

Blue Shield Report

A NEWSLETTER FOR PROFESSIONAL PROVIDERS AND THEIR STAFF MEMBERS

February 12, 2001

MAC-02-00

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MAC Implementation

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The Medical Advisory Committee (MAC) meeting came to a close on November 17, 2000. Several policy and procedure changes were discussed at liaison meetings for each professional field, and suggestions were brought forth to MAC. In collaboration with Blue Cross and Blue Shield of Kansas (BCBSKS), the suggestions were evaluated, and those that have been approved have become effective by February 1, 2001. The following pages outline the revisions.

Cardiology

Surgery Assistants

The issue of a medical need for an assistant during certain procedures has been reviewed for Current Procedural Terminology (CPT) codes. It was determined that an assistant at surgery is not medically necessary for the following procedures:

33282

33284

92961

Stress Test Prior to Cardiac Rehabilitation

BCBSKS guidelines have required administration of a stress test previous to approval for a cardiac rehabilitation program. Question was raised as to the appropriateness of this requirement and MAC agreed the requirement of a stress test prior to a cardiac rehabilitation program should be removed.

CPT Code 93320 no longer content of service of CPT Code 93325

CPT Code **93320** -*Doppler echocardiography, pulsed wave and/or continuous wave with spectral display (List separately in addition to codes for echocardiographic imaging); complete-* is currently content of service of CPT code **93325** -*Doppler echocardiography color flow velocity mapping (list separately in addition to codes for echocardiography)*. Although this issue has been discussed in several committee meetings, a recent request for review has brought a change to this policy. Effective January 1, 2001, color doppler will be allowed; CPT Code **93320** is not content of service of CPT Code **93325**. This means that each code can be billed individually.

Internal Medicine

Multiple Sclerosis (MS) Definitions

The following definitions for multiple sclerosis have been approved by MAC:

Relapsing MS

Relapsing MS is described as MS in which patients have acute episodes of worsening, lasting at least 24 to 48 hours with some return of function, but not necessarily to baseline. These episodes cannot be explained by metabolic factors such as heat, fever, infections, medication changes, etc.

Secondary Progressive MS

Secondary Progressive MS is defined as occurring when a patient who was previously a relapsing patient stops having relapses and starts a gradual worsening, occurring over months or years. Sometimes there is a transition period when the patient has started progressing but has a few relapses as well, or when they will have extremely frequent relapses with poorer recovery.

Primary Progressive MS

Primary Progressive MS is defined when the patient has never had a relapse, but instead has an insidious onset with a gradual worsening course. Some of these patients tend to have

MRIs that are less severe with fewer enhancing lesions. Some investigators think that these lack of inflammatory signs on the MRI explain why the patients do not respond as well to drugs that alter the immune system.

Chronic Progressive

Chronic Progressive is an old term. It lumps the primary and secondary progressive into a single category. This is generally believed to be inaccurate since it does not separate the two types of progressive MS. The term Chronic Secondary Progressive would be synonymous with Secondary Progressive.

Progressive Relapsing MS

Progressive Relapsing MS is a rare type in which the patients have a gradual worsening, but also have relapses. It is sometimes hard to identify.

Benign MS

Benign MS is sometimes used to refer to a patient with relapsing MS who over 10 years still has little accumulated disability.

Billing Intravenous Immune Globulin Treatment for Multifocal Neuropathy

The MAC-01-00 newsletter, published in June of 2000, indicated on page five that Intravenous Immune Globulin (IVIG) Treatment for Multifocal Neuropathy can be billed using code **J1565 -Injection, respiratory syncytial virus immune globulin, intravenous, 50 mg**. Upon review, it was determined that this code **should not** be used to bill IVIG for multifocal neuropathy. Since treatment is specific to IVIG, providers should bill the IVIG code that is non-specific to disease process.

Oncology

High Dose Chemotherapy (HDC) with Autologous Stem Cell Support (AuSCS)

1. The treatment of newly diagnosed or responsive multiple myeloma is not considered experimental/investigational, but the following information should be faxed to Medical Review at 785-291-8412 for review:
 - a. Response
 - b. Plan of treatment
 - c. Commorbidity
 - d. Protocol

2. When used in the treatment of ovarian cancer, the following information should be faxed to Medical Review at 785-291-8412 for review:
 - a. Response
 - b. Plan of treatment
 - c. Commorbidity
 - d. Protocol

Review by an Oncology Consultant should determine if the therapy is experimental/investigational for the patient's circumstances. If so, the therapy should be reviewed based on Research/Urgent criteria, if available in the insured's/member's contract.

Research-Urgent Criteria:

Research-Urgent means a drug, device, medical treatment, or procedure that is otherwise excluded by contract as experimental or investigation, but meet all the following criteria:

1. It is therapeutic (not diagnostic or supportive) treatment used to directly improve health outcomes for a condition that is either life threatening or severely and chronically disabling and that has a poor prognosis with the most effective conventional treatment.
 - a. For purposes of Research Urgent Benefits a condition is considered life threatening if it has a substantial probability of causing premature death and all other conventional treatments have failed.
 - b. For purposes of Research-Urgent Benefits a condition is considered severely and chronically disabling if the individual with the condition is unable to perform even the functions that are required for daily life and if the severe disability is not expected to improve with the most effective conventional treatment.

2. The treatment has the final approval from the appropriate government regulatory bodies, if applicable; or if a drug has final FDA approval for marketing for at least one indication or is an FDA Treatment Investigational New Drug, ("Treatment IND"), or FDA Group C status drug for the indication in question, or if a device has FDA approval as an Investigational New Device Exemption (IDE).

3. There is credible evidence that the treatment may provide a clinically significant and substantial improvement in net health outcome compared to the most effective conventional treatment or where conventional treatment has failed or is not medically appropriate.
4. The drug device, medical treatment or procedure is available to the insured seeking it and will be provided within a well designed clinical trial conducted by the National Institute of Health, inc. or by an institution or entity for which the protocol for the drug, device, medical treatment or procedure has been approved by its Institutional Review Board that has been issued a Federally approved assurance.
5. The drug, device, medical treatment, or procedure is not available free or at a reduced cost.
6. The drug, device, medical treatment, or procedure is not excluded by another provision of the Contract.

Autologous Bone Marrow Transplant (AMBT) for Breast Cancer

Autologous Bone Marrow Transplant (AMBT) should not be covered for breast cancer except as part of a clinical trial. This means that on contracts with Research/Urgent language, the ABMT for breast cancer should be reviewed under the Research/Urgent criteria.

Ophthalmology

Billing Contacts with an approved diagnosis

Insured's/member's contracts that exclude coverage for contact lenses may receive coverage for a lens, if it is for treatment of a medical condition on the approved diagnosis list.

For simple conditions that require contacts with a medical diagnosis, such as an abrasion:

- Use CPT codes **92002 – 92014** for evaluation and management, or for an Ophthalmology eye exam
- Use code **92070** -*Fitting of contact lens for treatment of disease, including supply of lens-*

For any other medical condition:

- Use the appropriate E & M or Ophthalmology eye exam code
- Use the appropriate CPT code (**92310, 92311, 92312** or **92313**)
- Use the appropriate V code (describe the lens)
- DO NOT use codes **92391** -*Supply of contact lenses, except prosthesis for aphakia-* or code **92396** -*supply of permanent prosthesis for aphakia; contact lenses.*

Iridotomy/Iridectomy by Laser Surgery

CPT code **66761** -*Iridotomy/iridectomy by laser surgery (eg, for glaucoma) (one or more sessions)*. For consistency in applying ophthalmology guidelines, the following will apply:

- Any treatment 0-4 weeks after initial treatment is content of service.
- Any treatment 4 weeks to 4 months, apply multiple surgery guidelines.

International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9) Diagnosis Code 367.9

The ICD-9 Code **367.9** *-unspecified disorder of refraction and accommodation-* will be added to the routine eye exam benefit.

Visudyne Therapy

Visudyne Therapy has been approved only for age related macular degeneration. Other diagnoses are evaluated on a post pay basis for medical necessity. Bill the drug as J3490 *-Unclassified Drug-*, along with the NDC number, quantity, and strength.

Optometry**Deleted Codes**

Codes **S0203, S0205, S0206, S0207, S0208** and **S0209** have been deleted.

HCPCS code V2710

Reimbursement for HCPCS code **V2710** *-Glass/plastic slab off prism-*, was brought to discussion. After review by BCBSKS, it has been determined that when patients have lens coverage, slab off prisms will be covered and should be billed utilizing modifier **50** *-Bilateral Procedure*.

Otolaryngology**Radiofrequency Ablation of the Tongue Base**

MAC has indicated that data regarding efficacy is not available and the procedure is still considered experimental/investigational.

OTOLam™ for Ear Infection

Proper billing for OTOLam™ was under discussion with indication that OTOLam™ is comparable to CPT Code **69420** *-Myringotomy including aspiration and/or eustachian tube inflation*. It was determined that if the treatment and result are the same, a distinction between the use of a knife or a laser is not differentiated for reimbursement purposes. MAC decided that OTOLam™ should be billed using CPT Code **69420**.

Botox Treatment Approved for Specific Diagnoses

Guidelines for the use of Botox with centrally mediated neurologically based spasticity are addressed by BCBSKS, but guidelines for non-centrally mediated conditions are not established. A discussion regarding guidelines for the proper use of Botox resulted in amendments to guideline #2 to include the condition of medical necessity. The new guideline will read "There must be a stated goal of treatment and medical necessity." This is necessary to distinguish common uses of Botox that are not appropriate,

such as the cosmetic use for removing wrinkles. The use of Botox has been approved for the following diagnoses:

1. Spasticity (stroke, spinal cord lesions, various dystonias)
2. Movement disorders (chorea, hemiballismus, facial/ocular spasms)
3. Chronic headaches (tension, migraine and mixed type if not responsive to standard therapy)
4. Sweating disorders (hyperhidrosis, if unresponsive to standard care and significant enough to produce a problem, not just as a convenience).
5. Spasmodic dysphonia
6. Cricopharyngeal achalsia

Guidelines for Botox Use:

1. There must be documented central mediated neurological based spasticity.
2. There must be a stated goal of treatment and medical necessity. 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 should not be repeated.
4. If it is felt that perhaps a therapeutic level was not obtained initially, a booster may be given.
5. Improvements should be noted within four to seven days.
6. Administration –one to three vials may be used in one treatment. This is dependent on how many muscles you intend to inject and the size of the muscle. Any claim using more than three vials or injecting more than three muscles at one time should 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 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.
9. May give indefinitely when there is improvement.

Radiology

Stereotactic Needle Localization and Biopsy

When the radiologist performs the localization only, procedure code **76095** –*Stereotactic localization guidance for breast biopsy or needle placement (eg, for wire localization or for injection), each lesion, radiological supervision and interpretation-* should be submitted with modifier **22**. The surgeon performing the biopsy should submit the biopsy procedure code **19100**, **19101** or **19103**. If the radiologist performs the localization and the biopsy, procedure code **76095** should be submitted along with the biopsy code **19100**, **19101** or **19103**. Please note that code **19103** is a new procedure code and until the ClaimCheck system has been updated to process this code automatically, it will be considered by report.

Therapeutic Radiology Simulation-Aided Field Setting

CPT code **77295** -*Therapeutic radiology simulation-aided field setting; three-dimensional* will be allowed for prostate or lung cancer when the procedure is:

1. performed with the proper equipment
2. in a facility with established protocol
3. meeting the guidelines for medical necessity.

When billing **77295**, please include the following information with the claim for review

1. Isodose treatment plans from the physician.
2. A copy of the calculations from which the 3-D was derived.
3. Computer prints of the port shapings from the physician.

Continuing Medical Physics Consultation

When provided in a freestanding facility, BCBSKS will reimburse CPT code **77336** -*Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy.*

Knee x-rays

Knee x-ray coding guidelines were reviewed and the following procedures have been approved.

1. Knee x-rays should be billed per number of views.
2. CPT Code **73564** -*Radiological examination, knee; complete, four or more views.*
3. A Merchant or Sunrise view is considered an x-ray view and should not be billed as CPT code **76499** -*Unlisted diagnostic radiologic procedure-*.
4. A weight Bearing x-ray is the same as a standing x-ray and should be billed using CPT Code **73565** -*Radiological examination, knee; both knees, standing, anteroposterior.*

MRI & MRA

A magnetic resonance image (MRI) without and with contrast followed by an MRA for an approved diagnosis, at the same setting, will be allowed. Multiple procedure guidelines will apply.

Contrast Agents/Radioisotopes

The contrast agents are not content of service of procedure codes **78465**, **78472** and **78473**. The contrast agents should be submitted using HCPCS **A9500**, **A9503**, **A9504**, **A9505**, and **A9507**, with a unit limitation of one.

Rehabilitation and Pain Management

Botox

Please see the Otolaryngology section on page six for information regarding Botox.

Warm Up Wound Therapy

Warm Up Wound Therapy, designed to promote rapid wound healing, is still under study and the evidence is currently inconclusive as to its effectiveness. At this time, Warm-Up Wound Therapy is determined to be experimental/investigational. When provided as a service, Warm-Up Wound Therapy should be billed **E1399** with the **GA** modifier to indicate that a waiver has been obtained prior to treatment. Please remember that the Federal Employee Program (FEP) does not recognize waivers for experimental and investigational procedures.

Intradiscal Electrothermal Therapy (IDET)

IDET is a catheter-based technique designed to shrink collagen fibers and thermocoagulate nerve tissue. IDET remains experimental/investigational. Providers should bill HCPCS code **S2370** –*single interspace*-, and **S2371** –*single interspace and each additional interspace*- with modifier **GA** in indicate that a waiver has been obtained prior to treatment. Please remember that the FEP does not recognize waivers for experimental and investigational procedures.

Surgery**Enterolysis and Enterectomy**

There has been some difficulty with reimbursement of CPT Code **44005** -*Enterolysis (freeing of intestinal adhesion)(separate procedure)*- as being content of service to CPT Code **44120** -*Enterectomy, resection of small intestine; single resection and anastomosis*. Depending on the complexity of care, the procedure could last from three minutes to several hours. To compensate for the difference, claims have been billed with modifier **22**, but at times they are still rejected because the operative report was missing. As a result, BCBSKS will apply multiple procedure guidelines to CPT Code **44005** when the code is submitted with modifier **22**. **An operative report that indicates the difficulty of the case (greater than one (1) hour) is required to accompany the claim. It is important to ensure the operative report indicates the time expended for lysing.**

Assistant at Surgery

The following codes do **not** require an assistant:

11980	13133	36819	49321	96571
13102	13153	44970	49322	99570
13122	36550	49320	96570	

The following surgery codes will be reviewed on an Individual Consideration basis. Please remember that supporting records must accompany the claim.

38129	43289	44979	49659	60659
38589	43659	47579	54699	
39599	44209	49329	55559	

Revision of Guidelines for Reduction Mammoplasty

The Paul L. Schnur, MD, FACS method for determination of reduction mammoplasty will replace the current guidelines. The Paul L. Schnur, MD, FACS method is noted for its objectivity. It is used to determine the patient's height and weight and the proposed grams to be removed from the right breast, which is plotted on nanogram to determine body surface area. The body surface measurement is then compared to the logarithm of weight of right breast tissue removed (in grams) in proportion to body surface area. The resulting figure shows the 5th and 22nd percentile lines. Above the 22nd percentile line indicates the surgery for medical reasons and below the 5th percentile for cosmetic reasons. Those cases that fall between the 5th and 22nd percentile would be considered based on symptoms and will be reviewed with documentation to support medical necessity.

CPT codes 19318 to 19325 are subject to this guideline. All claims that are less than the 22nd percentile will require record submission and predetermination. When submitting a claim, do not send pictures. Records must be attached, reporting the patient's height, weight, and grams removed in box 19, using modifier 22.

To calculate the body surface on-line using the Paul L. Schnur, MD, FACS method, log on to the Blue Cross and Blue Shield of Tennessee Internet site at www.BCBST.com and go to the provider section. Click on the "Medical Policy Manual" link and then search the manual for "reduction mammoplasty". You can go there directly by using the following address:

http://www.bcbst.com/MPManual/the_schnur_sliding_scale_chart.htm

Other BCBSKS News:

Drugs No Longer Reviewed

This issue was not discussed at MAC, but BCBSKS wanted to take this opportunity to inform providers about certain drugs that will no longer require submission of medical records or prior authorization when billing. They will, however, be audited periodically using the current guidelines. This became effective January 1, 2001 and includes the following:

Avonex	Flolan	Pulmozyme
Baclofen	Hyalgan	Rebatron
Betaseron	Interferon	Remicade
Botox	Lupron	Sandostatin
Copaxone	Lupron Depot	Synvisc
Enbrel	Prolastin	

Additionally, I.V antibiotics, antivirals, antifungals, and anti-infectives are no longer reviewed for medical necessity.

Claim Status On-line

The Internet is increasingly becoming an essential business tool. Instead of spending time in a phone queue, or waiting for the mailman to deliver requested forms, providers are finding the information they

need quickly and efficiently on-line. BCBSKS is redesigning their web site to give providers access to what they want, when they need it.

In March 2001, BCBSKS is scheduled to unveil the complete redesign of the BCBSKS web site, which will include the ability to check claim status on-line at www.bcbsks.com. The redesign adds a provider section, which will allow providers to access information such as newsletters, manuals and frequently requested forms. Of course, this area is created specifically for providers; therefore provider feedback and requests are essential for continued growth. Log on, check it out, and let us know!

www.BCBSKS.com