

# Blue Shield Report

A NEWSLETTER FOR PROFESSIONAL PROVIDERS AND THEIR STAFF MEMBERS

January 31, 2000

MAC

MAC-2-99

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### MAC NEWSLETTER:

The following guidelines were established and/or revised through recommendations from the liaison committees and agreement from the Medical Advisory Committee (MAC).

### QUESTIONS:

If you have questions, please 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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## **Effective Immediately**

Please be aware that these guidelines, new and updated, became effective JANUARY 1, 2000; therefore, your claims should reflect these changes immediately.

## RADIOLOGY

### Diagnosis Codes for Diagnostic Mammography

BCBSKS allows **76090** and **76091** (diagnostic mammograms) for the diagnosis codes listed below. These three diagnoses have been added to the list: Isolated skin changes, Palpable lymph nodes in patients with dense breast tissue, Abnormal calcification on abnormal screening mammography. **\* As these diagnoses do NOT have a specific ICD-9-CM code, modifier 22 needs to be appended to the CPT code and supporting documentation submitted with the claim.**

|               |   |
|---------------|---|
| <b>V10.3</b>  | Personal history of malignant neoplasm, breast  |
| <b>174</b>    | Malignant neoplasm of female breast   |
| <b>174.0</b>  | Nipple and areola   |
| <b>174.1</b>  | Central portion   |
| <b>174.2</b>  | Upper-inner quadrant  |
| <b>174.3</b>  | Lower-inner quadrant  |
| <b>174.4</b>  | Upper-outer quadrant  |
| <b>174.5</b>  | Lower-outer quadrant  |
| <b>174.6</b>  | Axillary tail   |
| <b>174.8</b>  | Other specified sites of female breast  |
| <b>174.9</b>  | Breast (female) unspecified   |
| <b>175</b>    | Malignant neoplasm of male breast   |
| <b>175.0</b>  | Nipple and areola   |
| <b>611.6</b>  | Galactorrhea not associated with childbirth   |
| <b>611.72</b> | Lump or mass in breast  |
| <b>611.79</b> | Other (induration of breast, nipple discharge, inversion of nipple, retraction of nipple) |
| <b>611.9</b>  | * Isolated skin changes   |
| <b>611.9</b>  | * Palpable lymph nodes in patients with dense breast tissue                               |
| <b>611.9</b>  | * Abnormal calcification on abnormal screening mammography                                |
| <b>793.8</b>  | Breast (abnormal mammogram)   |
| <b>996.54</b> | Complication due to breast prosthesis   |

If claims come in with a diagnosis not listed above, the claim will be suspended and the code will be changed to the screening mammography code **76092**. Only the specified diagnosis codes above are considered diagnostic mammograms.

Procedure code **76090** (Mammography; unilateral) and **76091** (Mammography; bilateral), each represent a complete mammography examination. No benefits are provided for "additional" views (i.e., pinch views) with either examination. Procedure code **76091** is to be used when billing for multiple views taken for those patients with breast implants. Other codes used to bill for additional views will continue to be denied content of service of codes **76090** and **76091**.

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**RADIOLOGY Cont'd.****Positron Emission Tomography (PET)**

The use of Positron Emission Tomography (PET) will be allowed for the following diagnoses:

- |   |                                  |
|---|----------------------------------|
| 1. Hodgkins/Non-Hodgkins Lymphoma                 | 5. Staging Breast Axillary Nodes |
| 2. Recurring Colorectal Cancer/Multifocal Disease | 6. Infection, Spinal             |
| 3. Solitary Pulmonary Nodules                     | 7. Neoplasms of the Brain        |
| 4. Ovarian Carcinoma                              | 8. Epileptic Seizures            |

For diagnoses not listed, the service will be reviewed on Individual Consideration basis. Supporting documentation should be included with the claim.

The following HCPCS/CPT codes should be used for submitting claims:

**HCPCS codes:** G0030, G0031, G0032, G0033, G0034, G0035, G0036, G0037, G0038, G0039, G0040, G0041, G0042, G0043, G0044, G0045, G0046, G0047

**CPT codes:** 78459, 78491, 78492, 78608, 78609, 78810

**Magnetic Resonance Angiography (MRA)**

**NOTE:** Local code **S9040** [Magnetic Resonance Angiography (additive)] has been replaced by the following AMA CPT procedure codes: **70541, 71555, 72159, 72198, 73225, 73725, 74185.**

- A. MRA is approved for known brain tumors, subject to Individual Consideration.
- B. MRA may be approved for reimbursement when billed with one or more of the following diagnosis codes. Renal artery stenosis and evaluation of pediatric cardiac patient in postoperative care are newly added to the list. **\* As this diagnosis does NOT have a specific ICD-9-CM code, modifier 22 needs to be appended to the CPT code and supporting documentation submitted with the claim.**

- |               |  |
|---------------|--|
| <b>325</b>    | Phlebitis and thrombophlebitis of intracranial venous sinuses                        |
| <b>430</b>    | Subarachnoid hemorrhage  |
| <b>431</b>    | Intracerebral hemorrhage   |
| <b>432.0</b>  | Non-traumatic extradural hemorrhage  |
| <b>432.1</b>  | Subdural hemorrhage  |
| <b>432.9</b>  | Unspecified intracranial hemorrhage  |
| <b>433.10</b> | Occlusion and stenosis of precerebral artery, without mention of cerebral infarction |
| <b>433.11</b> | Occlusion and stenosis of precerebral artery, with cerebral infarction               |
| <b>437.3</b>  | Cerebral aneurysm, nonruptured   |
| <b>440.1</b>  | Renal artery stenosis  |
| <b>453.0</b>  | Budd-Chiari syndrome   |
| <b>453.2</b>  | Venous embolism and thrombosis of vena cava  |
| <b>453.3</b>  | Venous embolism and thrombosis of renal vein   |
| <b>747.81</b> | Anomalies of cerebrovascular system  |
| <b>V58.9</b>  | * Evaluation of pediatric cardiac patient in postoperative care                      |

- C. Individual Consideration will be given to MRA claims with diagnoses not on this list.

**RADIOLOGY Cont'd.****Brachytherapy for Prostate Cancer**

High Dose Brachytherapy (**77781**) for prostate cancer should be predetermined for benefit availability. Claims should be submitted with supporting documentation of T2B – T3C stage of prostate cancer.

**Proton Beam Treatment Delivery for Prostate Cancer**

BCBSKS will review proton beam treatment (**77520, 77523**) for use in the treatment of prostate cancer on an Individual Consideration basis. Claims should be submitted with supporting documentation.

- 77520** Proton beam delivery to a single treatment area, single port, custom block, with or without compensation, with treatment set-up and verification images
- 77523** Proton beam delivery to one or two treatment areas, two or more ports two or more custom blocks, and two or more compensators, with treatment set-up and verification images

**Non-Ionic Contrast Media**

BCBSKS will allow non-ionic contrast on a flat fee basis, regardless of the diagnosis. HCPCS codes **A4644**, **A4645** and **A4646** should be used for submitting non-ionic contrast media. Local codes S9016 and S9018 have been deleted.

- A4644** Supply of low osmolar contrast material (100-199 mgs of iodine)
- A4645** Supply of low osmolar contrast material (200-299 mgs of iodine)
- A4646** Supply of low osmolar contrast material (300-399 mgs of iodine)

**Contrast Agents/Radioisotopes**

The contrast agents are no longer content of service of procedure codes **78465, 78472** and **78473**. The contrast agents should now be submitted using HCPCS **A9502** and **A9505** along with the procedure code.

- A9502** Supply of radiopharmaceutical diagnostic imaging agent, Technetium TC 99m Tetrofosmin, per unit dose
- A9505** Supply of radiopharmaceutical diagnostic imaging agent, Thallous Chloride TL 201, per MCI

**Stereotaxic Needle Localization and Biopsy Using a Mammotome**

When the radiologist performs the localization only, procedure code **76095** (Stereotaxic localization for breast biopsy, each lesion, radiological supervision and interpretation) should be submitted with modifier 22, and the surgeon performing the biopsy should then submit the biopsy procedure code **19100**. If the radiologist performs the localization AND the biopsy, procedure code **76095** should be submitted along with the biopsy code **19100**.

## **SURGERY**

### **Lymphedema Management Program**

The Lymphedema Management Program (**97140**) will be limited to 14 visits. After 14 visits, a consultant will review for medical necessity of continuing the program.

### **Radiofrequency Ablation of the Liver**

Radiofrequency ablation of the liver (**47399**) will be reviewed on an Individual Consideration basis. Please submit claims with supporting documentation.

### **Donor Cardiectomy**

Multiple surgery guidelines will NOT be applied to procedure code **33940** (Donor cardiectomy, with preparation and maintenance of allograft).

### **Procuren® Growth Factor Therapy**

Procuren® Growth Factor Therapy needs to be prior authorized for inpatient services and precertified for outpatient services. When calling for authorization, the following clinical information needs to be available:

- A. Primary diagnosis, including wound description and size
- B. Treatment history, including date of wound onset and response to treatments
- C. Treatment plan, including antibiotics, anticipated length of treatment, etc.

Inpatient Prior Authorization: Prior authorization for inpatient services will be handled by the standard hospitalization precertification process electronically or by phone: **1-800-782-4437** (Topeka) or **1-800-641-0972** (Wichita).

Outpatient Precertification: For outpatient precertification, contact the BCBSKS Case Management at **1-800-432-3990**, extension **6628** (Topeka) or **1-800-641-0972** (Wichita). BCBSKS Case Managers will establish a concurrent review process with the provider at the time of precertification and will monitor claims payment for evaluation of costs and patient outcomes.

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**SURGERY Cont'd.****Prophylactic Mastectomy**

The BCBSKS Breast Surgery guidelines have been revised to require only one biopsy if premalignant or atypical changes are confirmed by the biopsy (See section B.2.b.2, where *italicized*).

***Breast Surgery Guidelines***

**CONTRACT APPLICABILITY:** This Administrative Procedure is applicable to all local contracts. Applicable to National and Special Accounts Contracts unless individual contract specifies otherwise. Applicable to the Federal Employee Program. It is applicable to Premier Blue EXCEPT as noted.

**NOTE REGARDING BLUE SELECT/PREMIER BLUE:** These services require authorization by the patient's Primary Care Physician for the patient to receive the maximum level of benefits available. In the absence of such authorization, these services will be reimbursed at the Self-Referred Level. If the member has no Self-Referral Option, no benefits are available.

**A. BREAST REDUCTION**

This procedure must be prior-authorized for coverage determination. If through the prior authorization process, this service is determined to be cosmetic in nature, it shall be considered non-covered.

1. Indication: For hypertrophic breast disease and contralateral breast reduction for malignancy.

2. Coverage:

**NOTE REGARDING GUARANTEE ISSUE:** Guarantee Issue provides benefits for surgery and services to restore bodily function or correct deformity resulting from diseases, trauma, or congenital or developmental anomalies. This is applicable to all covered persons regardless of age. Therefore, all claims for all covered persons covered under Guarantee Issue for breast reduction are reviewed for medical necessity.

**Patient age 21 or older** – These claims are reviewed for medical necessity. Reduction mammoplasties justified by documentation of past medical history of pain (not amenable to other forms of treatment), intertriginous dermatitis or posture problems are covered with hypertrophic breast disease.

Any surgical procedure that improves the appearance of an individual by altering a physical characteristic but does not restore bodily function or correct a deformity is not covered and considered cosmetic surgery. In addition, reconstructive or cosmetic surgical procedures that are justified solely on the basis of psychiatric need are considered not medically necessary.

3. Information

a. The physician should provide for review:

1) Pre-operative review:

a) Whole body photo (lower half of body to be clothed) with features obscured if the Insured/Member wants to maintain confidentiality. Also, body height and weight should be included.

b) Size of breast to be indicated by bra size, proposed gram weight and percentage of breast tissue to be removed.

*Continued...*

**SURGERY Cont'd.**

- c) Alternative methods attempted to alleviate condition
- d) Symptoms
- 2) Postoperative Review (In the absence of Pre-operative Review)
  - a) Pathology report indicating gm weight removed
  - b) Operative Report
  - c) Postoperative Photos
  - d) Pain from muscular stretching or deep shoulder grooving, posture problems, inflammatory intertrigo, or other significant symptoms
  - e) Documentation of past medical history of pain not amenable to other forms of treatment, which include wide straps, weight loss, etc.

**B. MASTECTOMY**

- 1. Indication: Malignant disease of the breast.
- 2. Coverage
  - a. Covered services for malignant disease. If there is cancer, BCBSKS will allow mastectomy, then breast reconstruction, and then multiple adjustment surgery for complications as necessary within written established allowances.
  - b. **PROPHYLACTIC MASTECTOMY** (except subcutaneous) either bilateral or unilateral will be covered under the following circumstances. Individual consideration is required for conditions that fall outside these parameters.
    - 1) Personal history of breast cancer, including a single biopsy with hyperplasia with atypia, lobular carcinoma in situ; or ductal carcinoma in situ, or
    - 2) *A strong family history of breast cancer with a first degree relative, including a single biopsy if premalignant or atypical changes are confirmed by the biopsy.*
  - c. **SUBCUTANEOUS MASTECTOMY** - Accomplished for prophylactic reasons; requires individual consideration.
- 3. Mastectomy for the following diagnoses is reviewed for medical necessity determination:
  - a. Benign breast disease
  - b. Fibrocystic breast disease (Covered if atypical ductal hyperplasia is present histologically by biopsy)
  - c. Contralateral mastectomy for patient with breast cancer in opposite breast.
  - d. Mastodynia
  - e. Mammary dysplasia
  - f. Chronic cystic mastitis
  - g. Other benign breast conditions

If following individual consideration for medical necessity (or if atypical ductal hyperplasia is present histologically by biopsy) the mastectomy is considered to be medically necessary, the breast reconstruction and multiple adjustment surgeries for complications may also be considered eligible if within established guidelines.

**C. MASTOPEXY/MAMMOPLASTY ON UNDISEASED BREAST**

Mastopexy (symmetry surgery) on the **UNDISEASED** breast must be accomplished within two (2) years of the reconstructive surgery on the **DISEASED** breast. Mastopexy after the two-year period will be considered cosmetic and therefore, **NOT COVERED**.

**SURGERY Cont'd.****Assistant at Surgery Denial List**

An assistant at surgery will NOT be allowed for the following CPT procedures.

- 15001** Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); each additional 100 sq cm or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure)
- 15351** Application of allograft, skin; each additional 100 sq cm (List separately in addition to code for primary procedure)
- 15401** Application of xenograft, skin; each additional 100 sq cm (List separately in addition to code for primary procedure)
- 31623** Bronchoscopy; diagnostic, (flexible or rigid), with brushing or protected brushings
- 31624** Bronchoscopy; diagnostic, (flexible or rigid), with bronchial alveolar lavage
- 31643** Bronchoscopy; diagnostic, (flexible or rigid), with placement of catheter(s) for intracavitary radioelement application
- 32001** Total lung lavage (unilateral)
- 35500** Harvest of upper extremity vein, one segment, for lower extremity bypass procedure (List separately in addition to code for primary procedure)
- 36831** Thrombectomy, arteriovenous fistula without revision, autogenous or nonautogenous dialysis graft (separate procedure)
- 36833** Revision, arteriovenous fistula; with thrombectomy, autogenous or nonautogenous dialysis graft (separate procedure)
- 38792** Injection procedure; for identification of sentinel node
- 95970** Electronic analysis of implanted neurostimulator pulse generator system (eg, rate pulse amplitude and duration, configuration of wave form, battery status, electrode selectability, output modulation, cycling, impedance and patient compliance measurements); simple or complex neurostimulator pulse generator, without reprogramming
- 95971** simple neurostimulator pulse generator, with intraoperative or subsequent programming
- 95972** complex brain or spinal cord neurostimulator pulse generator/transmitter, with intraoperative subsequent programming, first hour
- 95973** complex brain or spinal cord neurostimulator pulse generator/transmitter, with intraoperative subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)
- 95974** complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, with or without nerve interface testing, first hour
- 95975** complex cranial nerve neurostimulator pulse generator/transmitter, with intraoperative or subsequent programming, each additional 30 minutes after first hour (List separately in addition to code for primary procedure)

*Continued...*

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**SURGERY Cont'd.**

An assistant at surgery will be ALLOWED for the following CPT procedures.

- 35682** Bypass graft; autogenous composite, two segments of veins from two locations (List separately in addition to code for primary procedure)
- 35683** Bypass graft; autogenous composite, three or more segments of vein from two or more locations (List separately in addition to code primary procedure)
- 36823** Insertion of arterial and venous cannula(s) for isolated extracorporeal circulation and regional chemotherapy perfusion to an extremity, with or without hyperthermia, with removal of cannula(s) and repair of arteriotomy and venotomy sites
- 45126** Pelvic exenteration for colorectal malignancy, with proctectomy (with or without colostomy), with removal of bladder and ureteral transplantations, and/or hysterectomy, or cervicectomy, with or without removal of ovary(s), or any combination thereof
- 56321** Laparoscopy, surgical; with adrenalectomy, partial or complete, or exploration of adrenal gland with or without biopsy, transabdominal, lumbar or dorsal

**ORTHOPEDICS****Synvisc and Hyalgan Guidelines - Revised**

Synvisc and Hyalgan injections for osteoarthritis of the knee will be allowed per the following medical necessity requirements. The guidelines have been revised where italicized/bold.

1. A diagnosis of osteoarthritis (degenerative arthritis) for knee only.
2. Failed conservative treatment, i.e., anti-inflammatory agents, physical therapy, weight loss, activity modification, knee brace, and occasional corticosteroid injection. Occasionally reconstructive surgery where knee is unstable.
3. Synvisc or Hyalgan injections are limited to *"one course" per a six month time period.*
4. The series of injections (one course) can be repeated every six months.
5. Patients who are not considered surgical candidates.
6. No time limit as to how long this can be used.
7. Synvisc therapy for the diagnosis of Chondromalacia should be predetermined.

**Continuous Passive Motion (CPM) Therapy**

Continuous Passive Motion therapy (CPM) (**E0935**) of the shoulder will be denied not medically necessary. However, CPM for the elbow, wrist, and hand will be reviewed for coverage on an Individual Consideration basis.

**Assistant at Surgery Denial List**

An assistant at surgery is NOT medically necessary when performing the following procedure:

- 27347** Excision of lesion of meniscus or capsule (eg, cyst, ganglion), knee

**ORTHOPEDICS Cont'd.****Electro Thermal Capsular Shrinkage**

Electro Thermal Capsular Shrinkage of the **KNEE** is considered to be experimental/investigational and will be denied accordingly. Electro Thermal Capsular Shrinkage of the **SHOULDER** is considered content of the corrective procedure, and therefore, should not be billed separately. Because there is no specific procedure code at this time, CPT code **29909** should be used to submit this service.

**Bone Growth Stimulators (E0747)**

The guidelines for bone growth stimulators for **Non Union Fractures** have been revised as follows:

- A. When treatment falls between 3 – 12 months post surgery, benefits may be available subject to individual consideration.
- B. When treatment is prior to 3 months post surgery, it is subject to review by a consultant.
- C. When treatment duration is extending beyond 12 months with no prior surgery, it is subject to review by a consultant.

**CARDIOLOGY****Coronary Arteries**

A maximum number of up to four (4) units will be allowed for primary and secondary branches (e.g., a total number of 4 units) for procedures **92981, 92984 and 92996**.

- 92980** Transcatheter placement of an intracoronary stent(s), percutaneous, with or without other therapeutic intervention, any method; single vessel
- 92981** each additional vessel (list separately in addition to code for primary procedure)
- 92982** Percutaneous transluminal coronary balloon angioplasty; single vessel
- 92984** each additional vessel (list separately in addition to code for primary procedure)
- 92995** Percutaneous transluminal coronary atherectomy, by mechanical or other method, with or without balloon angioplasty; single vessel
- 92996** each additional vessel (list separately in addition to code for primary procedure)

**Thoratec Ventricular Assist Device (VAD)**

The Thoratec Ventricular Assist Device (VAD) in the home setting will be allowed on an Individual Consideration basis for patients who are on a heart transplant waiting list. Case Managers can be contacted for review at **1-800-432-3990**, extension **6628** or **785-291-6628** in the Topeka area. In the Wichita area, the Case Managers can be reached at **1-800-641-0972** or **316-269-4426**. If allowed, the charges for the Thoratec VAD will not be applied to the insured's DME maximum dollar amount. These guidelines are also applicable to Premier Blue members.

**CARDIOLOGY Cont'd.****Transmyocardial Laser Revascularization (TMLR)**

The Transmyocardial Laser Revascularization (TMLR) procedure (**33140**) will be allowed based on the following criteria:

1. Severe coronary artery disease
2. Objective demonstration of viable myocardium not capable of revascularization by other surgical or percutaneous options
3. Severely limited lifestyle
4. An ejection fraction greater than 30%
5. No other percutaneous or surgical options at acceptable comparable risk

- Exclusion Criteria:
1. Ventricular arrhythmia
  2. Decompensated congestive heart failure (CHF)

**Assistant at Surgery Denial List**

An assistant at surgery is NOT medically necessary for the following procedures:

- |              |  |
|--------------|--|
| <b>35400</b> | Angioscopy (non-coronary vessels or grafts) during therapeutic intervention (List separately in addition to code for primary procedure)  |
| <b>92998</b> | Percutaneous transluminal pulmonary artery balloon angioplasty; each additional vessel   |
| <b>93508</b> | Catheter placement in coronary artery(s), arterial coronary conduit(s), and/or venous coronary bypass graft(s) for coronary angiography without concomitant left heart catheterization   |
| <b>93530</b> | Right heart catheterization, for congenital cardiac anomalies  |
| <b>93531</b> | Combined right heart catheterization and retrograde left heart catheterization, for congenital cardiac anomalies   |
| <b>93532</b> | Combined right heart catheterization and transseptal left heart catheterization through intact septum with or without retrograde left heart catheterization, for congenital cardiac anomalies  |
| <b>93533</b> | Combined right heart catheterization and transseptal left heart catheterization through existing septal opening, with or without retrograde left heart catheterization, for congenital cardiac anomalies   |
| <b>93571</b> | Intravascular doppler velocity and/or pressure derived coronary flow reserve measurement (coronary vessel or graft) during coronary angiography including pharmacologically induced stress; initial vessel (List separately in addition to code for primary procedure) |
| <b>93572</b> | Each additional vessel (List separately in addition to code for primary procedure)   |

An assistant at surgery will be **ALLOWED** for the following procedure:

- |              |  |
|--------------|--|
| <b>33496</b> | Repair of non-structural prosthetic valve dysfunction with cardiopulmonary bypass (separate procedure) |
|--------------|--|

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## OPTOMETRY

### Medical Emergency Diagnosis Codes

Two diagnosis codes (**368.15** and **369.9**) have been added to the Medical Emergency Diagnosis Code List. These are diagnoses that do NOT require a Primary Care Physician's referral to the optometrist if the diagnosis is discovered during the optometrist's routine eye exam.

|               |  |
|---------------|--|
| <b>368.15</b> | Other visual distortions and entopic phenomena (photopsia) |
| <b>369.9</b>  | Unspecified visual loss                                    |
| <b>379.21</b> | Vitreous degeneration                                      |
| <b>379.23</b> | Vitreous hemorrhage  |
| <b>379.24</b> | Other vitreous opacities                                   |
| <b>930.0</b>  | Corneal foreign body                                       |
| <b>930.1</b>  | Foreign body in conjunctival sac                           |

## OPHTHALMOLOGY

### Scanning Laser Ophthalmic Diagnostic Imaging

The following guidelines are applicable to CPT code **92135** [Scanning computerized ophthalmic diagnostic imaging (e.g., scanning laser) with interpretation and report, unilateral], which can detect nerve fiber damage not detectable by the naked eye.

1. Scanning laser glaucoma test is allowable for diagnoses 365.00 – 365.9.
2. Testing may be allowed every year. If testing is done more frequently than annually, the request would be reviewed by a BCBSKS consultant.
3. When submitting **92135**, modifier **RT** (right) or **LT** (left) needs to be included indicating which eye was tested. Use both **RT** and **LT** when both eyes are tested (e.g., **92135RTLTL**).
4. Reimbursement is comparable to the RVU map for **76512** [Ophthalmic ultrasound, echography, diagnostic; contact b-scan (with or without simultaneous a-scan for both eyes)].

### Ophthalmic Laser Procedure 67220 Guidelines

The following guidelines for **67145**, **67210** and **67228** will also be applied to the new CPT procedure code **67220** (Destruction of localized lesion of choroid (eg, choroidal neovascularization), one or more sessions, photocoagulation (eg, laser, ocular photodynamic therapy):

1. Only one billing will be allowed regardless of the number of times it is performed in a 30-day period.
2. Multiple surgery guidelines will be applied when additional treatments are performed from 4 weeks to 4 months after the initial treatment on the same eye.
3. An assistant at surgery will not be reimbursed for this procedure.
4. When submitting for these services, modifier **RT** (right) or **LT** (left) should be included indicating which eye was treated. If both eyes were treated, use both modifiers together (eg, **67220RTLTL**).

## UROLOGY

### Extracorporeal Magnetic Innervation

The Extracorporeal Magnetic Innervation (ExMI) (aka, Neotonus chair) is used for treatment of stress, urge and mixed incontinence by using electromagnetic energy to create a pelvic floor contraction. Currently, there are no studies indicating the effectiveness of this program; therefore, BCBSKS will deny the service as experimental/investigational. When submitting for this service, an NOC CPT procedure code will need to be used.

### Ultrasonic Treatment of Peyronie's Disease

It has been determined that the therapeutic ultrasonic treatment (**97035**) for Peyronie's disease (**607.89**) has not been proven to be clinically effective. Therefore, BCBSKS will deny this service as experimental/investigational. However, BCBSKS will continue to allow the diagnostic ultrasound (**76872**).

## INTERNAL MEDICINE

### Total Parenteral Nutrition (TPN) Therapy Guidelines

The indications for Total Parenteral Nutrition (TPN) therapy have been updated as follows:

- Short bowel syndrome
- Intestinal obstruction from carcinomatosis
- Inflammatory bowel syndrome
- Motility disorder (pseudo-obstruction)
- Radiation enteritis
- Mesenteric infarction
- Massive bowel resection
- Diagnosis of hyperemesis gravidarum
- Patients whose diseases are amenable to treatment and all attempts at enteral nutrition have been unsuccessful or are not feasible. TPN should initially provide 80% of the patient's caloric intake; weaning below 80% is allowed later in the course.

For complete TPN guidelines, please refer to the Blue Shield Report S-31-97, dated December 30, 1997.

### TPN for Cancer Patients

BCBSKS staff met with specialty consultants regarding the use of TPN for a patient with large bowel cancer with metastasis. We were advised that it was inappropriate to administer TPN to a patient with terminal cancer. The only exception to this would be for those patients in whom a transplant was being contemplated and TPN was being used on an interim basis to improve the nutritional status of the patient prior to transplant. All requests for TPN for cancer patients will be reviewed on an Individual Consideration basis by a BCBSKS oncology consultant.

**INTERNAL MEDICINE Cont'd.****Adult Growth Hormone Therapy**

Patients with adult growth hormone deficiency must meet the following criteria before initiation of replacement therapy with human growth hormone. The guidelines have been updated to include the information in bold/italics.

1. Have a biochemical diagnosis of adult growth hormone deficiency by means of subnormal response to ***two*** standard growth hormone stimulation tests (peak growth hormone equal to or less than 5ug/L), ***using two different stimulating agents, on two different dates***, and;
2. 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.

As an exception to the foregoing, human growth hormone therapy may 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 consideration. Strong clinical evidence of hypopituitarism would be history of pituitary surgery, cranial irradiation, congenital growth hormone deficiency, or documented pituitary injury following trauma.

**Intravenous Immunoglobulin (IVIG) for Multifocal Motor Neuropathy**

Intravenous Immunoglobulin (IVIG) therapy (**J1561, J1562 and J1565**) will be allowed for a well-defined diagnosis of documented multifocal motor neuropathy. Prior authorization is required.

When submitting for prior authorization, please include the patient's history, physical and any pertinent laboratory work reports that support the necessity of the IVIG therapy.

**LYMERix™ - Lyme Disease Vaccination**

LYMERix™ vaccination (**90665**) will be reimbursed per the following guidelines:

1. Eligible age range for vaccine is 15 – 70 years of age.
2. The individual should have an increased exposure to tick infested areas, i.e., landscapes, brush/trees, farming, forestry, wildlife/parks/recreational activities.
3. The vaccine will be denied if it is for a work-related requirement.
4. If the physician requests the vaccine because he/she feels the patient is at high risk, the vaccination will be allowed.

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**INTERNAL MEDICINE Cont'd.****Treatment of Progressive Type Multiple Sclerosis**

Standard therapy for chronic primary and secondary chronic progressive multiple sclerosis includes:

1. Low dose Methotrexate therapy (usually oral)
2. Low dose Imuran therapy
3. Solu-Medrol

The drugs Betaseron and Copaxone are considered for coverage for relapsing and remitting multiple sclerosis.

The drug Cladribine is considered experimental/investigational for any multiple sclerosis treatment; therefore, no benefits are allowed.

**ANESTHESIA****OB Epidural Anesthesia for Delivery**

Providers should no longer use the local codes **S4009** and **S4010** for epidural anesthesia for vaginal and cesarean deliveries. Epidural placement, monitoring and delivery anesthesia will now be reimbursed using the appropriate CPT codes for vaginal and cesarean deliveries. Providers will need to include on the claim the type of service (7). Use modifier 22 or 23 applied to the CPT code to indicate the epidural placement. Anesthesia time should be reported as total minutes of face to face anesthesia administration.

When a vaginal delivery with epidural anesthesia results in a C-section, the total time should be billed which includes the 15 minutes per hour of face to face epidural anesthesia plus the general anesthesia time for the delivery. Use the normal process for reporting general anesthesia time.

Post-pay audits will be conducted to verify billing and payment accuracy.

The reimbursement formula and the associated ASA points for the delivery is:

- 5 points = Vaginal deliveries (59400 – 59410)
  - 7 points = Cesarean deliveries (59510 – 59525)
  - 1 point = Epidural placement (identified by applying modifier 22 or 23)
  - 1 point = Per hour (15 minutes) of face to face epidural anesthesia monitoring
- Total points times the anesthesia conversion factor

Claims exceeding the maximum points - 20 points for Vaginal deliveries, 25 points for Cesarean deliveries – require anesthesia records to be submitted with the claim.

**Three claim examples with the reimbursement formula applied follow.**

**OB EPIDURAL ANESTHESIA Cont'd.****3 CLAIM EXAMPLES WITH THE REIMBURSEMENT FORMULA****EXAMPLE A:** C-Section (no epidural) - 90 minutes anesthesia

| DATE(S) OF SERVICE | PLACE OF SERVICE | TYPE OF SERVICE | PROCEDURES, SERVICES, OR SUPPLIES<br>(Explain Unusual Circumstances) | DIAGNOSIS CODE | \$ CHARGES | DAYS OR UNITS |
|--------------------|------------------|-----------------|--|----------------|------------|---------------|
| 010100 ; 010100    |                  | 7               | 59510  |                | 600 ; 00   | 090           |

**Formula:** CPT 59510 = 7 points  
90 minutes = 6 points

13 Total Points x Conversion Factor

**EXAMPLE B:** Vaginal delivery with epidural resulting in C-Section  
6 hours epidural anesthesia (15 minutes x 6 = 090)  
45 minutes general anesthesia (045) (Total anesthesia time = 135)

| DATE(S) OF SERVICE | PLACE OF SERVICE | TYPE OF SERVICE | PROCEDURES, SERVICES, OR SUPPLIES<br>(Explain Unusual Circumstances) | DIAGNOSIS CODE | \$ CHARGES | DAYS OR UNITS |
|--------------------|------------------|-----------------|--|----------------|------------|---------------|
| 010100 ; 010100    |                  | 7               | 59510 -22 (or 23)  |                | 1500 ; 00  | 135           |

**Formula:** CPT 59510 = 7 points  
Modifier 22 or 23 = 1 point  
Monitoring = 6 points  
45 minutes = 3 points

17 Total Points x Conversion Factor

**EXAMPLE C:** Vaginal Delivery with Epidural and Monitoring  
6 hours epidural anesthesia (15 minutes x 6 = 090)

| DATE(S) OF SERVICE | PLACE OF SERVICE | TYPE OF SERVICE | PROCEDURES, SERVICES, OR SUPPLIES<br>(Explain Unusual Circumstances) | DIAGNOSIS CODE | \$ CHARGES | DAYS OR UNITS |
|--------------------|------------------|-----------------|--|----------------|------------|---------------|
| 010100 ; 010100    |                  | 7               | 59400 -22 (or 23)  |                | 750 ; 00   | 090           |

**Formula:** CPT 59400 = 5 points  
Modifier 22 or 23 = 1 point  
Monitoring = 6 points

12 Total Points x Conversion Factor

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## MISCELLANEOUS

### Guidelines for Synagis IM

Synagis, Respiratory Syncytial Viral Specific IGIV (**90378**) is an IM injection that 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.

When billing for Synagis IM (**90378**), include the quantity and strength on the claim, as well as the appropriate administration code, i.e., **90789, 90471**, etc. The administration is content of service of an office visit.

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.
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.

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