

# Blue Shield Report

A Newsletter for  
Professional Providers and  
their Staff Members

July 11, 2002

MAC-01-02

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Communication  
Coordinator  
Larry Callahan

## Inside This Issue...

<b>General Information From MAC (met 5/16/02)</b>	<b>pg. 2</b>
Assistant At Surgery Denied Codes	pg. 2
<b>OB Epidural (Ad Hoc met 1/22/02)</b>	<b>pg. 2</b>
CPT Codes for 2003	pg. 2
<b>Orthopedic Liaison (met 1/23/02)</b>	<b>pg. 2</b>
Bilateral Spinal Procedures	pg. 2
Electrical Bone Growth Stimulator	pg. 2
Operating Microscope	pg. 3
CPM To Be Used With ACI	pg. 3
Percutaneous Vertebroplasty	pg. 4
Extracorporeal Shock Wave Therapy (Orthotripsy) for Plantar Fasciitis	pg. 4
<b>IVIG (Ad Hoc met 2/01/02)</b>	<b>pg. 5</b>
Immunodeficiency Syndromes	pg. 5
<b>Internal Medicine Liaison (met 2/06/02)</b>	<b>pg. 6</b>
Adult Growth Hormone Therapy	pg. 6
Camera Pill	pg. 7
Interferon Gamma-1B (i.e., Actimmune)	pg. 7
Osteoporosis Rescreening Guidelines	pg. 7
Electron-Beam Computerized Tomography (EBCT) Screening for Cardiovascular Calcium Deposits	pg. 7
<b>Podiatry Liaison (met 2/7/02)</b>	<b>pg. 7</b>
Extracorporeal Shock Wave Therapy (Orthotripsy) for Plantar Fasciitis	pg. 4
Electrical Bone Growth Stimulator	pg. 2
<b>Radiology Liaison (met 2/12/02)</b>	<b>pg. 8</b>
Percutaneous Vertebroplasty	pg. 4
Positron Emission Tomography (PET)	pg. 8
Additional Diagnosis Codes Covered for Diagnostic Mammography	pg. 9
Brachytherapy	pg. 10
MRI of the Breast	pg. 10
Electron-Beam Computerized Tomography (EBCT) Screening for Cardiovascular Calcium Deposits	pg. 11
Breast Ductal Lavage	pg. 11
<b>Oncology Liaison (met 2/19/02)</b>	<b>pg. 11</b>
Brachytherapy	pg. 10
Breast Ductal Lavage	pg. 11
BRCA I and BRCA II Guidelines Updated	pg. 11

## Medical Advisory Committee (MAC) News

The first MAC meeting of 2002 has concluded. You will find this newsletter arranged in chronological order according to meeting dates. Changes will be effective August 1, 2002, unless otherwise stated.



Sent to: CAP

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**General  
Information  
From MAC  
(met 5/16/02)**

**Assistant At  
Surgery Denied  
Codes**

The following new 2002 CPT/HCPCS codes will not be reimbursed for an assistant at surgery:

0008T	25651
0012T	25652
0013T	25671
0014T	29086
0019T	29805
0020T	29824
24332	29900
25001	29901
25024	29902
25025	91123
25275	S2112

**OB Epidural (Ad Hoc Met 1/22/02)**

**CPT Codes for 2003**

Billing for OB epidural anesthesia services will change January 1, 2003; the CPT anesthesia codes will be used. More information on proper billing will be published later this year.

**Orthopedic Liaison (Met 1/23/02)**

**Bilateral Spinal Procedures**

CPT codes: 63020 - 63044 and 63191

Regardless of any modifiers used, BCBSKS only reimburses for each level of spinal procedures and not as bilateral procedures.

**Electrical Bone Growth Stimulator**

CPT 20974 - 20975

HCPCS E0747 - E0749

Guidelines for determining the medical necessity of invasive and noninvasive electrical bone growth stimulators have been evaluated by the Orthopedic and Podiatry liaison committees.

**Medical necessity** is met if the following 1, 2, 3, 4, 5, or 6 is applicable to the case.

1. Both the invasive and noninvasive methods of electrical bone growth stimulation are considered medically necessary as an adjunct to spinal fusion surgery for individuals at high risk for pseudoarthrosis including, but not limited to, those with one or more of the following risk factors:
  - a. One or more previous failed spinal fusion(s)
  - b. Grade III or worse spondylolisthesis
  - c. Fusion to be performed at more than one level
  - d. Current smoking habit
  - e. Diabetes
  - f. Renal disease
  - g. Alcoholism
  
2. Noninvasive electrical bone growth stimulation is considered medically necessary as a treatment for individuals with failed spinal fusion. Failed spinal fusion is defined as a spinal fusion which has not healed for a minimum of six months after the original surgery, as evidenced by serial x-rays over a course of three months.

3. Noninvasive electrical bone growth stimulation is considered medically necessary for the treatment of fracture and osteotomy nonunion of long bones. Long bones are defined as the clavicle, humerus, radius, ulna, femur, tibia, fibula, metacarpal, and metatarsal. For a diagnosis of fracture nonunion, all of the following criteria must be met:
  - a. Serial x-rays over the preceding three months confirm no sign of healing;
  - b. The fracture gap is one centimeter or less; and
  - c. The fracture site can be adequately immobilized and consequently the patient is able to comply with nonweight bearing requirements.
  
4. Noninvasive electrical bone growth stimulation is considered medically necessary as a treatment for congenital (infantile) pseudoarthrosis in the appendicular skeleton (the appendicular skeleton includes the bones of the shoulder girdle, upper extremities, pelvis, and lower extremities).
  
5. Noninvasive electrical bone growth stimulation is considered medically necessary for the treatment of fracture nonunion of the scaphoid or navicular bones when all of the following criteria are met:
  - a. The fracture gap is one centimeter or less;
  - b. Three months or more have passed since alternative treatments were started (e.g., uninterrupted thumb spica cast treatment for a minimum of 12 weeks);
  - c. Serial x-rays over the preceding three months confirm no sign of healing;
  - d. There is no sign of intracarpal collapse;
  - e. There is no sign of synovial pseudoarthrosis;
  - f. There is no sign of radiocarpal degenerative change;
  - g. There is no sign of lunate instability (bone of the wrist).
  
6. Noninvasive electrical bone growth stimulation is considered medically necessary for the treatment of joint fusion secondary to failed arthrodesis of the ankle, knee or foot.

The application of electrical bone growth stimulation is considered **not medically necessary** for the treatment of fresh fractures, delayed union fractures, or any other indications not listed above.

**Note:** There may be times that a physician intraoperatively determines that the bone quality, blood supply or other factors may exist that would prevent healing of the fracture or osteotomy site and may require a stimulator. The medical necessity can be reviewed post-operatively based on the operative note or other documentation that supports the medical need.

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### **Operating Microscope**

CPT Code: 69990

After re-evaluation, it was determined that the use of an operating microscope continues to be content of service.

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### **CPM To Be Used With ACI**

CPT/HPCS Codes: E0935, 29999 and 27599

Continuous passive motion (CPM) (HPCS Code E0935) will be reimbursed for two weeks post-autologous chondrocyte implantation (ACI) (CPT Codes 29999 and 27599). This service code is subject to review and documentation of the surgical procedure is required.

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## **Percutaneous Vertebroplasty**

HCPCS: S2360 and S2361

CPT Codes: 22520, 22521, 22522

**Cervical** percutaneous vertebroplasty (S2360 and S2361) remains experimental/investigational.

**Thoracic** and **lumbar** percutaneous vertebroplasty (22520, 22521, and 22522) may be approved in patients who have failed standard non-surgical management and meet one of the following criteria:

1. Osteolytic vertebral metastasis or myeloma with severe back pain related to destruction of the vertebral body not involving the major part of the cortical bone, and chemotherapy and radiation therapy have failed to relieve symptoms.
2. Vertebral hemangiomas with aggressive clinical symptoms (severe pain or nerve compression) and /or aggressive radiological signs, and radiation therapy have failed to relieve symptoms.
3. Sub-acute osteoporotic vertebral collapse with persistent debilitating pain that has not responded to accepted standard medical treatment for at least six weeks (may include: initial bed rest with progressive activity and exercises to correct postural deformity and increase muscle tone; salmon calcitonin, bisphosphonates, calcium supplementation and bracing) and have a positive physical examination with positive bone scan.
4. Painful vertebral eosinophilic granuloma with spinal instability.

**All other uses of percutaneous vertebroplasty are considered investigational.**

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## **Extracorporeal Shock Wave Therapy (Orthotripsy) for Plantar Fasciitis**

CPT: 0020T

The guidelines for extracorporeal shock wave therapy (orthotripsy) have been evaluated and currently are as follows:

1. Medical record submission (minimal range: last six months of medical records).
2. Minimum six months of diagnosed plantar fasciitis pain (heel spurs and chronic heel pain).
3. Minimum six months of active professional treatment for the plantar fasciitis including a required treatment with non steroidal anti-inflammatory drugs (NSAIDs) or cortisone injections and a minimum of three (3) of the five (5) following conservative treatments:
  - a. Over the counter arch supports, insoles, or heel cups
  - b. Physical therapy, stretching, ultrasound, massage
  - c. Strapping immobilization

- d. Night splints
  - e. Custom orthotic devices
4. Failure of treatment to reasonably resolve plantar fasciitis symptoms and the patient continues to have intractable activity-limiting pain.
  5. Review prior to initial and additional treatments with a maximum of three (3) Orthotripsy treatments per each heel.
  6. Criteria applies to each heel independently.

## IVIG (Ad Hoc Met 02/01/02)

### Immunodeficiency Syndromes

Revised guidelines for Immunodeficiency Syndrome have been implemented and now read as follows:

Intravenous gammaglobulin is approved for the following immunodeficiency diagnoses:

- Functional immune deficiency (see A, B, & C below)
- Immunodeficiency syndrome (see A, B, & C below)
- Acquired Immunodeficiency – Combined Variable Immune Deficiency (CVID) (see A, B, & C below)
- Transient hypogammaglobulinemia of childhood (see A, B, C, & D below)
  - A. Impaired quantitative total IgG levels of less than 200 mg/dl and a history of life-threatening infections such as bacterial meningitis and/or sepsis. In these situations, testing for responses to antigenic stimulation would not be prudent and IVIG therapy will be allowed when these conditions exist.
  - B. In all other cases, a functional immune deficiency needs to have been demonstrated by the lack of antibody response to antigen stimulation (pneumococcus, tetanus, or hemophilus influenza) to which most normal patients would respond, i.e., pre and post immunization antibody levels. These results must be reviewed on an individual basis and correlated with the relevant clinical findings.
  - C. Use of IVIG therapy with any of the above diagnoses (1, 2, 3, 4) WITHOUT either A or B above will be DENIED as not medically necessary.
  - D. Transient hypogammaglobulinemia of childhood:

- 1) Similar to B except therapy is for a limited period of time, usually six months, then withdrawn. Lab values similar to B.
- 2) In children less than 5 years of age at the time of presentation of symptoms.

## Internal Medicine Liaison (Met 2/06/02)

### Adult Growth Hormone Therapy

The adult growth hormone therapy guidelines have been revised to now read:

An endocrinology consultant should review cases for:

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

Adult Growth Hormone is approved for organic hypopituitarism with documentation of "A" plus "B," or documentation of "C."

- A. Multiple hormone deficiencies (pan hypopituitarism-2 or more deficiencies, ACTH, gonadotropin deficiency, diabetes insipidus) as a result of pituitary or hypothalamic disease secondary to tumor, surgery, inflammation, radiation therapy, trauma or structural abnormality (septo-optic dysplasia, ectopic neurohypophysis),

PLUS

- B. Results of an abnormal standard growth hormone test using either insulin induced and documented hypoglycemia (blood sugars less than 40mg/dl or 50% decrease from baseline with symptoms) or GREF/ arginine as the secretagogue. With the GREF/arginine the peak value of growth hormone should be less than 9 ng/ml and using the insulin induced hypoglycemia the peak value of growth hormone should be less than 5 ng/ml.

OR DOCUMENTATION OF

- C. Congenital hypopituitarism documented in childhood with adult presentation may not need growth hormone testing to document severe growth hormone deficiency. This is especially true if childhood growth hormone testing indicated severe growth hormone deficiency. If growth hormone therapy in adult with organic hypopituitarism is to be approved without growth hormone testing, the other hormone deficiencies should be documented by appropriate testing.

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

- a) Weight loss (three periodic weight determinations)
- b) Improvement in lipid profile
- c) Increased bone mass
- d) Increased muscle strength

- e) Increase of IGF1 (insulin like growth factor body mass, decrease in fat mass and increase in bone mass can be documented by DEXA scan).

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## **Camera Pill**

The camera pill remains experimental/investigational.

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## **Interferon Gamma-1B (i.e., Actimmune)**

HCPCS Code J9216

Interferon Gamma-1B (i.e., Actimmune) remains experimental/investigational for pulmonary fibrosis.

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## **Osteoporosis Rescreening Guidelines**

CPT Codes 76075, 76076, 76977, 78350, and 78351

Rescreening bone densitometry will be reimbursed for a member that meets one of the following criterion:

1. An estrogen-deficient woman at clinical risk for osteoporosis
2. An individual with vertebral abnormalities
3. An individual receiving long-term glucocorticoid (steroid) therapy
4. An individual with primary hyperparathyroidism
5. An individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy

Coverage for rescreening of bone mass measurements will be limited to only one measurement every two years for members who receive bone mass measurements. Follow-up bone mass measurements performed more frequently for pathological diagnosis may be covered when medically necessary.

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## **Electron-Beam Computerized Tomography (EBCT) Screening for Cardiovascular Calcium Deposits**

HCPCS Code S8092

Using EBCT as a method to screen patients for calcium deposits in the cardiovascular system remains experimental/investigational.

## **Podiatry Liaison** (Met 02/07/02)

## **Extracorporeal Shock Wave Therapy (Orthotripsy) for Plantar Fasciitis**

CPT: 0020T

See page 4.

## Electrical Bone Growth Stimulator

See page 2.

## Radiology Liaison (Met 02/12/02)

### Percutaneous Vertebroplasty

See page 4.

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### Positron Emission Tomography (PET)

CPT Codes 78459, 78491, 78492, 78608, 78609, and 78810

HCPCS Codes, G0030 - G0047, G0125 and G0210 - G0234

Positron emission tomography (PET) is considered medically necessary for the following diagnoses:

1. Refractory epileptic seizures (failure to respond to medical therapy and being considered for surgical resection of brain focus)
2. Brain neoplasm
3. Recurring colorectal cancer
4. Esophageal cancer
5. Head & neck cancer (excluding thyroid)
6. Hodgkin's & non-Hodgkin's lymphoma
7. Malignant melanoma
8. Solitary pulmonary nodule
9. Metastatic disease (with an inconclusive CT scan)
  - a. Staging: should be used when the cancer stage remains in doubt after completing a standard diagnostic workup that might include things such as CT scans, MRI or ultrasound. It would also be covered if the clinical management of the patient would differ depending on the stage of the cancer identified.
  - b. Re-staging: would be covered after completion of treatment in order to detect residual disease or "for detecting suspected recurrence or to determine the extent of a known recurrence." Re-staging only occurs after a course of treatment is completed, and this is covered, subject to the conditions above.

10. Coronary revascularization – if candidate for coronary revascularization procedure – CABG  
(with an inconclusive SPECT scan)

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## **Additional Diagnosis Codes Covered for Diagnostic Mammography**

CPT Codes 76090 and 76091

HCPCS Codes G0202, G0204, and G0206

Covered guidelines for diagnostic mammography have been expanded to include the following diagnosis codes:

610.0 - Benign solitary cyst of breast

610.1 - Benign diffuse cystic mastopathy

- Chronic cystic mastitis
- Cystic Breast
- Fibrocystic disease of breast

611.6 - Galactorrhea not associated with childbirth

611.72 - Lump or mass in breast

611.79 - Other Signs and Symptoms in Breast

- Induration of breast
- Inversion of nipple
- Nipple discharge

611.8 - Other specified disorders of breast

- Hematoma (nontraumatic) of breast
- Infarction of breast
- Occlusion of breast duct
- Subinvolution of breast (postlactational) (postpartum)

996.69 - Infection and inflammatory reaction due to other internal prosthetic device, implant, and graft (breast prosthesis)

996.79 - Other complications due to other internal prosthetic device, implant, and graft (breast prosthesis)

NOTE: More codes for diagnostic mammography are published in MAC-2-99.

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## **Brachytherapy**

CPT Codes 77750-77799

Brachytherapy guidelines have been revised to now read as follows:

A. **MEDICALLY NECESSARY** (Must meet one criterion from either 1, 2, or 3):

1. Brachytherapy, when used alone or as a boost with chemotherapy and external beam radiotherapy (EBRT), is considered medically necessary in the following conditions:
  - a. Prostate cancer - for the treatment of localized prostate cancer
  - b. Cervical cancer - in the management of carcinoma of the uterine cervix
  - c. Endometrial/vaginal cancer
  - d. Breast cancer - initial treatment used as a local boost in patients who are also treated with breast conserving surgery (lumpectomy) and whole breast external beam radiotherapy (EBRT radiation)
  - e. Head and neck cancers
  - f. Non-small cell lung cancers and endobronchial cancers
  - g. Esophageal cancers including, intraluminal cancers
  - h. Bile duct cancer
  - i. Recurrent colorectal cancer in the pelvis
  - j. Anal or lower rectal cancers
  - k. Choroid (eye) melanomas
  - l. Recurrent brain tumors
  - m. Soft tissue sarcomas
2. High dose iridium 192 boost for the T2B through T3C cancers of the prostate.
3. Intravascular brachytherapy for in-stent re-stenosis.

B. **INVESTIGATIONAL:**

All other uses of brachytherapy (such as pleural mesotheliomas) not previously mentioned, are considered investigational.

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## **MRI of the Breast**

CPT Codes 76093-76094

MRI of the breast is considered experimental/investigational except for determining breast implant integrity, for which records need to be submitted with the claim.

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## **Electron-Beam Computerized Tomography (EBCT) Screening for Cardiovascular Calcium Deposits**

HCPCS Code S8092

Using EBCT as a method to screen patients for calcium deposits in the cardiovascular system remains experimental/investigational.

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## **Breast Ductal Lavage**

CPT Code 19499

Breast ductal lavage remains experimental/investigational.

Breast ductal lavage is a minimally invasive procedure that takes about 30 minutes and involves three steps. First, an anesthetic cream is applied to the nipple area. Gentle suction is applied to identify which milk ducts produce droplets of fluid on the nipple surface. Next, a hair-thin micro catheter is inserted gently into the natural milk duct opening on the nipple surface. Approximately 10-20 ml (2-4 teaspoons) of sterile saline is slowly infused through the micro catheter to “rinse” the duct and collect cells. The final step involves sending the ductal fluid to a laboratory for analysis to determine whether the sample contains normal, precancerous or cancerous (malignant) cells.

## **Oncology Liaison** (Met 02/19/02)

### **Brachytherapy**

CPT Codes 77750-77799

See page 10.

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## **Breast Ductal Lavage**

CPT Code 19499

Breast Ductal Lavage remains experimental/investigational. See above for description of service.

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## **BRCA I and BRCA II Guideline Update**

The fifth criterion for the BRCA I and BRCA II guideline has been amended. The guideline now reads:

### **BRCA TESTING CRITERIA**

It has been determined by a genetic evaluation that the individual has a significantly increased risk for

breast and/or ovarian cancer and will receive genetic counseling prior to and following the test and; (must include one of the following:)

1. Persons with breast and/or ovarian cancer who have two (2) or more first-degree\* or second-degree\*\* blood relatives (related through a single lineage) with either breast or ovarian cancer.
2. Person with breast and/or ovarian cancer who have one blood relative (less than 45 years of age at the onset of cancer) with either breast or ovarian cancer.
3. Persons with breast and/or ovarian cancer which developed at an early age (less than 35 years). Ages 35 and above will be reviewed by a consultant.
4. Persons with breast and/or ovarian cancer with multiple primary cancers or bilateral disease.
5. First-degree\* relatives of persons with documented mutations in the BRCA genes.

OR

BRCA testing should be allowed in individuals who have had two or more first-degree relatives or one first-degree relative plus two or more second-degree relatives who have had breast and/or ovarian cancer and who have not had BRCA testing.

\*First-degree relatives are parents, siblings or offspring.

\*\*Second-degree relatives are aunts, uncles, grandparents, nieces, nephews or half-siblings.

# Attention: All Health Care Providers

## Learn About HIPAA!

You are cordially invited to attend a FREE Health Insurance Portability and Accountability Act (HIPAA) Compliance information session. The session is sponsored by the Centers for Medicare and Medicaid Services (CMS), the Federal agency that administers the Medicare and Medicaid programs, and HIPAA Awareness and Readiness for Kansas organization (HARK). You'll hear about:



Key Administrative Simplification features of HIPAA.



Who is a "Covered Entity" under HIPAA?



Important HIPAA compliance deadlines you MUST know.



How to get a one-year extension for Transaction and Code Set compliance.



The E-Z 26-question compliance extension form and how to electronically file for IMMEDIATE confirmation.



FREE Provider resources... and much more.



### Calendar of Sessions

*These FREE sessions have been scheduled from  
6:00 pm to 8:00 pm on the following dates and locations:*

Monday	Tuesday	Wednesday	Thursday
July 22, 2002	July 23, 2002	July 24, 2002	July 25, 2002
<i>Ramada Inn, 1950 South Range Ave., Colby</i>	<i>St. Catherine's Hospital, 410 Walnut, Garden City</i>	<i>S.W. Medical Center, 315 W. 15<sup>th</sup> St., Liberal</i>	<i>Dodge City Community College, 2501 N. 14<sup>th</sup> Ave, Dodge City</i>

Additional outreach sessions are being planned for August and September in Junction City, Concordia, Great Bend, Medicine Lodge, Seneca, Atchison, Fort Scott, and Coffeerville. Watch your mail or check the HARK web site at [www.HARK.info](http://www.HARK.info) for the final dates and locations.

**No reservations are required.**

For more information, contact Uvonda Meinholdt (CMS) at 816-426-5783 or  
Ruth Cornwall (HARK) at 785-235-2383.

