

Blue Shield Report

A NEWSLETTER FOR PROFESSIONAL PROVIDERS AND THEIR STAFF MEMBERS

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MAC-01-01

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Medical Advisory Committee (MAC) Meets

The first MAC meeting of 2001 concluded on April 26th with resulting changes to policy, procedures, and updates for several specialty areas. You will find this newsletter arranged in chronological order according to liaison meeting dates. Changes will be effective July 1, 2001, unless otherwise stated.

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of Kansas**

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GENERAL UPDATE FROM MULTIPLE LIAISONS

Assistant at Surgery Codes

CPT codes allowing an assistant at surgery:

22318 22319 57287

CPT codes that do not allow for an assistant at surgery:

20979	27096	43231	43232	43240	43242
43256	43752	44370	44379	44383	44397
45327	45341	45342	45345	45387	57022
57023	58353				

ORTHOPEDIC

Continuous Passive Motion (CPM)

MAC discussed CPM and it was decided that the currently approved guidelines would remain unchanged. Those guidelines are as follows:

CPM for ACL (Anterior Cruciate Ligament) and Knee	Covered with length of therapy limited to two weeks.
CPM for Shoulder	Denied as not medically necessary (effective 1/1/00).
CPM for the elbow, wrist and hand	Reviewed on an individual consideration basis.
CPM of the Great Toe	Denied as not medically necessary.

Percutaneous Vertebroplasty

MAC has determined that Percutaneous Vertebroplasty remains experimental and investigational. This is applicable to the following CPT codes:

22520	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injections; thoracic
22521	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injections; lumbar
22522	Percutaneous vertebroplasty, one vertebral body, unilateral or bilateral injections; each additional thoracic or lumbar vertebral body (List separately in addition to code for primary procedure)

Autologous Chondrocyte Transplantation/Implantation (ACT/ACI)

Blue Cross and Blue Shield of Kansas (BCBSKS) will continue to cover ACT/ACI (**S4028** ~*Osteochondral allograft defect repair*~), but the guidelines have been amended. For coverage, the patient must satisfy the following criteria:

Indications:

- Age 15 through 55 years.
- Diagnosis of full-thickness cartilage defect on a weight-bearing surface of the femoral condyle (result of knee injury involving cartilage damage or extended wear and tear on the joint or diagnosis of osteochondritis dissecans).
- A Grade III or Grade IV full-thickness cartilage lesion on a weight-bearing surface of the femoral condyle (lateral, medial, or trochlear).

NOTE: The outerbridge cartilage grading scale is employed, where:

 - ~Grade I is softening and swelling of the cartilage.
 - ~Grade II shows fragmentation and fissuring of the superficial cartilage of less than one-half inch in diameter.
 - ~Grade III has fragmentation and deeper fissuring of more than one-half inch; and
 - ~Grade IV shows erosion of the cartilage down to the bone.
- Lesion-related symptoms that limit activities of daily living, such as pain, swelling, and locking or catching of the joint.
- A defect size of 1 square cm through 10 square cm.
- A stable and aligned knee (which can be accomplished by surgery in conjunction with ACT/ACI)

Contraindications:

- A total meniscectomy.
- A history of anaphylactic reaction to gentamycin or sensitivities to materials of bovine origin (gentamycin and fetal calf serum are used in culturing the cells).
- An infection, osteoarthritis, or inflammatory disease at the operative site.
- Instability, abnormal loading, or tracking of the knee (unless it has been corrected).
- A body mass index of 30 or greater.

Superior Labrum Anterior Posterior Procedure (SLAP)

BCBSKS will provide separate reimbursement for billing SLAP lesions as CPT code **29909** ~*Unlisted procedure, arthroscopy*~ if repair is not a component of the primary procedure.

Bone Growth Substitute

The **current** BCBSKS policy regarding bone bank procedures (20930, 20936, 20937, and 20938) is that they are content of service to the surgery. This means that separate reimbursement is not given for bone growth substitutes; however it was decided that CPT **Code 20931** ~*allograft for spine surgery only; structural*~ will receive separate reimbursement due to the additional work involved with shaping and seating the graft.

INTERNAL MEDICINE**Adult Growth Hormone Therapy Guidelines**

MAC has approved the new guidelines for adult growth hormone therapy as follows:

Adult Growth Hormone deficiency requires review by Endocrinology Consultant for:

1. Adequacy of the testing procedure
2. Medical necessity of the clinical history leading to the testing procedure

Approval for patients with adult growth hormone deficiency must meet the following criteria for biochemical or organic deficiency of growth hormone:

1. Biochemical deficiency-

Subnormal response to the standard Growth Hormone stimulation test - Insulin tolerance test. (Peak Growth Hormone values greater than 5 ng/ml to provocative stimuli with documented hypoglycemia - blood sugars less than 40 mg/dl or 50% decrease from baseline, with symptoms)

With documented contraindication to the insulin tolerance test, Growth Hormone Releasing Hormone (GHRH/GREF) + Arginine can be used as an alternate testing procedure.

OR

2. Organic deficiency-

Hypopituitarism, with documented multiple hormone deficiencies (requires lab test results)

- a. As a result of pituitary or hypothalamic disease secondary to tumor, surgery, inflammation, radiation therapy, severe head trauma, or structural abnormality.

OR

- b. Documented organic hypopituitarism of childhood with an adult presentation

Continuation of approval requires documented indication of a clinical response to the growth hormone during the first 12 months of therapy such as:

- Weight loss (three determinations)
- Improvement in lipid profile
- Increased bone mass
- Increased muscle strength
- Or increase of IGF-1 (insulin like growth factor 1) into the normal range

(Increase in lean body mass, decrease in fat mass and increase in bone mass can be documented by DEXA scan.)

Remicade Administration Becomes More Flexible

Remicade is currently approved for use with diagnoses of Rheumatoid Arthritis and Crohn's Disease, but has been limited to three administrations within a three-month period. In light of new literature, MAC has indicated that more flexibility is warranted for length and frequency of treatment; therefore BCBSKS will only monitor use. Post-pay reviews will be conducted.

Continuous Glucose Monitoring

The validity of technologically based continuous glucose monitoring, versus standard therapy, was evaluated. MAC approved the decision that continuous glucose monitoring is no longer considered experimental/investigational and would be approved after six (6) months of failed conservative treatment, by meeting the criteria of glycohemoglobin levels less than 4, or greater than 9, as well as one or more of the following:

1. Unexplained large fluctuations in daily pre-prandial glucose values
2. Unexplained frequent hypoglycemic attacks
3. Episodes of ketoacidosis
4. Hospitalizations for glucose out of control

OR

1. Certain diabetics, and newly pregnant or who are about to conceive
2. Patients who are about to start insulin for the first time using an insulin pump regimen

When billing, use **E1399** ~*durable medical equipment, miscellaneous*~ and submit supporting documentation that demonstrates medical necessity.

PLEASE NOTE: Interpretation is content of service of an office visit.

OB/GYN

Uterine Artery Embolization

Uterine Artery Embolization continues to be considered an experimental/investigational procedure. Therefore, when billing the following codes for the purpose of Uterine Artery Embolization, they will be considered experimental/investigational.

CPT Code	Description
36247	Selective catheter placement, arterial system; initial third order or more selective abdominal, pelvic, or lower extremity artery branch, within a vascular family.
37204	Transcatheter occlusion or embolization (eg, for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method, non-central nervous system, non-head or neck.
75894	Transcatheter therapy, embolization, any method, radiological supervision and interpretation.

Prophylactic Mastectomy

Current BCBSKS guidelines for Prophylactic Mastectomy are:

Prophylactic Mastectomy (except subcutaneous) either bilateral or unilateral will be covered under the following circumstances:

1. Personal history of breast cancer, including a single biopsy with hyperplasia with atypia, lobular carcinoma in situ or ductal carcinoma in situ.

2. Family history of breast cancer with first degree relative and only one biopsy is required if pre-malignant or atypical changes are confirmed by the biopsy.

The guidelines will now read:

Must have at least one of the following indications:

1. Personal history of breast cancer to include a single biopsy with hyperplasia, with atypia, lobular carcinoma in situ or ductal carcinoma in situ.
2. Family history of breast cancer in a first-degree relative and one biopsy confirming pre-malignant or atypical changes.
3. If determined by a Genetic Risk Assessment that the increased medical risk to the individual is twice the risk of the general population.

PEDIATRIC

Neonatal Intensive Care

MAC approved the following definition in order to differentiate when a neonate is critically ill and unstable (CPT Code 99296), from a critically ill though stable neonate (CPT Code 99297):

"An unstable condition (99296) is one in which the clinical course fluctuates frequently, necessitating assessments by a physician or physician extender [ARNP or PA] and requires adjustment to the treatment plan. When the physician or physician's extender's attendance to the baby is predictable and the need for frequent laboratory, other evaluations, and changes in therapy decreases; then the infant is stable (99297)."

Additionally, the physician or physician's extender must do frequent visits per day. Services by nursing personnel will be considered content of the physician services and cannot be counted towards the number of required visits per day.

Pediatric Growth Hormone Therapy

MAC has updated the Pediatric Guidelines. The following definitions will be added to the existing guidelines:

Pediatric growth hormone deficiency

1. Failure to respond to two growth hormone secretagogues (stimulating agents) or low IGF-1 value (less than 10 ng/ml hgh)
2. Growth rate less than 5 cm/yr (if over 3 years of age)
(Growth rate is to be determined by stadiometer measurement over 6 months or non-stadiometer growth data over 18 months that is consistent with a stadiometer measurement)

For Pediatric growth hormone insufficiency or partial deficiency (children with borderline stimulation test results and borderline growth hormone failure)

1. Two stimulated growth hormone values less than 15 ng/ml.
2. Height less than the 5th percentile for growth age.
3. IGF-I at the far lower end of the normal range or less than 25th percentile for growth age.
4. Growth rate of less than 25th percentile for growth age (calculated and plotted on the back of the growth chart).

Continuation of approval for Growth Hormone Therapy requires positive response to growth hormone therapy with increases of growth rate at least 2 cm/year above baseline and maintained until achievement of target height percentile.

ISSUES FROM NOVEMBER 2000 MAC MEETING**Neuromuscular Stimulators**

BCBSKS will provide reimbursement for the first month of neuromuscular stimulator rental. After one month rental, and with review of the prescribing provider's records for effectiveness of the therapy, purchase may be allowed. In the event BCBSKS does not purchase the stimulator, the patient may do so with the first month rental fee applied to the purchase price.