

# Blue Shield Report

A Newsletter for  
Professional Providers and  
their Staff Members

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## Questions:

Contact your Professional Relations Representative, or the Professional Relations Hotline in Topeka at 785-291-4135 or 1-800-432-3587.

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# Medical Advisory Committee (MAC)

Changes resulting from the first session for MAC in 2003 will be effective July 1, 2003. You will find this newsletter arranged in chronological order according to liaison dates.

## General MAC Update (April 24, 2003)

### Assistant At Surgery Not Medically Necessary

Assistant at surgery is considered not medically necessary for procedure codes 20612 and 29873.

## Podiatry Liaison (February 6, 2003)

### Noninvasive Bone Growth Stimulation

Section 3.C of the electrical bone growth stimulator guideline has been updated. The guideline now reads:

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

#### Medically necessary:

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 (surgical shoe, splint, cast, cane, walker, crutches as needed, etc.).
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.

**Not medically necessary:**

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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**Unna Boot**

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Unna boot treatment is considered content of service to an office visit; therefore you may bill for the unna boot and not the office visit to maximize reimbursement.

Strapping of the ankle, foot, or toes are subject to the guidelines used for unna boot codes.

## **Radiology Liaison (February 11, 2003 and April 1, 2003)**

### **Prostate Brachytherapy with Permanent Seeds and High Dose Rate Prostate Brachytherapy**

1. Permanent seeds for prostate brachytherapy is **not** considered experimental/investigational.
2. High dose rate prostate brachytherapy is experimental/investigational. This is an adjustment to current policy.

### **High Dose Rate Breast Brachytherapy with Permanent Seeds Via Mammo-Site Catheter**

The mammo-site catheter to deliver radiation seeds with **no** local external beam radiation is experimental/investigational.

### **Tumor Markers CA-27.29 and CA-15-3**

BCBSKS has employed the following guidelines for tumor markers CA-27.29:

Tumor marker CA-27.29:

1. May be used for monitoring an already elevated titer or antigen in patients with metastatic breast cancer
2. May be used in surveillance of breast cancer patients with elevated initial studies after the removal of an initial primary tumor
3. Should not be used for screening patients who have not been proven to have breast cancer
4. Is a superior test to CA-15-3; therefore CA-15-3 should not be used

CA 27.29 Testing frequency:

- a. Treatment – baseline and every six weeks to assess response
- b. Surveillance – every three months for posttreatment follow-up

NOTE: Testing will be audited on a postpay basis to evaluate unsupported reimbursement. Payments will be recovered when appropriate.

### **Ultrasound of Breast**

Reimbursement will be given for an ultrasound of the breast when a palpable breast lesion, an abnormal mammogram, or focal breast pain is present, but not for routine screening on females with dense breast tissue.

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**Positron Emission Tomography (PET) Scans**

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General rules that apply to a Positron Emission Tomography (PET) Scan:

1. PET scanning is not a covered service for screening purposes regardless of diagnosis.
2. PET scans must be medically necessary and influence the management of the patient. PET scans must not duplicate other covered diagnostic tests.
3. It is not sufficient to merely have the presence of a diagnosis, the criteria below should be taken into consideration in the determination of medical necessity for any particular PET scan in an individual patient.
4. The ordering physician is responsible for documenting the medical necessity of the study and that it meets the conditions specified below.

PET should be considered medically necessary if it is relating to malignancies and the following conditions apply:

1. Diagnosis: In general, for most solid tumors, a tissue diagnosis is made prior to the performance of PET scanning. PET results may assist in determining the optimal anatomical location to perform an invasive surgical diagnostic procedure. PET scans following a tissue diagnosis are performed for the purpose of staging, not diagnosing.
2. Staging and or Restaging: PET is covered in clinical situations in which
  - 1) (a) the stage of cancer remains in doubt after completion of a standard diagnostic workup, including conventional imaging (computed tomography, magnetic resonance imaging, or ultrasound)  
**or**  
(b) the use of PET would also be considered reasonable and necessary if it could potentially replace one or more conventional imaging studies when it is expected that conventional study information is insufficient for the clinical management of the patient  
**and**  
2) clinical management of the patient would differ depending on the stage of the cancer identified. PET will be covered for restaging after the completion of treatment for the purpose of detecting residual disease, for detecting suspected recurrence or to determine the extent of a known recurrence.
3. Monitoring: Use of PET to monitor tumor response during the planned course of therapy (i.e. when no change in therapy is being contemplated) is not covered. Restaging only occurs after a course of treatment is completed, and this is covered, subject to the conditions above.
4. Repeat Testing:
  - a. Repeat PET scan for staging purposes should occur no more frequently than every six months (and likely less often), except in the case of lymphomas where PET scanning might be on a three-month interval. Exceptions will be reviewed as requested.
  - b. Repeat PET scan for chemotherapy response should occur no more frequently than every six weeks. Exceptions will be reviewed as requested.
5. Clinical Conditions and allowed coverage

<b>Clinical Condition</b>	<b>Allowed Coverage</b>
a. Refractory Epileptic Seizures (failure to respond to medical therapy and being considered for surgical resection of brain focus)	Covered for pre-surgical evaluation only
b. Brain Neoplasm - Gliomas grade II and above (evaluation for differentiation of recurrent or residual disease versus radiation necrosis)	Staging and restaging
c. Colorectal Cancer	Staging and restaging
d. Esophageal Cancer	Staging and restaging
e. Head & Neck Cancer (excluding CNS and thyroid)	Staging and restaging
f. Hodgkin's & Non-Hodgkin's lymphoma	Staging and restaging
g. Melanoma	Staging and restaging; non-covered for evaluating regional nodes
h. Solitary Pulmonary Nodule	Characterization
i. Lung Cancer (Non-small Cell)	Staging and restaging
j. Breast Cancer	T-0: denied as not medically necessary (in situ, Stage 0, DCIS/TIS) T-1: will be reviewed by an oncology consultant T-2: As an adjunct to standard imaging modalities staging distant metastasis or restaging patients with locoregional recurrence or metastasis; and as an adjunct to standard imaging modalities for monitoring response to treatment for locally advanced and metastatic disease to determine if therapy should be changed
k. Coronary revascularization – if candidate for coronary revascularization procedure – CABG	Covered only following inconclusive SPECT
l. Myocardial Viability	Primary or initial diagnosis prior to revascularization, or following an inconclusive SPECT
m. Perfusion of the heart using Rubidium 82* tracer *Not FDG-PET	Covered for noninvasive imaging of the perfusion of the heart

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**Radiofrequency Ablation of Liver Tumors**

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Radiofrequency ablation of liver tumors is available for reimbursement in either of the two situations:

1. Hepatic metastases of no more than four lesions, less than three centimeters in diameter each
- OR**
2. Hepatic metastases as a palliative treatment

NOTE: Once BCBSKS has approved the initial treatment, additional treatment will be allowed without further review.

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**Chemoembolization of Primary or Metastatic Carcinoma Liver Tumors**

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Transcatheter arterial chemoembolization (TACE) is considered medically necessary as palliative treatment for patients with carcinoid tumors with hepatic metastases when systemic therapy has failed to control carcinoid syndrome (e.g., debilitating flushing, wheezing, and diarrhea).

**OR**

TACE is considered medically necessary for surgically unresectable primary hepatocellular carcinoma (HCC) when **all** of the following criteria have been met:

1. The patient has preserved liver function defined as Childs-Turcotte-Pugh class A or B, and
2. The patient has less than 3 encapsulated nodules which are less than 4 cms in diameter, and
3. The patient has no evidence of extra-hepatic metastases, and
4. The patient has no evidence of severe renal function impairment, and
5. The patient has no evidence of portal hypertension

NOTE: Once BCBSKS has approved the initial treatment, additional treatment will be allowed without further review.

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**Kyphoplasty/Vertebroplasty**

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BCBSKS guidelines for reimbursing vertebroplasty:

1. Osteolytic vertebral metastasis or myeloma with severe back pain related to destruction of the vertebral body
2. Vertebral hemangiomas with aggressive clinical symptoms
3. Sub-acute osteoporotic vertebral collapse with pain not responding to standard medical treatment for at least six weeks
4. Painful vertebral eosinophilic granuloma with spinal instability

Vertebroplasty in acute traumatic fractures with no underlying pathologic disease process is considered experimental/investigational.

Due to the lack of supporting studies, Kyphoplasty is considered experimental/investigational.

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**Magnetic Resonance Venography (MRV)**

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MRV of the head is considered medically necessary for a confirmatory diagnosis in the assessment of patients suspected of having intracranial venous sinus thrombosis. MRV may be performed with or without contrast.

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**Magnetic Resonance Angiography (MRA) Guidelines**

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1. In all circumstances, standard medical practice would require the ordering physician to:
  - a. Document a full history of presenting symptoms(s), and relevant past history.
  - b. Document a physical exam, of appropriate extent, to establish presence or absence of physical findings associated with disease process thought to be present, or to be excluded
  - c. Document with sufficient legibility, clarity, and detail to establish the clinical reasoning/thought to justify the ordered testing. This could include, but not be limited to:
    - i. a differential diagnosis,
    - ii. a specific highly-likely disease to confirm or exclude how treatment would be altered by the testing result.
  - d. Document a written order/statement of what test is being requested.
2. Meeting circumstances as outlined in the following presenting problems and approval criteria.

**Presenting Problem: Renal Conditions****Indications:**

1. Suspected renal artery stenosis if pre-test disease likelihood is high (20%)
  - a. Fibromuscular dysplasia – young female with new onset of significant, persistent hypertension.
  - b. Atherosclerotic renal artery stenosis:  
(three or more of the following)
    - Abdominal or flank systolic and diastolic bruit
    - High grade retinopathy (III-IV)
    - Signs or symptoms of significant peripheral vascular disease
    - Hypertension refractory to 3 or more medications
    - Elevation of serum creatinine after ACE inhibitor
    - Serum creatinine >1.4 mg/dl
    - Age >60
    - Incidental finding of asymmetrically sized kidneys

**Consultant Review:**

1. Suspected renal artery stenosis if pre-test disease likelihood is moderate (10-20%) (Any 2 of the above and expectation that member would benefit from alternative/surgical/PCI if significant lesion found)
2. Confirmation of other noninvasive study prior to invasive therapy.
3. Casual elevation of BP with/without medication.
4. Most mild to moderate hypertensive members.

Note: The member's history should be completely documented and significant high BP's recorded over time despite adequate anti-hypertensives in a compliant patient. The best test for diagnosis of RVHT

is not clear and likely should be based on individual facility expertise.  
From among Doppler ultrasound, captopril-augmented nuclear renography,  
MRA, CTA or Renal Arteriography.

**Presenting Problem: Systemic Disorders****Indications:**

Suspicious vascular lesion demonstrated on CT or MRI.

**Consultant Review:**

Sepsis, endocarditis, diabetes, inflammatory conditions, immune deficiencies, etc.  
which can lead to septic emboli or intravascular lesions.

**Presenting Problem: Trauma****Indications:**

Known traumatically induced cerebral or carotid lesion for follow-up to check  
expansion/recurrence of lesion – even without change in symptoms.

**Consultant Review:**

1. High level of suspicion by symptoms or examination; i.e., new bruit after injury,  
decreased/asymmetric pulse on carotid palpation, palpation of enlarged pulsatile  
segment of carotid artery, etc.,
2. Confirm significant carotid sonogram abnormality
3. Screening tool without contributory history
4. Type of injury and no symptoms with low likelihood that testing would change  
the course of treatment

**Presenting Problem: Family History of Arteriovenous Malformation (AVM) or  
Aneurysm****Indications:**

1. Abrupt severe headache.
2. Members with chronic headache syndromes: An abrupt severe headache, which  
is clearly different than the member's usual headache.
3. Personal history of AVM, aneurysm, or sub-arachnoid hemorrhage.

**Consultant Review:**

1. Neurological symptoms that may represent a mass effect. Examples of  
symptoms: diplopia, vertigo, cranial nerve abnormalities. However, other  
causes must be ruled out first; i.e., inner ear infections, metabolic causes, etc.  
Typical Bell's palsy should not require MRA.
2. Strong family history which is confirmed and well documented in records.  
Strong history = 2 or more 1<sup>st</sup> degree family members with known aneurysm or  
sub-arachnoid hemorrhage.
3. Personal history of polycystic kidney disease or Von-Hippel Lindau Syndrome  
or strong family history of same.
4. Screening without symptoms with possible genetic linkage.
5. Screening without symptoms with 1 family member or 2<sup>nd</sup> degree relative with  
confirmed history of aneurysm.

**Presenting Problem: Headache (HA)****Indications:**

Abrupt severe HA with documentation of hemorrhage (by CT scan, spinal tap or MRI)

NOTE: If surgery is planned, the surgeon may opt for angiography to further define the lesion.

**Consultant Review:**

1. Persisting HA with atypical features, especially if MRI reveals a suspicious vascular lesion. Used to rule out an expanding lesion or unknown congenital abnormality if HA is chronic.
2. Chronic headache syndrome with major change in character compared to previous evaluations.
3. Chronic headache syndrome where no imaging evaluation has been done.
4. Tool for simple HA without specifically described reasons on history and physical.
5. Previously normal study within last 18-24 months.

**Presenting Problem: Asymptomatic Conditions****Indications:**

After the initial workup is negative,

1. Cranial nerve symptoms where an expanding artery is suspected
2. Horner's syndrome

**Consultant Review:**

1. Unexplained finding on exam which may be mass or artery related by anatomic relationship with underlying neurological structures.
2. Screening tool without contributory history or physical findings and normal neurologic exam.

**Presenting Problem: Others****Indications: None****Consultant Review:**

1. Dizziness, syncope, blurry vision, and other non-specific complaints.
2. Should have other evaluations first and order MRA only if a specific, defined indication, or clinical question has been formulated.

**Orthopedic Liaison (February 12, 2003)****Noninvasive Bone Growth Stimulation** See page 2.**Kyphoplasty/Vertebroplasty** See page 7.

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**Service Content of Arthroscopy Shoulder Procedures**

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The following procedures are considered content of service when performed on the same date:

1. A decompression arthroscopic acromioplasty is content of service to a rotator cuff repair.
2. The arthroscopy rotator cuff repair surgery is content of service to SLAP repair surgery.
3. A partial claviclectomy (co-planing) is content of service to a decompression arthroscopy acromioplasty. If the surgery is more than co-planing of the distal clavicle, bill with modifier 22 and submit records for review.
4. An arthroscopic debridement is considered content of service per Policy Memo No. 11, A1.

**NOTE:** A decompression arthroscopic acromioplasty with a distal claviclectomy resection are considered separate procedures.

**NOTE:** An arthroscopic procedure without an available pure code will be reimbursed as a comparable open procedure code.

**Oncology Liaison (February 18, 2003 and April 1, 2003)**

Prostate Brachytherapy with Permanent Seeds and High Dose Rate Prostate Brachytherapy: see page 4

Tumor Markers CA-15-3 and CA-27.29: see page 4

High Dose Rate Breast Brachytherapy with Permanent Seeds Via Mammo-Site Catheter: see page 4

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