

Blue Shield Report

A NEWSLETTER FOR PROFESSIONAL PROVIDERS AND THEIR STAFF MEMBERS

May 19, 1999

MAC

MAC-1-99

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- Alpha Prefix – Insured's Identification Number
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ATTACHMENTS:

- Assistant at Surgery Denial List
- Major/Minor Classification List

QUESTIONS:

Contact your Professional Relations Representative, or the Professional Relations Hotline at **1.800.432.3587**, or in the Topeka area, **785.291.7060**.

OUR WEB ADDRESS:

<http://www.bcbsks.com>

ACKNOWLEDGEMENT:

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The following guidelines, which were recommended by their perspective liaison committees and approved by the Medical Advisory Committee (MAC), will become effective June 1, 1999.

Podiatry Guidelines

ASSISTANT AT SURGERY DENIAL LIST

It has been determined that an assistant at surgery is **NOT** medically necessary for the following procedures. Individual Consideration (IC) is available for atypical cases when submitted with modifier 22 and supporting documentation.

- 11055** Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); single lesion
- 11056** Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); two to four lesions
- 11057** Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus); more than four lesions
- 11719** Trimming of nondystrophic nails, any number
- 28289** Halux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint

Ob/Gyn Guidelines

ASSISTANT AT SURGERY DENIAL LIST

It has been determined that an assistant at surgery is **NOT** medically necessary for the following procedure. Individual Consideration (IC) is available for atypical cases when submitted with modifier 22 and supporting documentation.

- 57106** Vaginectomy, partial removal of vaginal wall

An assistant at surgery **WILL BE ALLOWED** for the following new 1999 CPT procedure codes.

- 57107** Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
- 57109** Vaginectomy, partial removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)

(Continued.)

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- 57111** Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy)
- 57112** Vaginectomy, complete removal of vaginal wall; with removal of paravaginal tissue (radical vaginectomy) with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy)

SALIVARY ESTRIOL (SALEST) TESTING

The Salivary Estriol (SalEst) test has not been proven to be effective; further studies are needed regarding its efficacy. Therefore, SalEst is not a covered service and will be denied as Investigational/Experimental.

BILLING PROCEDURES 57282 AND 57250

Benefits will be allowed for both procedures **57282** (Sacrospinous ligament fixation for prolapse of vagina) and **57250** (Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy) when performed at the same setting. Multiple surgery guidelines will be applied.

Pediatric Guidelines

SYNAGIS IM

Synagis, Respiratory Syncytial Viral Specific IGIV (**S9137**) is an IM injection which requires PREDETERMINATION. Synagis has been approved (by the FDA) for use in the prevention of severe Respiratory Syncytial Virus (RSV), lower respiratory tract disease in infants and children younger than 24 months with bronchopulmonary dysplasia or a history of premature birth (less than 32 weeks of gestation), and for children born between 23 and 35 weeks gestation with additional risk factors.

1. Covered Conditions
 - a. Children less than two (2) years of age with chronic lung disease who have had oxygen requirements within the last six months or are currently on oxygen. Patients greater than one (1) year of age who have surpassed one year through at least one RSV season without hospitalization would probably not be a candidate for Synagis benefits.
 - b. Premature infants with gestational age of 32 weeks or less without bronchopulmonary dysplasia. Major risks factors to consider are gestational age at birth and chronological age at the start of the RSV season. Infants with a gestational age of 28 weeks or less may benefit from prophylaxis up to 12 months of age. Infants 29 to 32 weeks of gestational age may benefit from prophylaxis up to six months of age.
 - c. Risks factors to be considered in groups a. and b.
 1. Children who are premature and are in crowded home environments with greater than four people;
 2. Older brothers and sisters in school;
 3. One of twins or triplets;
 4. Smoking in the home by a caretaker.

(Continued.)

2. Children born between 32 and 35 weeks of gestation with additional risk factors are outlined in "c" above.
3. The following groups will NOT be considered candidates for Synagis therapy:
 - a. Cyanotic Heart Disease – Available data indicates that Synagis should NOT be used in patients with cyanotic heart disease.
 - b. Asymptomatic acyanotic heart disease (These patients MAY benefit if they ALSO meet the covered conditions listed in 1.a. and b. above.)
4. Although specific recommendations for all immunocompromised patients cannot be made, children with severe immunodeficiencies may benefit from Synagis. Providers may consider substituting Synagis during the RSV season for patients receiving IGIV monthly.

EVENT RECORDING INTERPRETATION (APNEA MONITOR DOWNLOADS)

The interpretation of the apnea monitor download will be denied content of service of the general pediatric care. For the physician who is not the patient's general care physician but reads the download for the general care physician, benefits for the interpretation will be allowed on an Individual Consideration (IC) basis.

Pediatric & Internal Medicine Guidelines

BOTOX® FOR SPASTICITY

It has been determined that Botox® for spasticity will be allowed per the following guidelines. Before submitting, a PREDETERMINATION should be obtained. When submitting for services, **J0585** should be used for billing the drug and **64999** for the physician services.

1. There must be documented neurological-based spasticity.
2. There must be a stated goal of treatment. It may be very simple: improve comfort, hygiene, or skin care. It does not have to be dramatic like walking again, etc.
3. Repeat injection would be approved only if improvement was documented from first injection. If no improvement after an adequate trial, treatment should not be repeated.
4. If it is felt that perhaps a therapeutic level was not obtained initially, a booster may be given, or a larger dose or selection of different muscles at the next injection.
5. Improvement should be noted within 7 to 21 days.
6. Administration – One to three vials may be used in one treatment. This is dependent on how many muscles are intended for injection and the size of the muscles. Any claim using more than three vials or injecting more than two limbs at one time will be reviewed. More muscles than that can be injected at one time, but it needs to be investigated before approving.
7. There is no age limit. It has been found that pre-school children do require a lesser dose. School-age children, however, often take an adult dose. This would be a clinical judgement.
8. If there is documented improvement with initial treatment, then Botox may be given every three months. It may be given sooner with Individual Consideration (IC). (Usually when spasticity returns, maybe four or five months, but could be shorter.)
9. May give indefinitely when there is improvement.
10. Review only:
 - a. If documentation of improvement is unclear; or
 - b. If being given regularly more frequently than every three months.

Internal Medicine Guidelines

LUNG VOLUME REDUCTION SURGERY (LVRS)

The current guidelines for Lung Volume Reduction Surgery (LVRS) will continue to be utilized but with an amendment to B. of the Exclusion Criteria (in italics). PREDETERMINATION is required.

- A. A pre-op evaluation composed of basic pulmonary function tests, blood gases, chest x-ray and a CT scan of the chest to make sure the patient with a low FEV1 has emphysema and has heterogenous appearance which shows bullous emphysema primarily in upper lobes.
- B. No bronchospastic asthmatic component
- C. Disabling emphysema (homebound)
- D. 70 years of age or less
- E. Must have failed maximum medical therapy
- F. The FEV₁ should be between 15% and 35% predicted.
- G. The PCO₂ should be below 60.
- H. The patient must have hyperinflation.
- I. The residual volume has to be greater than 150% predicted as measured in the body box.
- J. Lung perfusion scan – The target areas for excision should show marked hypoperfusion.
- K. Cardiac disease evaluation must be done to include stress echo with catheterization if there is evidence of coronary disease.
- L. Six minute walk test to determine level of disability.
- M. Smoking cessation at least 6 months prior to procedure.
- N. The patient must have successfully participated in a pulmonary rehabilitation program for a minimum of three times per week for eight weeks with emphasis on exercise, education and nutrition in order to improve strength and endurance for physical activity. Patients who are unable to participate in such rehabilitation will not be considered candidates for the operation, nor are patients who derive such substantial benefit from rehabilitation that the surgery is no longer indicated.

Exclusion Criteria

- A. High dose steroids – more than 20 mg's per day
- B. Systemic pulmonary hypertension *more than 50 mm Hg systolic or with clinical evidence of pulmonary hypertension*
- C. Previous chest surgery (pleurodesis or thoracotomy)
- D. Extensive pleural disease to include chronic bronchitis, asthma, restrictive lung disease or malignancies of the lung
- E. Disease of heart, liver, kidney
- F. Non-ambulatory or very dependent patients who cannot go through rehabilitation
- G. Severe scoliosis/hyphosis
- H. Obesity or cachexia

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SAHARA ULTRASOUND SYSTEM BONE DENSITY TESTING

Benefits for the Sahara Ultrasound testing system will be allowed once per year, per insured, based on the same criteria as the DEXA. Procedure code **76977** [Ultrasound bone density measurement and interpretation, peripheral site(s), any method)] should be used for submitting Sahara services.

Bone Density Testing Guidelines

Bone density testing will be allowed when submitted with one of the following diagnoses.

252.0, 256.2, 275.4, 275.41, 275.42, 275.49	805.00 through 805.18
733.00, 733.01, 733.02, 733.03, 733.09, 733.10, 733.11, 733.12, 733.13, 733.14, 733.15, 733.16, 733.19	805.2, 805.3, 805.4, 805.6, 805.8 806.00 through 806.29

Any other diagnosis code will be considered by Individual Consideration when submitted with procedure code **76977** and modifier 22; medical records are required with the claim submission. The medical records should include an osteoporosis risk evaluation sheet, if available.

INSULIN PUMP

Benefits for an insulin pump (**E0784**) will be allowed per the following guidelines. **PREDETERMINATION** is required for insulin pump placement and documentation of the following should be included with all requests.

Prerequisites:

- Patient has demonstrated ability to self-monitor blood glucose levels (greater than or equal to 4x/day) and
- Patient is motivated to achieve and maintain improved glycemic control, and
- Patient is monitoring blood glucose levels pre- and post-exercise, and HS (bedtime) blood sugar.

One or more of the following must be documented:

- History of severe glycemic excursions (commonly associated with brittle diabetes, hypoglycemic unawareness, nocturnal hypoglycemia, extreme insulin sensitivity and/or very low insulin requirements).
- Dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dL.
- Early neuropathy or nephropathy (microalbuminuria).
- Preconception or pregnancy with a history of suboptimal glycemic control.
- Suboptimal glycemic and metabolic control post-renal transplant.

Consideration for the following will be given:

- Glycosylated hemoglobin (HbA1c) level >7.0% where upper range of normal <6.05%; for other assays, 1% over upper range of normal.
- Wide fluctuations in blood glucose before mealtime (e.g., preprandial blood glucose level commonly exceeds 140 mg/dL).
- Day-to-day variations in work schedule, mealtimes and/or activity level, which confound the degree of regimentation required to self-manage glycemia with multiple insulin injections.

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INFLIXIMAB DRUG

Benefits for the Infliximab drug will continue to be PREDETERMINED and reviewed on an Individual Consideration (IC) basis, to include previous conventional therapy.

- Used for treatment of moderate to severe Crohn's disease in patients who have not responded well to traditional treatments, including steroids and other immunosuppressants and antibiotics.
- Used for treatment of patients with fistulizing Crohn's disease for the reduction in the number of draining fistulas.
- Any requests over three will be reviewed by a consultant for medical necessity as the safety and efficacy of therapy continued beyond three doses has not been studied.
- All requests for Infliximab for ulcerative colitis will be reviewed on an IC basis by a gastrointestinal consultant.

THAIRAPY® VEST

Benefits for the ThAIRapy® vest (**E1399**) will be determined per the following guidelines.

Absolute criteria for medical necessity approval for adults (*must meet all three*):

- Documented evidence of clinical diagnosis of Cystic Fibrosis
- Documented history of chronic bronchodilator therapy
- Receiving chest percussion therapy daily with the number of treatments and the effectiveness of chest percussion therapy documented.

NOTE: If only two of the absolute criteria are met and supporting criteria are present, benefits will be reviewed for Individual Consideration by a BCBSK consultant.

Supporting medical history criteria (*must meet at least one*):

1. Recent abnormal/or changing pulmonary function tests (PFTs)
 - a) FEV1 of less than 80% predicated
 - b) FVC less than 50% predicated
 - c) Small airway score as noted 25% decrease over past year as documented on PFTs
2. Patient has a history of oral steroid dependency for greater than one year
3. Continued documented chronic prophylactic antibiotic therapy
4. Documented aberrant cystic fibrosis
5. Individual considerations as listed:
 - a) No caregiver available to provide chest percussion therapy, living alone, etc.
 - b) Non-compliance with the chest percussion therapy treatments is not in itself considered by BCBSKS to be failure of treatment, but will be reviewed for individual consideration, especially in young children.

PREDETERMINATION is required before the ThAIRapy® Vest is ordered or purchased. A three-month trial period and follow-up evaluation will be allowed to determine the need for continued use. All rental benefits paid will be applied towards the purchase of the ThAIRapy® Vest.

ADULT GROWTH HORMONE THERAPY

Benefits for adult growth hormone therapy (**S9140**) will be allowed for appropriate candidates per the following guidelines. The therapy must be **PREDETERMINED** as patients with adult growth hormone deficiency must meet the following three criteria before initiation of replacement therapy with human growth hormone:

1. A biochemical diagnosis of adult growth hormone deficiency by means of a subnormal response to a standard growth hormone stimulation test (peak growth hormone equal to or less than 5ug/L), **AND**
2. Adult-onset: Patient's who have adult growth hormone deficiency (either alone or with multiple hormone deficiencies) as a result of pituitary disease; hypothalamic disease; surgery; radiation therapy; trauma, or be an adult who was growth hormone deficient during childhood, confirmed as an adult before replacement therapy with human growth hormone.
3. Human growth hormone therapy will be approved with a single supporting provocative test only if there is strong clinical evidence of hypopituitarism. Otherwise, two separate abnormal provocative tests will be required for Individual Consideration (IC).

Miscellaneous**ALPHA PREFIX – INSURED'S IDENTIFICATION NUMBER**

Please remember to include the alpha prefix with the insured's 9-digit numeric identification number when submitting claims for services rendered. For example: XSA 123456789

STRAPPINGS

The following strapping codes have been removed from the Blank list and added to the 0-Day list. An updated list has been included with this newsletter.

29200, 29220, 29240, 29260, 29280, 29520, 29530, 29540, 29550, 29580

Please remember that strapping is denied content of service of an E&M service when billed on the same date and by the same provider, of fracture codes that involve wedging and bivalving of the cast, and of the initial fracture care.

Strapping is **NOT** content of an office procedure (i.e., physical therapy modalities).

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