systemic sclerosis.
- Foreshortening of the esophagus such that insufficient tissue exists to permit a valve reconstruction.
- High surgical risk for valvuloplasty procedure.
- Failed previous attempts at surgical treatment with valvuloplasty procedures.

Transesophageal endoscopic treatment for GERD, including transesophageal endoscopic gastroplasty, radiofrequency ablation, endoscopic implantation of polymethylmethacrylate beads, and injections of ethylene-vinyl-alcohol, is 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.

The appropriate diagnosis codes to report these services are: Diseases of esophagus, stomach, and duodenum (530.1, 530.11-530.21, 530.81, 530.82, 530.85); Symptoms (787.1, 787.2).

The following code is appropriate to report endoscopic implantation of polymethylmethacrylate beads and ethylene-vinyl-alcohol injections: Upper gastrointestinal endoscopy, including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with injection of implant material into and along the muscle of the lower esophageal sphincter for treatment of gastroesophageal reflux disease (S2215).
Reduction Mammoplasty

**COVERED: ACCORDING TO CERTAIN CRITERIA**

Reduction mammoplasty is a surgical procedure that excises a portion of the breast, including the skin and underlying glandular tissue. This procedure reduces the size, shape, and weight of mammary tissue to minimize shoulder, neck, or back pain or recurrent intertrigo in the mammary folds due to macromastia (a marked enlargement of one or both breasts).

Reduction mammoplasty is medically necessary when all of the following medical necessity criteria are met:

- An individual has macromastia (enlargement of the breasts) or gigantomastia.
- Clinical symptoms of breast, neck, back, or shoulder pain, or painful shoulder grooving that are present for a minimum six-week period and not responding to conservative measures.
- The individual meets the minimum specimen weight of breast tissue to be removed based on the individual's body surface area (BSA).

When a request is made for reduction mammoplasty, photographs documenting breast size are required.

The Schnur Sliding Scale Chart is used to determine the minimum estimated specimen weight (in grams) of breast tissue that the surgeon will remove from each breast, based on the individual's BSA.

The simplified formula for calculation of BSA is:

$$\text{BSA (in m}^2) = \text{[height (cm)]}^{0.718} \times \text{[weight (kg)]}^{0.427} \times 0.007449$$

Requests for reduction mammoplasty procedures that do not meet medical necessity criteria are considered cosmetic and, therefore, not covered.

The appropriate diagnosis codes to report this service are: Disorders of breast (611.1, 611.8).

Total Parenteral Nutrition (TPN)/Intradialytic Parenteral Nutrition (IDPN)

**COVERED: ACCORDING TO CERTAIN CRITERIA**

Total parenteral nutrition (TPN), also known as parenteral hyperalimentation, involves the delivery of micronutrients and macronutrients via infusion to an individual with complex nutritional needs. TPN consists of the optimal levels of glucose, amino acids, electrolytes, vitamins, minerals, and fats; the concentration of each component is calculated for the individual's specific metabolic need. TPN may be part of the treatment plan for individuals with severe pathology of the digestive system that does not allow for the absorption of sufficient nutrients to maintain weight and strength.

TPN is administered through central intravenous line access or a peripherally inserted central catheter (PICC). An infusion pump regulates the flow of the solution on either a continuous (24-hour) or intermittent schedule.

Intradialytic parenteral nutrition (IDPN) refers to the delivery of micronutrients and macronutrients to individuals who have complex nutritional needs during the time of hemodialysis. IDPN treats protein calorie malnutrition in an effort to decrease associated morbidity and mortality.

TPN is medically necessary for individuals with the following condition:

- A clinical diagnosis of a permanent, severe pathology of the alimentary (digestive) tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the individual's general condition, as described by one of the following:
  - Disorder of the small intestine and/or its exocrine glands that significantly impairs the absorption of nutrients.
  - Disorder of the stomach and/or intestine that impairs the ability of nutrients to be transported through the GI system.
  - Hyperemesis gravidarum.
IDPN is medically necessary for individuals with the following condition:

- A clinical diagnosis of a permanent, severe pathology of the alimentary tract that does not allow absorption of sufficient nutrients to maintain weight and strength commensurate with the individual’s general condition, and both of the following:
  - Infusion is necessary because the individual cannot maintain a vital stability on oral or enteral feedings.
  - Infusion is not used as a supplement to a deficient diet or deficiencies caused by dialysis.

TPN/IDPN is not medically necessary for individuals in any of the following scenarios:

- When the intravenous infusion is for weight maintenance only, and one of the following methods can be used:
  - Modifying the nutrient composition of the enteral diet (e.g., lactose free, gluten free, low in long-chain triglycerides, substitution with medium-chain triglycerides, provision of protein as peptides or amino acids).
  - Utilizing pharmacologic means to treat the etiology of the malabsorption (e.g., pancreatic enzymes or bile salts, broad-spectrum antibiotics for bacterial overgrowth, prokinetic medication for reduced motility).

- When the GI tract is functioning in the presence of one of the following medical conditions:
  - Swallowing disorders (e.g., dysphagia associated with cerebral vascular accident [CVA]).
  - A temporary defect in gastric emptying (e.g., metabolic or electrolyte disorders).
  - A psychological disorder impairing food intake (e.g., depression).
  - A metabolic disorder inducing anorexia (e.g., cancer).
  - A physical disorder impairing food intake (e.g., severe dyspnea).
  - Side effect of a medication.
  - Renal failure and/or dialysis.

When an infusion therapy service in the home setting is covered, all services provided in association with the infusion therapy service (e.g., solutions, additives, equipment and/or supplies, nursing) are covered and eligible for reimbursement.

When the home infusion therapy service is noncovered, all services provided in association with the infusion therapy service (e.g., solutions, equipment and/or supplies, nursing) are noncovered and ineligible for reimbursement consideration.

Services should be reported using the most comprehensive code.

When services are billed by participating home infusion providers, TPN/IDPN is paid in accordance with a standard fee schedule based on the number of liters the individual requires. The fee includes all required equipment and supplies. Skilled nursing visits are considered for separate reimbursement. Benefit limits may apply.

When services are billed by non-participating providers, reimbursement is subject to any out-of-network penalties, coinsurance, deductibles, and pre-authorization requirements.

The appropriate codes to report this service are:

- Home infusion therapy, total parenteral nutrition (TPN); 1 liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem (S9365).
Home infusion therapy, total parenteral nutrition (TPN); more than 1 liter but no more than 2 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem (S9366).

Home infusion therapy, total parenteral nutrition (TPN); more than 2 liters but no more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem (S9367).

Home infusion therapy, total parenteral nutrition (TPN); more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment including standard TPN formula (lipids, specialty amino acid formulas, drugs other than in standard formula and nursing visits coded separately), per diem (S9368).

Trastuzumab (Herceptin®)

COVERED: ACCORDING TO CERTAIN CRITERIA

Trastuzumab (Herceptin®) is a monoclonal antibody that binds to HER-2/neu and is used for the treatment of individuals with metastatic breast cancer whose tumors overexpress the human epidermal growth factor receptor 2 (HER-2)/neu protein.

Trastuzumab (Herceptin®) is medically necessary for the following U.S. Food and Drug Administration (FDA)-approved indications:

- For the treatment of individuals with metastatic breast cancer whose tumors overexpress the HER-2/neu protein and who have received one or more chemotherapy regimens for their metastatic disease.
- When used in combination with paclitaxel for the treatment of individuals with metastatic breast cancer whose tumors overexpress HER-2/neu protein and who have not received chemotherapy for their metastatic disease.

All off-label indications for trastuzumab (Herceptin®) are considered experimental/investigational and, therefore, not covered.

The appropriate diagnosis codes to report this drug are:
Malignant neoplasm of bone, connective tissue, skin, and breast (174.0-174.9, 175.0, 175.9).

The appropriate code to report this drug is: Trastuzumab, 10 mg (J9355).

The appropriate code to report paclitaxel when provided in combination with trastuzumab (Herceptin®) is: Paclitaxel, 30 mg (J9265).
Wireless Capsule Endoscopy

Covered: According to Certain Criteria

Wireless capsule endoscopy (WCE) is an ingestible telemetric gastrointestinal (GI) capsule imaging system. It is an adjunctive tool used to detect abnormalities in the area of the small bowel mucosa that is not accessible to standard upper endoscopy and colonoscopy.

WCE using a device approved by the U.S. Food and Drug Administration (FDA) is medically necessary for individuals 10 years of age and older to establish the diagnosis of occult GI bleeding, small bowel neoplasm, and/or Crohn's disease.

The use of WCE is limited to individuals for whom a GI bleeding workup has failed to reveal a source of bleeding and/or a diagnosis. In these instances, WCE is used as an alternative test.

Occult GI Bleeding

WCE is indicated for the diagnosis of occult GI bleeding, the site of which has not previously been identified by any of the following: upper GI endoscopy, colonoscopy, push enteroscopy, nuclear imaging, or radiological procedures. It is especially helpful in the diagnosis of angiodysplasias of the GI tract.

Small-bowel Neoplasm

WCE is indicated for the detection of neoplasms of the small bowel, when the diagnosis has not been previously confirmed by upper GI endoscopy, colonoscopy, push enteroscopy, nuclear imaging, or radiological procedures. The patient must be symptomatic for a neoplasm (e.g., partial bowel obstruction, GI bleeding), and other diagnostic testing (i.e., upper GI endoscopy, colonoscopy) must not have previously diagnosed the patient's condition.

Crohn's Disease

WCE is indicated for the diagnosis of Crohn's disease when the condition has not been previously confirmed. The use of WCE is limited to patients who are symptomatic for Crohn's disease (e.g., diarrhea, GI bleeding, abdominal pain) who have undergone complete lower GI studies (i.e., colonoscopy, barium enema, and stool specimen) that failed to reveal the source of the patient's symptoms.

WCE for all other indications not listed above is considered experimental/investigational and, therefore, not covered. Experimental/investigational indications include but are not limited to:

- Screening for colorectal cancer.
- Hematemesis.
- Confirmation of lesions or pathology normally within the reach of upper or lower endoscopes (lesions proximal to the ligament of Treitz or distal to the ileum).
- Diagnosing conditions outside the small bowel.

The appropriate diagnosis codes to report this service are:

- Malignant neoplasm of digestive organs and peritoneum (152.0-152.9); Secondary malignant neoplasm of small intestine, including duodenum (197.4); Benign neoplasm of duodenum, jejunum, and ileum (211.2); Carcinoma in situ of other and unspecified parts of intestine (230.7); Regional enteritis of small intestine (555.0); Other diseases of intestines and peritoneum (560.9, 562.02, 562.03, 569.85, 569.86); Other diseases of digestive system (578.1, 578.9); Symptoms (787.91, 789.00-789.09); Nonspecific abnormal finding in stool contents (792.1).
**Zoledronic Acid (Zometa®)**

**COVERED: ACCORDING TO CERTAIN CRITERIA**

Zoledronic acid (Zometa®) is an intravenous (IV) bisphosphonate drug for the treatment of hypercalcemia of malignancy. The principal pharmacologic action of zoledronic acid (Zometa®) is inhibition of bone resorption. Zoledronic acid (Zometa®) inhibits the increased osteoclastic activity and skeletal calcium release that are induced by the various stimulating factors released by tumors.

Zoledronic acid (Zometa®) is medically necessary for the following indications as approved by the U.S. Food and Drug Administration (FDA):

- Individuals with hypercalcemia of malignancy.
- Individuals with multiple myeloma.
- Individuals with documented bone metastases from solid tumors, in conjunction with standard antineoplastic therapy.
- When used for bone metastases associated with prostate cancer, zoledronic acid (Zometa®) should only be administered following one course of hormonal therapy with evidence that the disease has progressed.

The only off-label indication for zoledronic acid (Zometa®) that is considered medically necessary is for individuals with osteolytic lesions due to metastases. All other off-label indications for zoledronic acid (Zometa®) are considered experimental/investigational and, therefore, not covered.

The appropriate codes to report this drug are:
- Malignant neoplasm of respiratory and intrathoracic organs (162.0-162.9);
- Malignant neoplasm of bone, connective tissue, skin, and breast (174.0-174.9, 175.0, 175.9);
- Malignant neoplasm of prostate (185);
- Malignant neoplasm of other and unspecified sites (197.0, 198.5, 198.81);
- Malignant neoplasm of lymphatic and hematopoietic tissue (203.00, 203.01); Hypercalcemia (275.42);
- Disorder of bone and cartilage, unspecified (733.90).

The appropriate code to report this drug is: Injection, zoledronic acid, 1 mg (J3487).

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**Adoptive Immunotherapy**

**NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL**

Adoptive immunotherapy is intended to enhance the capability of a cancer patient’s own immune system to suppress or eliminate cancer. In adoptive immunotherapy, lymphocytes are removed from a patient, treated and reproduced in vitro, then returned to the same patient. This process is not regulated by the U.S. Food and Drug Administration (FDA).

Adoptive immunotherapy 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.

The appropriate code to report this service is: Adoptive immunotherapy, i.e., development of specific anti-tumor reactivity (eg, tumor-infiltrating lymphocyte therapy) per course of treatment (S2107). However, this code will deny as experimental/investigational.

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**Artificial Intervertebral Disc Insertion**

**NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL**

The use of spinal fusion to treat degenerative disc disease alters the biomechanics of the back and may cause premature disc degeneration at adjacent levels. To avoid this problem, a new technique has been developed in which the diseased spinal disc is surgically replaced with an artificial intervertebral disc that consists of two metal endplates and a central free component. The central component is held in place by the surrounding soft tissues and moves within the disc space during spinal motion. The goal of this procedure is to reduce or eliminate back pain while maintaining spinal curvature, flexibility, and load bearing.

Artificial intervertebral disc insertion 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.
Clitoral Therapy Device

**NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL**

The Eros Clitoral Therapy Device (CTD) (UroMetrics Inc., St. Paul, Minn.) is a battery-powered device designed to increase blood flow to the clitoris by creating a vacuum in the area, thus achieving engorgement and increased blood flow to the genitalia. It is theorized that increased blood flow to the clitoris may result in swelling and expansion of the arteries in the area, putting pressure on the nerves, which may result in increased sensation and vaginal lubrication.

In April 2000, the U.S. Food and Drug Administration (FDA) approved this device for use in the treatment of female sexual arousal disorder (FSAD). According to an FDA Talk Paper, FSAD is a persistent or recurrent inability to attain or maintain adequate vaginal lubrication and/or expansion and swelling of the external genitalia during sexual activity. Women with sexual dysfunction complain of insufficient vaginal lubrication, painful intercourse, decreased arousal or lack of desire, and difficulty achieving an orgasm.

The clitoral therapy device is considered experimental/investigational because the safety and/or efficacy of the use of this device for FSAD cannot be established by review of the available published literature. Therefore, this service is not covered.

The appropriate code to report this service is: Durable medical equipment, miscellaneous (E1399). However, this code will deny as experimental/investigational.

Endorectal Coil Magnetic Resonance Imaging for Prostate Cancer

**NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL**

Endorectal coil magnetic resonance imaging (eMRI) uses a disposable coil that is positioned in the rectum to visualize the internal architecture of the prostate and periprostatic structures to allow for staging of prostate cancer.

The U.S. Food and Drug Administration (FDA) has approved the use of the endorectal coil only for phased-array imaging of the pelvis to improve the ability to visualize the internal architecture of the prostate and periprostatic structures, including the prostate capsule and the neurovascular bundles.

eMRI for evaluation of prostate cancer 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.

Codes for magnetic resonance imaging of the pelvis should not be reported when eMRI for prostate cancer is performed.
Endovascular Stent-Graft Repair of Thoracic Aortic Aneurysm

**NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL**

An aneurysm is an abnormally dilated portion of an artery. When an aneurysm enlarges and ruptures it results in internal hemorrhage, which can lead to serious morbidity or mortality, especially in large vessels, such as the aorta.

There are several grafts in development for endovascular thoracic aortic aneurysm repair. However, no endovascular stent grafts have been specifically approved by the U.S. Food and Drug Administration (FDA) for use in the thoracic aorta.

Endovascular stent repair for the treatment of thoracic aortic aneurysms 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.

The FDA has not evaluated the use of endovascular stent grafts for this particular indication and, therefore, has not issued its final regulatory approval for this indication. In addition, published literature does not support the use of these products for this indication. If FDA approval is granted, further review regarding the safety and efficacy of these products will be undertaken.

Magnetic Resonance Imaging (MRI)-Guided Focused Ultrasound Ablation of Uterine Leiomyomata (Fibroids)

**NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL**

Uterine leiomyomata, commonly known as fibroids or myomas, are the most common uterine neoplasms of the female genital tract. MRI-guided focused ultrasound ablation for uterine fibroids has been proposed to provide a minimally invasive alternative for the treatment of uterine fibroids; it involves focused ultrasound heating of tissue, monitored by MRI. The device used for MRI-guided focused ultrasound ablation for uterine fibroids, the ExAblate 2000 System (InSightec, Tirat Carmel, Israel), received U.S. Food and Drug Administration (FDA) approval on October 22, 2004.

MRI-guided focused ultrasound ablation for uterine leiomyomata (fibroids) 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.

Noncontact Normothermic Wound Therapy

**NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL**

Noncontact normothermic wound therapy (NNWT) is a wound care procedure that employs radiant heat to promote wound healing. The theory is that wounds are hypothermic relative to normal body temperature and that, by increasing their temperature to normal, wound healing will be advanced.

NNWT 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.

The appropriate codes to report this service are: Noncontact wound warming cover for use with the noncontact wound warming device and warming card (A6000); Heat/cold application (E0231-E0232). However, these codes will deny as experimental/investigational.

Prolotherapy

**NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL**

The term “prolotherapy” is a derivation of “proliferative injection therapy.” Prolotherapy consists of a series of intraligamentous and intratendinous injections of sclerosing agents into trigger points of affected areas to induce the proliferation of new cells and relieve chronic pain. This is different from trigger point injections, which infuse anesthetics and/or anti-inflammatory agents into affected areas. Proponents of prolotherapy suggest that looseness in the supporting ligaments and tendons around the joints causes the muscles to contract against the ligament and irritate the nerve endings, thereby causing pain.
Prolotherapy 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.

The appropriate code to report this service is: Prolotherapy (M0076). However, this code will deny as experimental/investigational.

**Pulsed Magnetic Neuromodulation for Incontinence**

**NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL**

Pulsed magnetic neuromodulation is a noninvasive technique that utilizes extracorporeal magnetic innervation (ExMIT®) technology to deliver nerve impulses to the pelvic floor area to increase muscular contractions in an attempt to improve bladder control. The NeoControl® Pelvic Floor Therapy System (Neotonus, Inc., Newington, NH) employs this technology for the treatment of urinary incontinence in women. The system consists of a control unit and treatment chair. Pulsing magnetic fields generated by the chair's therapeutic head stimulate the individual’s 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.

**Topical Oxygenation**

**NOT COVERED: CONSIDERED EXPERIMENTAL/INVESTIGATIONAL**

Topical oxygenation 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. Because TMS can deliver rapid, repetitive stimulation to the brain, it is now being investigated as an alternative to electroconvulsive therapy (ECT) in the treatment of depression. In addition, TMS is being investigated in the treatment of epilepsy, Alzheimer’s disease, and other neurological disorders.

The U.S. Food and Drug Administration (FDA) has not evaluated the use of this procedure for these particular indications and therefore has not issued its final regulatory approval and labeling for these indications. Published literature does not support the use of this procedure for off-label use. However, if FDA approval is granted, further review regarding the safety and efficacy of this procedure will be undertaken.

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.

The appropriate code to report this service is: Topical hyperbaric chamber, disposable (A4575). However, this code will deny as experimental/investigational.
Claim Payment Policies

**Autologous Blood Services (Collection, Storage, Transfusion, and Perioperative Salvage) are Considered Eligible for Reimbursement by Most Company Products When the Scheduled Surgical Procedure is Covered**

Autologous blood collection and storage occurs when an individual has his/her own blood drawn and stored for personal use, such as self-donation in advance of a planned surgical procedure (preoperative). Autologous blood transfusion is the collection and subsequent infusion of an individual’s own blood. Perioperative blood salvage is the collection and reinfusion of autologous blood lost during (intraoperative) and immediately after (postoperative) a surgical procedure.

Autologous blood services, including collection, storage, transfusion, and perioperative salvage, are covered and eligible for reimbursement consideration by most Company products and groups when the scheduled surgical procedure is covered. Individual benefits must be verified, as some group contracts exclude coverage for these services.

When the transfusion occurs in a participating 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.

**Online Evaluation and Management Service is Not Eligible for Reimbursement**

An online medical evaluation is a type of evaluation and management (E&M) service provided by a physician or qualified health care professional to a member using only Internet resources in response to a member’s online inquiry.

The reportable services involve the physician’s timely response to the individual’s inquiry and must involve permanent storage (electronic or hard copy) of the encounter. The service encompasses the sum of communication (e.g., related telephone calls, prescription provision, laboratory orders) pertaining to the online individual’s encounter or problem.

Physicians may incorporate secure web-based messaging services or they may utilize vendors to facilitate online communication with members.

The Company does not cover online E&M services. Since there is no face-to-face (which implies in-person) communication between the physician and the individual, this service is not eligible for reimbursement.

The appropriate code should be used for reporting this service. It is inappropriate to use the unlisted E&M code or any other E&M code to report this service. This service should not be reported for member contact (e.g., related telephone calls) considered to be pre- or post-service work for other E&M or non-E&M services.
Ostomy Supplies are Considered Eligible for Reimbursement

Ostomy supplies are categorized as prosthetic devices and are used by individuals with a surgically created opening (stoma) to divert urine, feces, or ileal contents outside of the body. They can also be used for drainage of an abnormal opening or from a malfunctioning organ (e.g., fistula).

The Company covers and considers for reimbursement ostomy supplies as needed by the member when all of the following criteria are met:

• The member has the benefit for prosthetics.
• The ostomy supplies are supplied to replace all or part of an absent body organ or the function of a permanently inoperative or malfunctioning organ.
• The supplies are prescribed by an eligible health care provider.
• The supplies are supplied by an eligible ancillary provider.

The coverage and reimbursement for ostomy supplies vary by product and/or group. Individual benefits must be verified.

The following codes are appropriate for reporting ostomy supplies: Extension drainage tubing, any type, any length, with connector/adaptor, for use with urinary leg bag or urostomy pouch, each (A4331); Ostomy supplies (A4361-A4434); Additional ostomy supplies (A5051-A5093); Supplies for either incontinence or ostomy appliances (A5119-A5200).

Revision of a Previous Cosmetic Procedure is Not Eligible for Reimbursement

A cosmetic procedure changes the appearance of a body part without improving the physiological functioning of that body part. Performing an additional procedure to improve, correct, or further alter the appearance without improving the physiological function is considered revision of a cosmetic procedure.

A procedure performed to revise the outcome of a previous cosmetic procedure is considered cosmetic and, therefore, a benefit contract exclusion. Therefore, this service is not covered.

Sex Transformation Surgery is Not Eligible for Reimbursement

Sex transformation surgery, also known as sex reassignment surgery or intersex surgery, is the culmination of a series of procedures designed to change the anatomy of transsexuals to conform to their gender identity. For the male-to-female transsexual, surgery entails castration, penectomy, and vulva-vaginal construction. Surgery for the female-to-male transsexual consists of bilateral mammectomy, hysterectomy, and salpingo-oophorectomy, which may be followed by phalloplasty and the insertion of testicular prostheses.

Surgical procedures to revise ambiguous external sex characteristics to conform to chromosomal configuration are not considered sex transformation surgeries.

Sex transformation surgery is a benefit contract exclusion and not eligible for reimbursement consideration except when a group has purchased a benefit for sex transformation surgery. Therefore, individual benefits must be verified.

The appropriate diagnosis codes to report this service are: Neurotic disorders, personality disorders, and other nonpsychotic mental disorders (302.50-302.52, 302.6, 302.85).
More Information

Physician Volunteers Needed to Assist in Developing Medical Policies

AmeriHealth is currently recruiting physician consultants 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 physician 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 this 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

Contact Provider Services

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<tr>
<th>Provider Services</th>
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<th>Delaware</th>
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<td>PPO Policies/Procedures/Claims</td>
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