AmeriHealth

CODING GUIDELINES AND POLICY UPDATE

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Important Note:

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

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

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

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

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

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

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Special Note

Due to the frequent release of CPT, HCPCS, and ICD-9-CM coding updates, code ranges will no longer be included in the *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.

Medical Policies

Application and Removal of Tattoos (11.08.05b)

Covered: According to Certain Criteria

The application of a tattoo is considered medically necessary and, therefore, covered when:

- Performed to conceal corneal leukoma (Peter's anomaly).
- The patient's treatment plan requires that precise landmarks be placed on the skin in preparation for delivery of radiation therapy.
- Provided as part of a reconstructive breast procedure following mastectomy or injury in order to create a nipple and areola.

The removal of a tattoo is considered medically necessary and, therefore, covered:

- To eliminate a traumatic tattoo that resulted from a skin abrasion where pigment from the abraded surface has been forcefully embedded into the skin.
- To eliminate skin markings which were originally applied to an individual for the purpose of administering precise radiation therapy.

The application and/or removal of nontherapeutic tattoos is a cosmetic service and is a benefit contract exclusion for all of the Company's products.

Auditory Brainstem Implant (11.01.04)

Covered: According to Certain Criteria

The auditory brainstem implant is a device intended to impart useful hearing in people with neurofibromatosis type 2 who have bilateral deafness from the removal of auditory nerve tumors that are associated with the disease. The auditory brainstem implant restores the ability to detect certain environmental and speech sounds, although it does not re-establish normal hearing.

Auditory brainstem implants are medically necessary for individuals 12 years of age or older who have bilateral deafness from acoustic neuromas due to neurofibromatosis type 2 (NF2).

Aural rehabilitation associated with and required for the proper functioning of an auditory brainstem implant is covered if the member meets the coverage guidelines above for the implantation of the device.

Assistive listening devices for use with an auditory brainstem implant are a benefit contract exclusion, as they do not meet the definition of durable medical equipment (DME). Therefore, these items are not covered and not eligible for reimbursement consideration.

Replacement batteries that are required for the external components (as described above) are a benefit contract exclusion, as they do not meet the definition of DME. Therefore, these items are not covered and are not eligible for reimbursement consideration.

Upgrades to an existing external system for aesthetic improvement, such as a smaller profile component, or a switch from a body-worn to a behind-the-ear (BTE) model are deluxe features that serve no medical purpose and are, therefore, considered not medically necessary.

The replacement of the internally implanted components is medically necessary in individuals who have an inadequate response to existing internal components.

Elective Abortion (11.06.02c)

Covered: According to Certain Criteria

Elective abortion is the voluntary expulsion or extraction of the products of conception from the uterus that results in the termination of a pregnancy.

An elective abortion is a covered service according to the criteria specified in the member's group benefit contract and according to the applicable state laws and mandates.

Coverage limitations for elective abortion may vary by product or group. Therefore, individual member benefits must be verified.

The coverage for Medicare members is as follows:

Elective abortions are excluded under the Medicare program, except:

- In instances of rape or incest, or
- If a woman suffers from a physical disorder, physical injury, or physical illness (including a life-endangering condition caused by the pregnancy itself) that would, as certified by a physician, place the woman in danger of death unless the abortion is performed.

Medicare covers a surgical abortion in the circumstances described above but does **not** cover a medical abortion (i.e., an abortion induced by a pharmaceutical agent/ medication).

Federal Employee Plan (FEP) Preferred Provider Organization/Point of Service (PPO/POS) and Federal Employee Health Benefits Program (FEHBP) Health Maintenance Organization (HMO):

Elective abortion procedures (including services, drugs, and supplies relating to abortion) are excluded except when the pregnancy is the result of rape or incest, or when the life of the mother would be endangered if the fetus were carried to term.

The following guidelines apply to all lines of business:

First-trimester (less than or equal to 14 weeks' gestation) abortion procedures are typically performed in a physician's office or in a freestanding outpatient facility that provides abortion services, except under unusual conditions such as, but not limited to:

- Requirement for special anesthesia (e.g., general or spinal).
- Need for genetic studies on the products of conception.
- Anatomical considerations.
- Medical conditions for which the usual setting is potentially dangerous.

Procedures performed at or after 15 weeks' gestation are typically performed in the Ambulatory Surgery Center (ASC) or Short Procedure Unit (SPU) setting.

Under the provision of the Direct Access OB/GYN℠ program, HMO members are not required to obtain a referral from their primary care physician in order to obtain abortion services.

Services related to an elective abortion that is a result of an act of rape or incest or if the woman is in danger of death unless an abortion is performed should be reported with the applicable CPT or HCPCS procedure code appended with the appropriate modifier used to identify that this criteria was met.

Esophageal pH Monitoring (07.05.05)

Covered: According to Certain Criteria

Gastroesophageal reflux disease (GERD) is usually diagnosed by clinical history and endoscopy, and then treated with a trial of medical management (e.g., lifestyle and diet changes, antacids, H-2 blockers, proton pump inhibitors). In individuals who have not responded to medical management or those with atypical refractory symptoms (e.g., coughing, wheezing, laryngitis, pharyngitis, and/or other vocal disturbances), esophageal pH monitoring is used to confirm the diagnosis of GERD. A pH of four or less is generally considered to be injurious to the esophagus. A pH monitoring of the esophagus is performed to provide quantitative data on both esophageal acid exposure and a correlation between symptoms and instances of reflux.

Esophageal pH monitoring may be considered medically necessary and, therefore, covered in individuals (adults, children, or adolescents) who are able to report or describe symptoms of reflux if they present diagnostic problems associated with atypical symptoms or if their symptoms are suggestive of reflux but conventional diagnostic tests have not confirmed the presence of reflux for any of the following:

- Endoscopy-negative individuals being considered for surgical anti-reflux repair.
- Evaluation of individuals after anti-reflux surgery who are suspected of having ongoing abnormal reflux.
- Evaluation of individuals with reflux symptoms that are refractory to proton pump inhibitor therapy (medications that block acid production in the stomach).
- Evaluation of refractory reflux in individuals with chest pain after cardiac evaluation and after a one-month trial of proton pump inhibitor therapy.
- Evaluation of suspected otolaryngologic manifestations of GERD (i.e., laryngitis, pharyngitis, chronic cough, voice disturbance) that have failed to respond to at least four weeks of proton pump inhibitor therapy.

- Evaluation of concomitant GERD in an adult-onset, nonallergic asthmatic individual suspected of having reflux-induced asthma or an unspecified respiratory abnormality.
- Esophagitis.
- Ulcers of the esophagus.
- Barrett's esophagus.
- Heartburn.
- Dysphagia.

Esophageal pH monitoring may be considered medically necessary and, therefore, covered in individuals (non-communicative adults, adolescents, or children and infants) who are unable to report or describe symptoms of reflux for any of the following clinical indications:

- Unexplained apnea.
- Bradycardia.
- Refractory coughing or wheezing, stridor, or recurrent choking (aspiration).
- Persistent or recurrent laryngitis.
- Recurrent pneumonia.
- Unspecified respiratory abnormality.

Evaluation and Management of Diabetic Peripheral Neuropathy with Loss of Protective Sensation (LOPS) (07.03.15)

Covered: According to Certain Criteria

Peripheral neuropathy is a nerve disorder that can affect the upper and lower extremities of an individual with diabetes. Peripheral neuropathy leads to loss of protective sensation (LOPS), whereby an individual is unable to feel minor trauma from mechanical, thermal, or chemical sources. Sores or blisters may appear in some areas, and the reduction in autonomic nerve functions may also inhibit wound healing. Injuries that are not promptly treated may lead to amputation due to the spread of infection to the bone.

Evaluation & management (E&M) of diabetic peripheral neuropathy with LOPS is considered medically necessary and, therefore, covered every six months for individuals with a documented diagnosis of diabetic sensory neuropathy and LOPS.

External Counterpulsation (ECP) (07.02.05c)

Covered: According to Certain Criteria

External counterpulsation (ECP) is a noninvasive procedure used to treat chronic and disabling angina in individuals who are not suitable candidates for standard therapies such as balloon angioplasty and cardiac bypass surgery. ECP uses pneumatic cuffs that are wrapped around the individual's calves, thighs, and lower abdomen. The cuffs are rapidly and sequentially inflated when the heart enters its resting phase (diastole), and then deflated just before the heart's next contraction (systole). This action appears to improve myocardial perfusion and reduce cardiac workload and oxygen requirements.

ECP is considered medically necessary and, therefore, covered for individuals who have been diagnosed with disabling angina (Class III or IV of the Canadian Cardiovascular Society Classification, or equivalent classification) whose disease, in the opinion of a cardiologist or cardiothoracic surgeon, is not readily amenable to surgical intervention, such as balloon angioplasty or cardiac bypass, because of one of the following:

- The individual's condition is inoperable.
- The individual's is at high risk of operative complications or post-operative failure.
- The individual's coronary anatomy is not readily amenable to such procedures.
- The individual has comorbid states that create excessive risk.

Hospital Beds and Accessories (05.00.56)

Covered: According to Certain Criteria

A hospital bed is a bed that provides head and leg elevation and height adjustments.

Hospital beds are considered medically necessary and, therefore, covered when required for individuals who have a medical condition (e.g., cardiac disease, chronic obstructive pulmonary disease) and require frequent or immediate adjustments or position changes due to conditions such as aspiration, shortness of breath, pain and/or require assistance with activities of daily living (ADLs) when the following criteria are met:

- A fixed-height hospital bed is considered medically necessary and, therefore, covered when the individual meets one or more of the following medical necessity criteria:
  - Adjustments of the bed position are required to alleviate pain.
  - A head elevation of more than 30 degrees is necessary due to dyspnea or the risk of aspiration.
  - Traction equipment only be attached only to a hospital bed is required.
- A variable-height hospital bed is considered medically necessary and, therefore, covered when the individual meets one or more of the medical necessity criteria for a fixed-height hospital bed and meets one of the following medical necessity criteria:
  - Requires bed height adjustment for caregiver to assist with ADLs or transfers to chair, wheelchair, or standing position.
  - Requires bed height and adjustment different from that provided by a fixed-height hospital bed for independence with transfers.
- A semi-electric hospital bed is considered medically-necessary and, therefore covered, when the individual meets one or more of the medical necessity criteria for a fixed-height hospital bed and requires frequent and/or immediate adjustments in body positioning (e.g., due to problems with aspiration or shortness of breath).
- A heavy-duty hospital bed is considered medically necessary and, therefore, covered when the individual meets one or more of the medical-necessity criteria for a fixed-height hospital bed and when his/her weight exceeds 350 lbs, but is less than 600 lbs.
- An extra heavy-duty hospital bed is considered medically necessary and, therefore, covered when the individual meets one or more of the medical-necessity criteria for a fixed-height hospital bed and when his/her weight exceeds 600 lbs.

A total electric hospital bed is not considered medically necessary because the electric height adjustment feature does not aid in the treatment of the individual's condition. Therefore, this device is not covered.

Accessories:

In addition to the individual meeting the medical-necessity requirements for the bed, the following accessories are considered medically necessary and, therefore, covered when the following criteria are met:

- Bed cradle: When the individual has one of the following conditions:
  - Acute gouty arthritis.
  - Second- or third-degree burns to the trunk and limbs (excluding wrist and hand).
- Trapeze bar: When the individual has one of the following conditions:
  - Inability to sit up independently.
  - Inability to change positions independently.
  - Inability to get in/out of bed independently.
- Side rails: When they are not an integral part of the hospital bed and the individual's condition requires bed side rails.

Medical and Surgical Treatment of Keloidal or Hypertrophic Scars (11.08.25)

Covered: According to Certain Criteria

Keloidal and hypertrophic scars are characterized by an abnormal proliferation of fibrous dermal tissue that develops after a cutaneous injury heals. Unlike hypertrophic scars, which stay within the edges of the wound, keloids extend beyond the borders of the original insult and create a thick puckered effect that can simulate a tumor.

Under most circumstances, the medical or surgical treatment of a keloidal or hypertrophic scar is a cosmetic service and a benefit contract exclusion. However, treatment is medically necessary and, therefore, covered when the location of the scar creates chronic irritation, itching, or pain that makes it difficult to perform the activities of daily living or when the scar has resulted in a contracture that restricts the individual's movement.

- When the above criteria are met, the following treatment modalities are considered medically necessary and, therefore, covered when:
  - Intralesional corticosteroids: primary therapy for hypertrophic scars and small keloids or as adjunctive therapy with surgery for large or earlobe keloids.
  - Cryotherapy: for treatment of small, recently formed keloids and mature hypertrophic scars (formed for at least one year).
  - Scalpel or laser excision with adjuvant radiation therapy and/or intralesional injections of corticosteroids: for treatment of large keloids (including earlobe keloids).
  - Compression therapy: for prevention of scarring after burn injury and for treatment of hypertrophic scars.

Silicone gel sheeting is considered experimental/investigational for the treatment of abnormal scars because there is a paucity of prospective, well-designed trials that support the efficacy of this modality. Therefore, silicone gel sheeting for the treatment of abnormal scars is not covered.

Intralesional injections of interferon, verapamil or 5-fluorouracil (5-FU) and topical therapy with imiquimod five percent cream (Aldara) are considered experimental/investigational for treatment of abnormal scars because there is a paucity of data from clinical trials to support its efficacy for these agents. Additionally, the U.S. Food and Drug Administration (FDA) has not approved any of these agents for the treatment of abnormal scars. Therefore, these services are not covered.

Medical Evaluation and Management for Attention-Deficit Hyperactivity Disorder (ADHD) (07.03.03b)

Covered: According to Certain Criteria

Evaluation

All of the following are considered medically necessary and, therefore, covered for the medical evaluation of attention-deficit hyperactivity disorder (ADHD):

- A complete physical examination within the last 12 months (including blood tests such as lead levels and quantitative plasma amino acid assays to detect phenylketonuria).
- A comprehensive medical history.
- Interviews with the parents and child to establish problem pattern of behavior and parent-child and child-peer conflicts.

Neuropsychological testing for the evaluation of a previously diagnosed ADHD is considered not medically necessary and, therefore, not covered. It should only be performed if there is a suspicion of a neurological deficit that requires additional evaluation.

Management

Pharmacological therapy in the management of ADHD may be covered under the prescription plan when the member has a pharmacy benefit.

Not Medically Necessary

Nontraditional treatments for ADHD such as, but not limited to, the following, have not shown positive health outcomes and are, therefore, considered not medically necessary:

- Elimination diets (e.g., Feingold diet).
- Nutritional supplements (e.g., megadoses of vitamins).
- Antifungal therapy.
- Electroencephalogram (EEG) biofeedback.
- Antimotion sickness medication.
- Spinal manipulation.

Physical, occupational, and/or speech therapy is considered not medically necessary and, therefore, not covered in the treatment of ADHD, unless the individual has a neurological or physical deficit that requires such therapy.

Experimental/Investigational Policies

Nontraditional treatments for ADHD lack validation and scientific support and, therefore, are considered experimental/investigational and not covered. Examples of nontraditional treatments for ADHD include:

- Sensory integration therapy.
- Optometric vision training (orthoptic/pleoptic).
- Interactive metronome training (a computerized version of keeping the beat, which provides auditory feedback).
- Chiropractic therapy.

Outpatient Speech Therapy (10.06.01a)

Covered: According to Certain Criteria

Speech pathology services are services that are deemed necessary for the diagnosis of speech and language disorders. Speech therapy is the medically prescribed treatment of speech and language disorders due to disease, surgery, injury, congenital anomalies, speech language delay, or previous therapeutic processes that result in communication disabilities and/or swallowing disorders.

Medical Necessity Criteria

Speech pathology evaluation and services related to the speech therapy process that are within the scope of the member's benefit contract are considered medically necessary and, therefore, are covered when all of the following criteria are met:

- The evaluation is prescribed by a physician and performed by a speech/language pathologist who is licensed in the state where the services are being performed and who is certified by the American Speech-Language-Hearing Association (ASHA).
- The services must be of such a complex nature that they can only be performed by a speech/language pathologist.
- The medical condition must be such that there is a reasonable expectation that the services will bring about a significant improvement within a reasonable time frame, regardless of whether the individual has a coexisting disorder.
- The services are provided in accordance with an ongoing plan of care specific to the diagnosis.
  - The plan of care should be updated at least weekly, or more frequently as the treatment progresses, goals change or are met. Upon request, documentation must be available that shows measurable progress toward meeting the short- and long-term goals outlined in the plan of care.
- The therapy is performed for a communication disorder that is a result of at least one of the following:
  - Disease (e.g., Parkinson's disease that results in increased difficulty in swallowing and speaking).
  - Surgery (e.g., surgical removal of a malignant growth on the head or neck).
  - Injury (e.g., automobile accident that results in a subdural hematoma influencing the speech center and causing neurogenic stuttering or aphasia following a cerebrovascular accident [CVA]).
  - Congenital anomalies (e.g., inborn defect of the skull, cleft lip, or cleft palate).
  - Speech-language delay that is developmental in nature.

or

• The therapy is performed for a swallowing disorder (dysphagia) that results from a condition such as, but not limited to, a CVA regardless of whether a communication disorder also exists.

Speech therapy performed for reasons other than those listed above is considered not medically necessary and, therefore, are not covered except as required by law.

Conditions That Do Not Meet Medical Necessity Criteria

Conditions or situations that do not meet medical necessity criteria for speech pathology evaluation and services related to the speech therapy process include, but are not limited to:

• Psychological speech delay.

• Behavior problems (e.g., impulsive behavior).

• Except as required by law, mental retardation, autism, attention disorders, or pervasive developmental disorders (PDDs) in the absence of a documented communication co-morbidity that is amenable to speech therapy with a reasonable expectation of achieving sustainable, measurable improvement in a reasonable time frame.

- Social communication disorder is not considered a medically necessary co-morbidity.

• Stammering and stuttering with the following exception:

- Speech therapy is considered medically necessary for neurogenic stuttering caused by acquired brain damage.

• Programs that are primarily educational in nature or that support an academic program.

• Speech therapy for the maintenance of a chronic condition when the therapeutic goals of a treatment plan have been achieved, no additional functional improvement is apparent or expected to occur, and the provision of services for a condition ceases to be of therapeutic value.

- Maintenance therapy is defined as a continuation of care and management of the individual when the therapeutic goals of a treatment plan have been achieved, no additional functional improvement is apparent or expected to occur, and the provision of services for a condition ceases to be of therapeutic value. This includes maintenance services that seek to prevent disease, promote health, and prolong and enhance the quality of life.

• Services that otherwise would not require the skills of a qualified speech/language pathologist, such as treatments that maintain function by using routines and repetitions.

- Examples of these services include, but are not limited to, word drills for developmental articulation errors, computer-based programs (e.g., Fast Forward), and procedures that may be performed by the individual, family, and/or caregivers.

Duplicate Therapy

When individuals are receiving both occupational and speech therapy, the therapies must provide different treatments with separate treatment plans and goals in order for each to be covered and be separately reimbursed. Otherwise, the therapy is considered duplicate therapy and coverage and reimbursement is only available for one therapy.

Benefit Limitations

Limitations, frequency, and annual maximums may be applied and vary by product or by group. Individual member benefits must be verified, as speech therapy benefits vary by product and group.

Speech Therapy Services Provided in Conjunction with Speech Generating Devices, Electronic Speech Aids, and Computer-Based Programs

Speech generating devices including computer-based programs:

Speech therapy provided in association with a speech generating device, including a computer-based program, is considered medically necessary

and, therefore, covered when the device is considered medically necessary consistent with the applicable medical policy.

Electronic speech aids and other electronic devices for speech:

Electronic speech aids/devices are considered medically necessary and, therefore, covered only when an individual has had a laryngectomy or has a nonfunctional larynx consistent with the applicable medical policy. There are several electronic speech aids/devices approved by the U.S. Food and Drug Administration (FDA) for use with speech therapy. Speech therapy provided in association with an approved electronic speech aid/device is considered medically necessary and, therefore, covered in accordance with the terms defined in the applicable medical policy.

Electronic speech devices that are designed to improve fluency problems (such as stuttering) rather than aid in communication disabilities are considered experimental/investigational because the efficacy of these devices cannot be established by review of the available published literature. Therefore, these devices are not covered. Examples of these types of electronic devices include, but are not limited to:

- SpeechEasy (Janus Development Group, Inc., Greenville, NC).
- FluencyMaster (National Medical Equipment, Inc., New Hyde Park, NY).

Pulse Oximetry Device in the Home Setting (05.00.31a)

Covered: According to Certain Criteria

A pulse oximetry device indirectly measures the arterial oxygen saturation levels in the blood by using a noninvasive sensor probe on the ear or finger. A pulse oximetry device in the home setting is considered medically necessary and, therefore, covered for individuals who meet all of the following criteria:

- Home oxygen therapy is required.
- Adjustments in oxygen concentration are required due to desaturation from an acute or chronic condition.
- A trained caregiver, or the individual for whom the device is being prescribed, has the physical and cognitive capacity to adjust the oxygen levels according to established guidelines set forth by the physician.
- One or more of the following conditions are present:
  - Apnea.
  - Asthma.
  - Bronchiectasis.
  - Bronchopulmonary dysplasia.
  - Central nervous system disorders affecting respiratory control.
  - Chronic airway obstruction.
  - Chronic interstitial lung disease.
  - Chronic obstructive pulmonary disease.
  - Congestive heart failure.
  - Corpulmonale.
  - Cystic fibrosis.
  - Emphysema.
  - Laryngotracheomalacia.
  - Lung mass.
  - Other apnea and respiratory distress.
  - Neuromuscular diseases (e.g., multiple sclerosis, amyotrophic lateral sclerosis).
  - Pertussis syndrome.
  - Pneumonoconiosis.
  - Pulmonary fibrosis
  - Severe gastroesophageal reflux or severe oral feeding issues.
  - Sleep apnea.
  - Status post acute respiratory distress syndrome (ARDS).

When the above criteria are not met, the use of a pulse oximetry device in the home setting is considered not medically necessary and, therefore, not covered.

Removal of Breast Implants (11.08.14b)

Covered: According to Certain Criteria

Breast augmentation/reconstruction can include the insertion of implants. The implantation can be either for medically necessary indications (e.g., following mastectomy surgery/trauma) or for cosmetic reasons. Implanted breast prostheses are silicone shells filled with saline or a combination of saline and silicone gel.

Complications can occur with breast implants that may require removal of the implant.

The removal of a silicone or saline breast implant is considered medically necessary and, therefore, covered for the following indications:

- Documented implant rupture.
- Infection.
- Extrusion.
- Baker Class III contracture (breast is firm, palpable, and the implant [or its distortion] is visible).
- Baker Class IV contracture (breast is hard, painful, cold, tender, and distorted).
- Surgical treatment of breast cancer.

Removal of intact silicone breast implant(s) for asymptomatic individuals or individuals with systemic symptoms (e.g., symptoms attributed to connective tissue or autoimmune diseases) is considered not medically necessary and, therefore, not covered.

Rhinoplasty and Septorhinoplasty (11.16.01a)

Covered: According to Certain Criteria

Under most circumstances, rhinoplasty and septorhinoplasty are cosmetic services and benefit contract exclusions. However, these procedures are considered medically necessary and, therefore, covered in certain clinical situations in which the following criteria are met:

- When the individual's medical record documents significant impairment of nasal function caused by any of the following:
  - Nasal injury (e.g., nasal fracture).
  - Nasal obstruction.
  - Nasal birth defect.
  - Acquired deformity due to trauma, tumor, and/or infection.

All requests for rhinoplasty and septorhinoplasty require review by the Company's Cosmetic Review Team. All requests must include photographs and a letter of medical necessity that lists any medications prescribed during medical management and the length of time each was used.

Rhinoplasty and septorhinoplasty that do not meet the medical necessity criteria are considered cosmetic services and, therefore, benefit contract exclusions are applicable.

Treatment for Hyperhidrosis (11.15.11)

Covered: According to Certain Criteria

Essential (primary or idiopathic) hyperhidrosis is a condition in which localized excessive sweating occurs, most frequently on the palms of the hands, soles of the feet, and/or in the axillae. The disorder, which affects up to one percent of the population, is often socially embarrassing and, to some degree, disabling, particularly in occupational situations. Severe primary hyperhidrosis can lead to skin maceration and secondary infections. In the case of secondary hyperhidrosis, which results from a variety of diseases or drugs, the underlying condition should be treated.

The hyperhidrosis disease severity scale (HDSS) measure is a four-point scale designed to assess the severity of hyperhidrosis in everyday clinical practice or in clinical research. It also evaluates the effectiveness of treatment. The HDSS can be administered by an interviewer or completed independently by the individual. The HDSS assesses disease severity based on the extent that the sweating impacts an individual's activities of daily living.

The following are medically necessary medical/surgical treatment(s)/procedure(s) for hyperhidrosis:

- Topical prescription antiperspirants as a primary treatment (i.e., axillary, palmar, plantar).
- Systemic prescription agents (e.g., sedatives, anticholinergic drugs, if tolerated).
- Administration of botulinum toxin for axillary, palmar, plantar, and/or gustatory hyperhidrosis.
- Iontophoresis performed in a medically supervised setting for axillary, palmar, and plantar hyperhidrosis.
- Subcutaneous curettage of axillary glands.
- Liposuction for axillary hyperhidrosis.
- Excision of eccrine glands (axillary).
- Open or endoscopic lumbar sympathectomy for treatment of plantar, hyperhidrosis (not commonly performed due to the risk of sexual side effects).
- Transthoracic endoscopic sympathectomy (TES) (sympathetic nerves cut or clipped) for upper extremity and axillary hyperhidrosis.
- Open thoracic sympathectomy for upper extremity and axillary hyperhidrosis.

For individuals who develop compensatory hyperhidrosis following a clipping of the sympathetic nerves, the surgical removal of the clips is considered medically necessary and, therefore, covered.

Secondary hyperhidrosis results from a variety of diseases or drugs, in which case the underlying condition should be treated.

Treatment of Twin-Twin Transfusion Syndrome (TTTS) (11.00.14)

Covered: According to Certain Criteria

TTTS is a disorder of the placenta that occurs when blood passes from one fetus to the other (in monozygotic twinning) through connecting blood vessels within the shared placenta. This can create growth retardation in the donor twin and vascular engorgement leading to congestive heart failure and hydrops (excessive accumulation of serous fluid in tissues and bodily cavities) in the recipient twin.

Amnioreduction, laser photocoagulation of placental vessels, or amnioreduction in combination with laser coagulation is considered medically necessary when provided as a treatment in TTTS when all the following criteria are present:

- Gestational age of less than 25 weeks.
- Ultrasonographic examination showing a single, monochorionic placenta.
- Massive polyhydramnios of the recipient twin (vertical pool of amniotic fluid 8-18 cm).
- Severe oligohydramnios (deepest pool less than 1 cm) or anhydramnios of the donor twin.
- Donor appears as a stuck twin fixed to the uterine wall by the intertwin membrane.
- Donor shows signs of oliguria, with either a very small, or empty, bladder.
- Recipient shows signs of polyuria, with a distended bladder.
- Fetuses are discordant in size (15-25 percent).
- Umbilical artery Doppler ultrasonography reveals the absence or reversal of end-diastolic velocities as a sign of markedly increased placental resistance.

Ultraviolet Light Therapy for Treatment of Dermatological Disorders (07.07.02a)

Covered: According to Certain Criteria

Phototherapy, defined as exposure to ultraviolet radiation (UVR) for therapeutic purposes, has a long history in the treatment of skin disorders. Although UV therapy is one of the safest treatments for many skin disorders, overexposure can result in erythema (sunburn) and degenerative and neoplastic changes in the skin. Clinically, therapeutic dosage is measured by minimum erythema dose (MED) and is subject to skin type.

Subdivisions of ultraviolet light include wavelength light A (UVA) (320-400 nm) and shorter wavelength ultraviolet light B (UVB) (290-320 nm). Photochemotherapy involves the use of photosensitizing drugs (psoralens) prior to the use of UVA.

UVA, UVB, and PUVA therapy are considered medically necessary and, therefore, covered for treatment of the following conditions:

- Psoriasis.
- Mycosis fungoides.
- Parapsoriasis.
- Vitiligo.
- Atopic dermatitis.
- Photodermatoses.
- Lichen planus.
- Pityriasis lichenoides.
- Pruritic eruptions of human immunodeficiency virus (HIV).
- Alopecia areata.
- Urticaria pigmentosa (cutaneous mastocytosis).
- Cutaneous graft-versus-host disease.
- Localized scleroderma.

Additionally, UVB is considered medically necessary and, therefore, covered for the following only:

- Pityriasis rosea.
- Uremic pruritus.

Narrow-band UVB is considered medically necessary and, therefore, covered for the following:

- Psoriasis refractory to broad-band UVB.
- Resistant plaques.
- Plaques in difficult to treat places such as hands, elbows, knees, and feet.
- Atopic dermatitis.
- Vitiligo.

An ultraviolet light box/cabinet for home use is considered medically necessary and, therefore, covered when all the following conditions are met:

- It is prescribed by a health care provider for an appropriate diagnosis listed in this policy.
- It is able to deliver UVB light waves between 290 nm and 320 nm.
- It is approved by the US Food and Drug Administration.

The excimer laser is considered medically necessary and, therefore, covered for the treatment of psoriasis. All other indications for the excimer laser are considered experimental/investigational because the safety and/or efficacy cannot be established by review of the available published literature. Therefore, this service is not covered.

Analysis of Human DNA in Stool Samples as a Technique for Colorectal Cancer Screening (06.02.25)

Not Covered: Considered Experimental/ Investigational

Recently there has been interest in fecal DNA testing for colorectal cancer screening. The hypothesis is that precancerous or cancerous lesions in the colon or rectum will shed mutated cells into the feces. The DNA from these mutated cells can be extracted and analyzed for the presence of specific, cancer-associated mutations. The studies performed thus far have been small, nonrandomized clinical studies from which permanent scientific conclusions cannot be drawn. Furthermore, opinion and evaluations by national medical associations, in particular the American Cancer Society, are not recommending fecal DNA testing for colorectal cancer based on the lack of studies evaluating its effectiveness to reduce colorectal cancer mortality.

Analysis of human DNA in stool samples as a technique for colorectal cancer screening 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.

Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedure (11.14.17)

Not Covered: Considered Experimental/ Investigational

Computer-assisted navigational orthopedic procedures use navigational systems during musculoskeletal surgery to provide additional information and to further integrate preoperative planning with how the surgery is being performed. Navigational systems are typically used to improve the placement and positioning of a prosthetic and/or surgical instrument during the procedure. Computer-assisted navigational orthopedic procedures can also be used as an adjunct to fixation of pelvic, acetabular, or femoral fractures and as an adjunct to hip or knee arthroplasty procedures.

A computer-assisted musculoskeletal surgical navigational orthopedic procedure 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.

Cryoablation of Neuromas (11.15.21)

Not Covered: Considered Experimental/ Investigational

Cryoanalgesia, also known as cryosurgery, cryolysis, cryoneurolysis and cryoablation, uses extremely low temperatures to produce a reversible nerve block similar to that delivered by local anesthesia. No randomized or controlled studies have tested cryoanalgesia specifically for pain control of neuromas.

Cryoablation of neuromas 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.

Sctintimammography (09.00.39)

Not Covered: Considered Experimental/ Investigational

Scintimammography, also known as mammoscintigraphy, has been proposed primarily as an adjunct to standard film mammography using radiopharmaceutical agents (radioactive tracer [e.g., technetium-99m sestamibi]) to provide tumor-specific imaging of the breast. Scintimammography has also been proposed for the detection of axillary lymph node metastases in individuals with breast carcinoma; however, it has not been fully investigated for this purpose. There is insufficient data comparing the use of scintimammography for decision making regarding nodal dissection versus standard nodal dissection. Although scintimammography is currently being performed, the published medical literature does not support its efficacy in differentiating malignancies when compared with using surgical biopsy.

Scintimammography 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.

Subfascial Endoscopic Perforator Surgery (SEPS) (11.02.23)

NOT COVERED: CONSIDERED EXPERIMENTAL/ INVESTIGATIONAL

Subfascial endoscopic perforator surgery (SEPS) is performed as a minimally invasive way to treat individuals with chronic venous insufficiency of the lower extremities. Guided by ultrasound scanning, small incisions are made into the skin that is unaffected by severe chronic venous insufficiency. Using endoscopic techniques, the perforating veins are clipped or divided by endoscopic scissors.

SEPS is considered experimental/investigational because the efficacy of this procedure cannot be established by review of the available published literature. Therefore, this service is not covered.

Claim Payment Policies

Electrocardiogram (ECG/EKG) Performed in Conjunction with Pacemaker Evaluation (03.02.13)

COVERED: ACCORDING TO CERTAIN CRITERIA

An electrocardiogram (ECG/EKG) is a test that records the electrical activity of the heart and is used to measure the rate and regularity of heartbeats as well as the size and position of the chambers, the presence of any damage to the heart, and the effects of drugs or devices used to regulate the heart (such as a pacemaker).

A pacemaker is an electrical device that can control the beating of the heart by a series of rhythmic electrical impulses that makes the heart beat at a certain programmed rate. An evaluation of the pacemaker includes the rate, pulse amplitude and duration, configuration of waveform, and/or testing of sensory function of the pacemaker, telephonic analysis, electrocardiograms, and physician's interpretation of the findings.

The Company covers ECG/EKG services. However, when an ECG/EKG is performed in conjunction with a pacemaker evaluation, the ECG/EKG is considered to be an integral part of the pacemaker evaluation and is therefore not eligible for separate reimbursement consideration.

Modifier–57: Decision for Surgery May be Used When the Decision to Perform a Major Surgical Procedure is Made During an Evaluation and Management Service (03.00.16)

There are circumstances in which the decision to perform a major surgical procedure is made during an evaluation management (E&M) service. Modifier-57 (decision for surgery) is appended to the appropriate level of E&M procedure code to denote this information.

The following are appropriate uses of Modifier-57 when appended to the Current Procedural Terminology (CPT®)* and/or Healthcare Common Procedure Coding System (HCPCS) procedure codes:

- The E&M service results in the decision to perform a major surgical procedure.
- The E&M service is performed the same day as or the day before a major surgery with a 90-day postoperative period.
- The decision to perform surgery or a procedure is made during a general ophthalmologic service.

The following are inappropriate uses of Modifier-57:

- When the modifier is appended to a surgical procedure code.
- When the modifier is appended to the hospital visit code for the day before or the day of surgery when the decision to perform the major surgical procedure was made in advance of the surgery.
- When the modifier is appended to an E&M service furnished on the same day as a minor procedure with a 0- or 10-day postoperative period.

When Modifier-57 is used, E&M services performed on the day of or the day before the major surgery are not included in the global surgery payment. The E&M service, consultation, or ophthalmologic services are eligible for separate reimbursement consideration.

The procedures listed in this policy are reportable with Modifier-57. Inclusion of a code in this policy does not imply reimbursement. Eligibility, benefits, limitations, exclusions, precertification/referral requirements, provider contracts, and applicable policies still apply.

For additional information regarding the reporting of E&M services with a minor procedure with a 0- or 10-day postoperative period, refer to the Modifier-25 policy on significant, separately identifiable evaluation and management services.

Work Hardening and Work Conditioning is Not Covered Under Most of the Company's Products (10.05.02)

Work-hardening services address physical, functional, behavioral and vocational needs of the worker by utilizing real or simulated work activities. Additionally, work hardening includes education (e.g., body mechanics, work pacing, safety and injury prevention). A work hardening program begins at four hours per day and builds to eight hours per day over the course of the program, usually four weeks. Work hardening requires a specific return to work goal. Work hardening services relate directly to specific work skills and do not provide any diagnostic or therapeutic rehabilitation benefit for the individual.

Work conditioning (including reconditioning) utilizes physical conditioning and functional activities related to work. These services bridge a gap between acute outpatient therapy and a structured work hardening program or return to work. Work conditioning/re-conditioning may or may not include an education component. Work conditioning/re-conditioning is typically four hours/day or less and there is no specific return to work goal required.

Work hardening and work conditioning are benefit contract exclusions for some of the Company's products. If the group benefit contract does not provide a specific exclusion for work hardening, the service is considered not medically necessary as it is considered vocational in nature and does not provide any diagnostic or therapeutic benefit of a medical nature for the individual.

More Information

Physician Volunteers Needed to Assist in Developing Medical Policies

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

Medical policies are research-based documents that allow AmeriHealth to evaluate the medical necessity of services, devices, biologics, and procedures for its members. In addition, medical policies provide guidelines for obtaining benefits and reimbursement in accordance with 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 adhere to our confidentiality statement.
- Maintain a high ethical standard, evidenced by the absence of any AmeriHealth investigation into personal or group claims practices.
- Complete and sign a Conflict of Interest Statement and Confidentiality Agreement prior to becoming a member of the advisory panel.

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

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

Contact Provider Services

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

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