



# CODING GUIDELINES AND POLICY UPDATE

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## Important Note:

The medical policies referenced in this document apply to all HMO, POS, and PPO products of Independence Blue Cross ("IBC"), including its affiliates, as well as to traditional indemnity products to the extent the applicable covered services are underwritten by IBC or its affiliates. Please note that some of IBC's traditional indemnity products are jointly underwritten by Highmark Blue Shield and therefore Highmark's medical policy may apply. You may refer to the member's ID card for the entity that is responsible for underwriting the product.

This document was developed to assist IBC in administering the provisions of its benefits programs and does not constitute medical advice. Professional providers are responsible for providing medical advice and treatment. Even though this document may conclude that a particular service or item is medically necessary, such conclusion is NOT based upon the terms of a particular member's benefit plan. Members must refer to their specific benefit program for the terms, conditions, limitations and exclusions of coverage.

Please note that the Policy Bulletins which are referenced herein describe the status of a specific topic at the time the Policy Bulletin was created. Policy Bulletins are updated biennially and when new medical evidence becomes available, therefore, they are subject to change.

Please be aware that the actual Policy Bulletins which are discussed herein are used as a guide only. Coverage decisions are made on a case-by-case basis by applying Policy Bulletin criteria to the member's medical history, condition, and proposed course of treatment as well as the member's benefit program. Providers should review Policy Bulletins with Members as treatment options are discussed, as the Policy Bulletins are designed to be used by our professional staff in making coverage determinations and can be highly technical.

Information contained in this document and the actual Policy Bulletin does not constitute an offer of coverage, medical advice, or guarantee of payment. Please note that, if there is a conflict between the Policy Bulletin and a member's benefit program, the terms of the benefit program will govern.

Please note that providers who opted out of the class action settlement may not be entitled to certain claim payment policy changes. Therefore, any payments made pursuant to such policy changes to providers who opted out of the class action settlement are subject to retroactive adjustments.

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### View Full Policies Online

The descriptions provided in this document are summaries. Full descriptions of these policies are available online at [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy) under the Medical section.

# Medical Policies

## Biofeedback Therapy (07.00.01d)

### COVERED: ACCORDING TO CERTAIN CRITERIA

Biofeedback therapy is a training technique that provides visual, auditory, or other evidence of the status of certain bodily functions so that a person can exert voluntary control over the functions and alleviate deficits. The term biofeedback refers to the biological signals that are fed back, or returned, to the individual to assist in developing techniques to manipulate or control certain bodily functions.

Biofeedback therapy is considered medically necessary and, therefore, covered for any of the following when a documented functional deficit is present:

- Muscle re-education of specific muscle groups
- Treatment of incapacitating muscle spasm and/or weakness
- Treatment of pathological muscle abnormalities when conventional treatments (heat/cold massage, exercise, support) have not been successful
- Treatment of stress and/or urge urinary incontinence in cognitively intact individuals who have failed a documented trial of pelvic muscle exercise (PME) training designed to increase periurethral muscle strength
- Failure is defined as no clinically significant improvement in urinary continence after completing four weeks of an ordered regimen of PMEs.
- Treatment of constipation secondary to proven neuromuscular pelvic floor dysfunction

When biofeedback therapy is performed for any of the reasons listed above, the individual's medical records should document an ongoing treatment plan, which includes the following:

- Diagnosis
- Frequency goals
- Patient instruction (e.g., practice and follow-through)
- Frequency of treatment (e.g., two times per week)

In addition, the individual's medical records should document that all of the following criteria have been met:

- The individual is motivated to actively participate in the treatment plan and is responsive to the care plan requirements (e.g., practice and follow-through at home).
- The individual is capable of participating in the treatment plan (physically and cognitively).
- The condition is able to be appropriately treated with biofeedback (i.e., there is no pathology to prevent success of the treatment).

Supporting medical necessity documentation must be maintained in the individual's medical record and made available to the Company upon request.

Biofeedback therapy for any purpose other than those listed above including, but not limited to, the treatment of ordinary muscle tension states (e.g., tension headaches) or psychosomatic conditions is considered not medically necessary and, therefore, not covered.

Biofeedback therapy sessions are limited to 24 visits per 12-month calendar year for single or combination medical condition(s). Sessions beyond these limits are considered not medically necessary and, therefore, not covered.

Individual benefits must be verified as some groups exclude coverage for biofeedback therapy.

Devices used in biofeedback therapy (e.g., electromyography [EMG], biofeedback device) in the office or outpatient setting are not eligible for separate reimbursement; they are inherent to the biofeedback service.

The following are not eligible for reimbursement:

- Group biofeedback education training (i.e., more than one individual involved with a practitioner in training)
- Home use of biofeedback therapy and devices (e.g., EMG, biofeedback device)

## Decongestive Lymphedema Therapy (07.06.01a)

### COVERED: ACCORDING TO CERTAIN CRITERIA

The lymphatic system has two primary immunologic functions: activating the inflammatory response and controlling infections. In addition, the lymphatic system drains protein-containing fluid from body tissue and conducts it in a unidirectional flow to the circulatory system. Interruption in this drainage system results in the swelling of a body part, usually an extremity. This accumulation of fluid is referred to as lymphedema.

Currently, there is no cure for lymphedema. One treatment option is a decongestive lymphedema therapy (DLT) program. DLT is referred to by several terms, which may include the following:

- Noninvasive complex lymphedema therapy
- Conservative lymphedema management
- Complicated physiotherapeutic therapy
- Multimodal lymphedema therapy
- Palliative lymphedema therapy
- Lymphedema drainage therapy (LDT)
- Manual lymphedema treatment (MLT)
- Complete decongestive physiotherapy (CDP)

DLT is an individualized therapy program that generally consists of three sessions per week. The average duration of supervised DLT therapy is one-to-two weeks, depending on the progress of therapy. Typically, a DLT program includes education for the individual and the individual's caregiver, including instructions for skin care, manual lymphedema drainage, short-stretch compression bandaging, remedial exercise, and supportive garments.

A DLT program is considered medically necessary and, therefore, covered when all of the following medical necessity criteria are met:

- A lymphedema diagnosis is documented by a physician and submitted with a treatment plan that includes history and limb measurements for both the affected and unaffected limbs.
- The individual is symptomatic (e.g., numbness, tightness, stiffness, heaviness, and limb swelling) for lymphedema with functional limitation (e.g., difficulty dressing, decreased walking endurance).

- The individual or caregiver is able to comprehend, comply with, and continue the treatment regimen independently in the home setting.
- A physician ordered the services, and the services will be performed by an eligible health care provider who has received specialized training in this form of treatment.

Re-evaluations are performed when medically necessary (e.g., a medical complication has caused an interruption in therapy or a relapse in lymphedema). Requests for additional DLT visits must meet the same criteria as that of the initial treatment.

### Documentation

When an individual is receiving DLT, the initial and subsequent medical record documentation must include the following:

- Initial bilateral limb measurements
- Subsequent limb measurements and progress reports showing a reduction in size
- Progress reports addressing the expected outcome as well as the expected duration of treatment
- A response from the individual or the individual's caregiver confirming their understanding of the education and ability to take on responsibilities for the treatment

### Billing Guidelines

Providers should report DLT services with the global Healthcare Common Procedure Coding System (HCPCS) code S8950.

### Capitation

In geographic areas with capitated physical therapy (PT) programs, DLT is excluded from PT capitation when reported with HCPCS code S8950.

## Home Oxygen Therapy (05.00.58a)

### COVERED: ACCORDING TO CERTAIN CRITERIA

Home oxygen therapy is used to treat chronic, stable medical conditions that cause significant hypoxemia, such as severe lung disease (e.g., chronic obstructive pulmonary disease [COPD], interstitial fibrosis, cystic fibrosis, and pulmonary neoplasm), pulmonary

hypertension, and congestive heart failure related to cor pulmonale. Appropriate evidence of significant hypoxemia includes arterial blood gas studies, pulse oximetry, and certain clinical signs such as elevated pulmonary artery pressure, dependent edema, and polycythemia vera.

Home oxygen may be delivered via nasal cannula, face mask, or transtracheal catheter. Supply sources include a stationary or portable compressed gas tank, stationary or portable liquid oxygen tank, or stationary oxygen concentrator.

Home oxygen is covered and eligible for reimbursement when all of the following medical necessity criteria are met:

- The treating physician has determined that the individual has a severe lung disease or hypoxia-related symptoms that might be expected to improve with oxygen therapy.
- The individual's blood gas study or pulse oximetry meets the criteria stated below (i.e., severity of illness is determined as Group I or II).
- The qualifying study was performed by an eligible health care provider.
- The qualifying study was obtained under one of the following conditions:
  - If performed during an inpatient hospital stay, the reported test must be the one obtained closest to, but no earlier than, two days prior to the hospital discharge date.
  - If not performed during an inpatient hospital stay, the reported test must be performed while the individual is in a chronic stable state (i.e., not during a period of acute illness or an exacerbation of an underlying disease).
- Alternative treatment measures have been tried or deemed clinically ineffective (e.g., nebulizer treatments or steroid therapy).

## Group I Criteria

Home oxygen therapy is considered medically necessary and, therefore, covered when one of the following Group I Criteria is met:

- The individual demonstrates an arterial partial pressure of oxygen (PO<sub>2</sub>) at or below 55 mm Hg or

an arterial oxygen saturation at or below 88 percent taken at rest (awake) breathing room air.

- The individual demonstrates both of the following:
  - An arterial PO<sub>2</sub> at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent while awake
  - An arterial PO<sub>2</sub> at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent for at least five\* minutes during sleep
- The individual demonstrates a decrease in arterial PO<sub>2</sub> more than 10 mm Hg or a decrease in arterial oxygen saturation more than five percent for at least five\* minutes during sleep associated with symptoms or signs reasonably attributable to hypoxemia (e.g., cor pulmonale, P-pulmonale on electrocardiogram (EKG) [P-wave greater than 3 mm in standard leads II, III, or AVF], documented pulmonary hypertension and polycythemia vera).
- The individual demonstrates both of the following:
  - An arterial PO<sub>2</sub> at or below 55 mm Hg or an arterial oxygen saturation at or below 88 percent during exercise
  - An arterial PO<sub>2</sub> at or above 56 mm Hg or an arterial oxygen saturation at or above 89 percent during the day while at rest. In this case, oxygen is provided for during exercise if documentation shows it improves hypoxemia when the individual breathes room air during exercise.

## Group I Certification and Recertification Requirements

### Certification Requirements:

- Initial coverage for individuals meeting Group I criteria is limited to 12 months or the physician-specified length of need, whichever is shorter.
- The individual must be seen and evaluated, including a blood gas study or pulse oximetry measurement, by the treating physician within 30 days prior to the date of initial certification.

### Recertification Requirements:

- A repeat blood gas study or pulse oximetry must be performed within 30 days prior to the date of the revised certification.

## Group II Criteria

Home oxygen therapy is considered medically necessary and, therefore, covered when one of the following Group II Criteria is met:

- The individual demonstrates an arterial PO<sub>2</sub> of 56-59 mm Hg.
- The individual demonstrates an arterial blood oxygen saturation of 89 percent at rest (awake), during sleep for at least five\* minutes, or during exercise (as described under Group I Criteria) and one of the following:
  - Dependent edema suggesting congestive heart failure
  - Polycythemia vera with a hematocrit greater than 56 percent
  - Pulmonary hypertension or cor pulmonale, determined by measurement of pulmonary artery pressure, gated blood pool scan, echocardiogram, or P-pulmonale on EKG (P-wave greater than 3 mm in standard leads II, III, or AVF)

## Group II Certification and Recertification Requirements

### Certification Requirements:

- Initial coverage for individuals meeting Group II criteria is limited to three months or the physician-specified length of need, whichever is shorter.

### Recertification Requirements:

- The most recent study performed between the 61st and 90th day following initial certification must be reported on the recertification.

## Group III Criteria

Home oxygen therapy is considered not medically necessary and, therefore, not covered when either of the following Group III Criteria is present:

- The individual demonstrates arterial PO<sub>2</sub> levels at or above 60 mm Hg.
- The individual demonstrates arterial blood oxygen saturations at or above 90 percent.

*\*For all the sleep oximetry criteria described above, the five minutes does not have to be continuous.*

When both arterial blood gas (ABG) and oximetry tests have been performed on the same day under the same conditions (i.e., at rest/awake, during exercise, or during sleep) the ABG result will be used to determine if the coverage criteria were met. If an ABG test at rest/awake is nonqualifying, but an exercise or sleep oximetry test on the same day is qualifying, the oximetry test will determine the coverage.

Portable oxygen systems are considered medically necessary and, therefore, covered when the individual is mobile within the home and the qualifying blood gas study was performed while at rest (awake) or during exercise. If the only qualifying blood gas study was performed during sleep, portable oxygen is considered not medically necessary and, therefore, not covered.

If all of the coverage conditions specified above are not met, the oxygen therapy will be denied as not medically necessary and, therefore, not covered.

Home oxygen therapy is considered not medically necessary and, therefore, not covered in the treatment of:

- Angina pectoris in the absence of hypoxemia
- Dyspnea without cor pulmonale or evidence of hypoxemia
- Terminal illnesses that do not affect the respiratory system
- Peripheral vascular disease

All home oxygen therapy equipment from contracted providers is rented rather than purchased. Oxygen supplies (e.g., nasal cannula, tubing, face mask) are included in the rental reimbursement.

## Documentation

The Company may conduct reviews and audits of services provided to our members, regardless of the participation status of the provider. This process will include, but is not limited to, review of all services related to the claims prior to payment and post-payment review/audit of paid claims. Reviews may focus on adequate documentation of the certificate of medical necessity (CMN) for home oxygen according to the physician's prescription or other medical documentation. The CMN must be completed by the treating physician or another health care provider employed by the physician (nurse, respiratory therapist, etc.) The CMN may not be completed by the durable

medical equipment (DME) supplier. The CMN must include the diagnosis of the disease requiring home use of oxygen and the results of specific testing as required to meet the criteria noted above. A current CMN must be maintained by the DME supplier and made available to the Company upon request.

## Insertion of Implantable Infusion Pumps (11.15.03d)

### COVERED: ACCORDING TO CERTAIN CRITERIA

An implantable infusion pump is a drug delivery system that provides for the continuous infusion of an agent (e.g., morphine, chemotherapy drug) at a constant and precise flow rate. It is surgically placed in a subcutaneous tissue pocket in the abdomen or chest. The device consists of a surgically placed catheter that administers the prescribed medication and a pump that has a reservoir for medication storage.

The insertion of implantable infusion pumps is considered medically necessary and, therefore, covered when used for one or more of the following indications or conditions:

### Chemotherapy for Cancer

The insertion of implantable infusion pumps is considered medically necessary and, therefore, covered for any of the following chemotherapy regimens:

- Intra-arterial infusion of 5-fluorodeoxyuridine (5-FUdR) for the treatment of liver cancer for individuals with primary hepatocellular carcinoma
- Intravenous infusion for the treatment of Duke's Class D colorectal cancer, in which metastases are limited to the liver, and either the disease is unresectable or the individual refuses surgical excision of the tumor
- Intravascular infusion for the administration of U.S. Food and Drug Administration (FDA)-approved chemotherapeutic agents as treatment for head and neck cancer

### Antispasmodic Drugs for Severe Spasticity

The insertion of implantable infusion pumps is considered medically necessary and, therefore, covered for the intrathecal administration of antispasmodic

drugs (e.g., baclofen) to treat chronic intractable spasticity in individuals who have proven unresponsive to less invasive medical therapy, as determined by *both* of the following criteria:

- An individual cannot be maintained on noninvasive methods of spasm control, such as oral antispasmodic drugs, either because these methods fail to control the spasticity adequately or they produce intolerable side effects, as indicated by at least a six-week trial.
- Prior to pump implantation, an individual must have responded favorably to a trial intrathecal dose of the antispasmodic drug.

### Opioid Drugs for the Treatment of Chronic Intractable Pain

The insertion of implantable infusion pumps is considered medically necessary and, therefore, covered for the intrathecal or epidural administration of opioid drugs (e.g., morphine) to treat severe, chronic, intractable pain of a malignant or nonmalignant origin in individuals who have a life expectancy of at least three months and who have proven unresponsive to less invasive medical therapy, as determined by *one* of the following criteria:

- An individual's history must indicate that he/she did not respond adequately to noninvasive methods of pain control (e.g., systemic opioids and attempts to eliminate physical and behavioral abnormalities that may cause an exaggerated reaction to pain).
- A preliminary trial of intraspinal opioid drug administration must be undertaken with a temporary intrathecal/epidural catheter to substantiate adequately acceptable pain relief, the degree of side effects (including effects on the activities of daily living), and individual acceptance. These must be documented in the individual's medical record.

Determinations may be made on the medical necessity of other uses of implantable infusion pumps if all of the following criteria are met:

- The drug is medically necessary for the treatment of the individual.
- The drug can only be administered by an implantable infusion pump.

- The drug being administered and the purpose for its administration are consistent with the indicated uses in the pump’s FDA-approved labeling.

The insertion of implantable infusion pumps is contraindicated for individuals with one or more of the following:

- A known allergy or hypersensitivity to the drug being administered (e.g., baclofen or morphine)
- An infection
- Insufficient body size to support the weight and bulk of the device
- Other implanted programmable devices (because crosstalk between devices may inadvertently change the prescription)

The revision, replacement, and/or removal of implantable infusion pumps or catheters that are required for the pump are considered medically necessary for the individual’s treatment and, therefore, covered.

Professional services for the care and maintenance of implantable infusion pumps that are reported using Current Procedural Terminology (CPT®\*) codes 62367, 62368, 95990, 95991, and 96522 are eligible for reimbursement consideration.

Refill kits and supplies that are reported by a physician using Healthcare Common Procedure Coding System (HCPCS) codes A4220 and A4221 are considered integral to the physician’s services when reported in conjunction with CPT codes 95990, 95991, or 96522. Therefore, refill kits and supplies are not eligible for separate reimbursement consideration for contracted professional providers.

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## Needle Electromyography (EMG) Studies (07.03.09b)

### COVERED: ACCORDING TO CERTAIN CRITERIA

Electromyography (EMG) is the study and recording of the intrinsic electrical properties of skeletal muscles. EMG is performed to diagnose, define, and follow

diseases of the peripheral nervous system and muscle. Needle EMG is performed by inserting an electrode through the skin into appropriate muscles, one at a time. The needle translates the amount and intensity of the electrical activity into waveforms that are displayed on a computer screen.

Only those who are properly trained to perform needle EMGs should perform these tests. Competency to perform needle EMGs can be demonstrated through the completion of specialized training and documented experience performing cases under appropriate supervision.

## Single-fiber EMG

Single-fiber EMG is a specially designed needle electrode used to record and identify action potentials (APs) from individual muscle fibers. These recordings are used to calculate the neuromuscular jitter and the muscle fiber density (FD). Increased jitter, blocking, or both may occur in a variety of primary disorders of neuromuscular transmission (e.g., myasthenia gravis). Jitter and FD may be measured in one or more muscles depending on the condition being evaluated and the results of the testing.

Needle EMG is considered medically necessary and, therefore, covered for the following suspected indications:

- Mononeuropathy and polyneuropathy (metabolic, degenerative, hereditary)
- Myopathy (including polymyositis and dermatomyositis; myotonic and congenital myopathies)
- Nerve compression syndromes (including carpal tunnel syndrome and other focal compressions)
- Neuromuscular junction disorders (myasthenia gravis)
- Plexopathy (idiopathic, trauma, infiltration)
- Radiculopathy (cervical, lumbosacral)

In addition, needle EMG is considered medically necessary and, therefore, covered for localization prior to the administration of either of the following:

- Botulinum toxin type A (Botox®) (when used for Company covered indications)

- Phenol or other substances used for nerve blocking or chemodenervation

Eligible health care professional providers performing EMGs must be properly trained, licensed, and acting within their state board defined scope of their practice. Documentation of the performing provider's qualifications must be made available to the Company upon request.

- Only physicians are eligible to receive reimbursement for the professional component of EMGs. Physicians may also receive reimbursement for the technical component if they performed that service.
- Non-physician professional providers are only eligible to receive reimbursement for the technical component of EMGs.

## Reporting Requirements for Needle EMGs

### CPT® Codes 95860-95864

- Codes 95860-95864 should be billed as only one unit of service. The code covers all muscles tested, including the related paraspinal muscles and the recording of motor unit recruitment, amplitude, and configuration, both at rest and with muscle contraction.
- Codes 95860-95864 should be used to report complete studies of the extremities. These codes require evaluation of extremity muscles that are innervated by three nerves (e.g., radial, ulnar, median [upper extremities], tibial, peroneal, femoral [lower extremities], not sub-branches) or four spinal levels, with a minimum of five muscles studied per limb.
- Codes 95860-95864 can appropriately be reported in combination with CPT code 95869 (needle EMG; thoracic paraspinal muscles) only if paraspinals between T3 and T11 are studied.
  - 95869 may not be billed with 95860-95864 if only T1 and/or T2 are studied along with an upper extremity.

### CPT Codes 95865 and 95866

- 95865 is used for needle examination of the larynx.
- 95866 is used for needle examination of the hemidiaphragm.

### CPT Codes 95867 and 95868

- 95867 is used for the needle examination of one or more muscles that are supplied by cranial nerves on one side of the body.
- 95868 is used for the needle examination of one or more muscles that are supplied by cranial nerves on both sides of the body.
- Do not report codes 95867 and 95868 together; only one study/unit should be reported.

### CPT Code 95869

- Code 95869 should be used when studying thoracic paraspinal muscles exclusively.
- Code 95869 can be billed as one unit, despite the number of levels studied, whether it is unilateral or bilateral.

### CPT Code 95870

- Code 95870 should be used for the limited testing of specific muscles during an examination. This code should be used only when the muscles tested do not fit more appropriately under another CPT code.
- Code 95870 can be billed at one unit per extremity and can be used for muscles of the thorax or abdomen (unilateral or bilateral). One unit may be billed for studying cervical or lumbar paraspinal muscles (unilateral or bilateral), regardless of the number of levels tested.
- Code 95870 can be billed as multiple units in a single study.
- Code 95870 can be billed with 95860-95864 if a limited study is performed in conjunction with a full-limb study.

### CPT Code 95872

- Code 95872 should be used to record and identify action potentials (APs) from individual muscle fibers.
- The physician's report should identify the muscles tested.

### CPT Code 95874

- Code 95874 is an add-on code used for an EMG performed for localization for needle placement when giving an injection for botulinum toxin type A (Botox®) or phenol and other substances.

- Code 95874 should be reported in addition to the primary injection procedure performed.

## Nerve Conduction Studies (NCS) (07.03.18a)

### COVERED: ACCORDING TO CERTAIN CRITERIA

Nerve conduction studies (NCS) can be used to evaluate both motor and sensory nerve function. NCS aid in the diagnosis of peripheral nerve injuries (e.g., carpal tunnel syndrome, sciatica) and diseases that affect the peripheral nervous system (e.g., hereditary progressive muscular dystrophy, myasthenia gravis). During NCS, a nerve is stimulated electrically to assess the speed (conduction velocity and/or latency), size (amplitude), and shape of the response.

Motor NCS are performed by applying electrical stimulation at various points along the course of a motor nerve while recording the electrical response from an appropriate muscle. Sensory NCS are performed by applying electrical stimulation near a sensory nerve and recording the response from a distant site along the nerve. Mixed NCS are performed by applying electrical stimulation near a nerve that contains both motor and sensory fibers and recording the response from a different location along that same nerve.

### Short-latency Evoked Potentials (SEPs)

While motor and sensory NCS generally detect function in large-caliber peripheral nerve fibers, SEPs test conduction in central sensory pathways. SEPs are an extension of the electrodiagnostic evaluation. SEPs are noninvasive studies performed by repetitive submaximal stimulation of a sensory or mixed sensorimotor peripheral nerve. Amplitude, peak, and interpeak latency measurements with side-to-side comparisons are used to assess conduction abnormalities. SEPs have proven useful in evaluating various conditions including, but not limited to, spinal cord trauma, subacute combined degeneration, nontraumatic spinal cord lesions, and multiple sclerosis.

### Quantitative Sensory Testing (QST)

QST is the noninvasive assessment and quantification of sensory nerve function. QST involves psychophysical tests that are performed to provide a quantitative value to the subjective feeling of sensation. A transcutaneous

electrical stimulus is used to determine the minimum stimulus that evokes sensation in the individual. Proponents of this test claim that neuropathies can be diagnosed by using transcutaneous electrical stimulus. Stimuli used in QST include touch, pressure, pain, temperature, and vibration.

Competency to perform NCS can be demonstrated through the completion of specialized training. Regardless of the performing provider, only properly trained physicians should interpret the NCS results.

NCS are considered medically necessary and, therefore, covered for the following:

- Localization of focal neuropathies or compressive lesions, such as carpal tunnel syndrome, ulnar neuropathies, or root lesions
- Diagnosis and prognosis of traumatic nerve lesions
- Diagnosis or confirmation of suspected generalized neuropathies (e.g., diabetic, uremic, metabolic, or immunologic)
- Repetitive nerve stimulation to assist in the diagnosis of neuromuscular junction disorders (e.g., myasthenia gravis, myasthenic syndrome)
- Differential diagnosis of symptom-based complaints (e.g., pain, weakness, disturbance in skin sensation [e.g., burning or tingling]) related to peripheral nerve injuries or diseases that affect the peripheral nervous system

Motor NCS (with and without an F-wave study) and sensory NCS at a frequency of two sessions per calendar year are considered medically necessary and, therefore, covered for most conditions requiring such testing. Please refer the entire policy for more detailed information on the recommendations regarding the maximum number of studies that are appropriate for certain conditions and examples of clinical situations where additional testing is considered medically necessary.

In individuals with carpal tunnel syndrome, motor NCS with an F-wave study are considered not medically necessary and, therefore, not covered.

QST for diagnosing and/or managing a disease is considered experimental/investigational and, therefore, not covered because the safety and/or efficacy of QST cannot be established by a review of the available published literature.

Eligible health care professional providers performing NCS must be properly trained, licensed, and acting within their state board-defined scope of practice. Documentation of the performing provider's qualifications must be made available to the Company upon request.

- Only physicians are eligible to receive reimbursement for the professional component of NCS. Physicians may also receive reimbursement for the technical component if they performed that service.
- Non-physician professional providers are only eligible to receive reimbursement for the technical component of NCS.

## Coding Requirements for Reporting NCS

### CPT® Codes 95900-95904

- Codes 95900, 95903, and/or 95904 should be reported only once per nerve tested when different stimulation sites along the nerves are tested (inching).
- Codes for motor (95900 or 95903), sensory (95904), and mixed sensory (95904) studies on an individual nerve may be billed separately when the nerve has a contralateral counterpart that needs to be studied for comparison purposes.

### CPT Codes 95900 and 95903

- Codes 95900 and 95903 can be billed together for a given individual on the same day of service when multiple nerves are tested (some with and some without F-wave studies), because they describe two distinct and independent services that are provided on the same day.
- Codes 95900 and 95903 cannot be billed together for a given individual for the same day of service for the same nerve.

### CPT Codes 95925, 95926, and 95927 (SEPs)

- Code 95925 is reported when testing the upper limbs.
- Code 95926 is reported when testing the lower limbs.
- Code 95927 is reported when testing the trunk or the head.

### CPT Codes 95934 and 95936

- Codes 95934 and 95936 are defined as unilateral H-reflex study codes and are intended to be reported per study. Two H-reflex studies are generally appropriate in a given examination.
  - H-reflex studies are typically performed bilaterally because symmetry of responses is an important criterion to determine abnormality. When a bilateral H-reflex study is performed, the entire procedure must be duplicated for both locations.

### CPT Code 95903

- F-wave studies are billed in combination with the motor nerves that are examined (95903). Although the setup for an F-wave study is similar to the setup for motor NCS, the testing is performed separately from motor NCS and utilizes different machine settings and separate stimulation in order to obtain a larger number of responses (at least ten).
- The number of F-wave studies that need to be performed on an individual depends on the working diagnosis and the electrodiagnostic testing findings already in evidence. It may be appropriate to perform some motor NCS with and some without F-wave studies in the same individual.

Neuromuscular junction testing is generally appropriate for two repetitive stimulations per date of service.

## Outpatient Speech Therapy (10.06.01b)

### COVERED: ACCORDING TO CERTAIN CRITERIA

Speech/language pathology services are services deemed necessary for the diagnosis of speech and language disorders. Speech therapy is the medically prescribed treatment of speech and language disorders due to disease, surgery, injury, congenital anomalies, speech/language delay, or previous therapeutic processes that result in communication disabilities and/or swallowing disorders.

The American Speech-Language-Hearing Association (ASHA) is recognized internationally as the professional, scientific, and credentialing association for speech/language pathologists, audiologists, and speech, language, and hearing scientists.

This policy is consistent with state mandates.

## Medical Necessity Criteria

Speech pathology evaluation, and services related to speech therapy that are within the scope of the member's benefit contract, are considered medically necessary and, therefore, covered when all of the following criteria are met:

- The evaluation (92506) is prescribed by a physician and performed by a speech/language pathologist who is licensed in the state where the services are being performed and who is certified by ASHA.
  - The evaluation submitted should reflect a current functional status that is within three months of the requested start date of the therapy.
- The services must be of such a complex nature that they can only be performed by a speech/language pathologist.
- The medical condition must be such that there is a reasonable expectation that the services will bring about a significant improvement within a reasonable time frame, regardless of whether the individual has a coexisting disorder.
- The services are provided in accordance with an ongoing plan of care specific to the diagnosis.
  - The plan of care should incorporate ongoing care and be updated at least weekly, or more frequently as the treatment progresses and goals change or are met. Upon request, documentation must be made available to the Company to show measurable progress toward meeting the short- and long-term goals outlined in the plan of care.
  - The therapy is performed for a communication disorder that is a result of at least one of the following:
    - o Disease (e.g., Parkinson's disease resulting in increased difficulty in swallowing and speaking)
    - o Surgery (e.g., surgical removal of a malignant growth on the head or neck)
    - o Injury (e.g., automobile accident resulting in a subdural hematoma influencing the speech center causing neurogenic stuttering; aphasia following a cerebrovascular accident [CVA])

- o Congenital anomalies (e.g., inborn defect of the skull, cleft lip, or cleft palate)
- o Speech/language delay that is developmental in nature

- The amount, frequency, and duration of the services must be consistent with accepted standards of practice.
- Continuous assessment of the individual's progress is a component of ongoing therapy services and is not a re-evaluation.
  - A re-evaluation (S9152) is the re-assessment of the individual's performance and goals, after a plan of care has been instituted. A re-evaluation may be considered medically necessary and, therefore, covered when a significant improvement, decline, or change in the individual's condition occurs, or if requested by the Company to determine the medical necessity of ongoing intervention.

OR

- The evaluation (assessment) (92610) and therapy is performed for a swallowing disorder (dysphagia) resulting from a condition such as, but not limited to, a CVA regardless of whether a communication disorder also exists.

Speech therapy services performed for reasons other than those listed above are considered not medically necessary and, therefore, not covered.

## Conditions That Do Not Meet Medical Necessity Criteria

Conditions or situations that do not meet medical necessity criteria for speech pathology evaluation and services related to speech therapy include, but are not limited to:

- Psychological speech delay
- Behavior problems (e.g., impulsive behavior)
- Except as required by law, speech therapy for biologically-based mental illnesses (BBMI) in the absence of a documented communication comorbidity that is amenable to speech therapy with a reasonable expectation of achieving sustainable, measurable improvement in a reasonable time frame.

- Social communication disorder is not considered a medically necessary comorbidity.
- Stammering and stuttering, with the following exception:
  - Speech therapy is considered medically necessary for neurogenic stuttering caused by acquired brain damage.
- Programs that are primarily educational in nature or that support an academic program
- Speech therapy for the maintenance of a chronic condition
  - Maintenance therapy is defined as a continuation of care and management of the individual when the therapeutic goals of a treatment plan have been achieved, no additional functional improvement is apparent or expected to occur, and the provision of services for a condition ceases to be of therapeutic value.
- Services that otherwise would not require the skills of a qualified speech/language pathologist, such as treatments that maintain function by using routines and repetitions
  - Examples of these services include, but are not limited to: word drills for developmental articulation errors, computer-based programs (e.g., Fast ForWord®), and procedures that may be performed by the individual, family, or caregivers.

## Duplicate Therapy

When individuals are receiving both occupational and speech therapy, the therapies must provide different treatments with separate treatment plans and goals in order for each to be covered and be separately reimbursed. Otherwise, the therapy is considered duplicate therapy, and coverage and reimbursement is only available for one therapy.

## Benefit Limitations

Limitations, frequency, and annual maximums may be applied and vary by product or by group. Individual member benefits must be verified, as outpatient speech therapy benefits vary by product and group.

## Documentation

Documentation of the member's plan of care should be available for review upon request from the Company. Specifically, any trained health care provider should be able to review a medical record and clearly understand the status of the individual on a visit-to-visit basis, his/her diagnosis, treatment plans, therapeutic goals, medical necessity or appropriateness of treatment being rendered, and expected outcome from the prescribed plan of care.

The Company reserves the right to conduct reviews and audits of services provided to our members, regardless of the participation status of the treating provider. This process may include, but is not limited to: review of all services related to the claim prior to payment, post-payment review/audit of paid claims, adequate documentation, the proper usage of Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes according to the appropriate level of service provided, and the utilization of speech therapy services.

## Speech Therapy Services Provided in Conjunction with Speech-generating Devices and Computer-based Programs

### Speech-generating Devices Including Computer-based Programs

Speech therapy provided in association with a speech-generating device, including a computer-based program, is considered medically necessary and, therefore, covered when the device is considered medically necessary in accordance with the terms defined in the applicable medical policy on this topic.

Electronic speech devices that are designed to improve fluency problems (such as stuttering) rather than to aid in communication disabilities are considered experimental/investigational and, therefore, not covered as the efficacy of these devices cannot be established by a review of the available published literature. Examples of these types of electronic devices include, but are not limited to:

- SpeechEasy®
- Fluency Master®

## Billing Guidelines

Speech therapy sessions are service-based codes, not time-based codes. Therefore, these services are reported and reimbursed based on the service provided, not the duration of the service. Providers should report a single encounter with “1” as the unit of service, regardless of the duration of the service on a given day.

In geographic regions with a capitated outpatient rehabilitation program, outpatient speech therapy services are not included in capitation.

## Partial Coherence Interferometry (07.13.08b)

### COVERED: ACCORDING TO CERTAIN CRITERIA

During pre-cataract surgery evaluation, calculations such as axial eye length, corneal radius, and anterior chamber depth are made to determine the appropriate power of the pseudophakic intraocular lens (IOL) to be implanted. These calculations must be accurate in order to promote optimal postoperative refraction.

Partial coherence interferometry, also known as optical (ocular) coherence biometry or laser Doppler interferometry, is a newer technique for measuring the axial length of the eye. This procedure uses a laser Doppler function to calculate the echo delay and the intensity of infrared light that is reflected back from inner eye surfaces. Because it does not require direct contact with the eye, partial coherence interferometry is a more comfortable technique; it also avoids the refractive errors that can occur with transducer misplacement.

Partial coherence interferometry is considered medically necessary and, therefore, covered for the preoperative determination of the power of the IOL to be implanted after cataract removal.

## Percutaneous Balloon Valvuloplasty (11.02.03c)

### COVERED: ACCORDING TO CERTAIN CRITERIA

Mitral, aortic, and pulmonary stenosis refer to the narrowing of cardiac valves that can be caused by calcification, fibrosis, or congenital anomalies. Treatments for cardiac valvular stenosis include

medication, surgery, and percutaneous balloon valvuloplasty, a procedure in which a catheter with a collapsed balloon at the tip is inserted through the skin into the femoral artery or vein. The catheter is then advanced into the heart and valve. Once the balloon is positioned at the affected valve, it goes through a cycle of inflation and deflation in order to decrease the degree of obstruction within the valve.

Percutaneous balloon valvuloplasty is considered medically necessary and, therefore, covered in the following situations:

- For the treatment of severe uncomplicated mitral valve stenosis in individuals in whom the anatomical features of the valve are favorable
- For the treatment of aortic valve stenosis in the following individuals:
  - Neonates, infants, children, and young adults
  - Individuals in cardiogenic shock for whom percutaneous balloon valvuloplasty acts as a bridge to surgery
  - Elderly individuals with systemic disease who are not candidates for surgery
- For the treatment of pulmonary valve stenosis

## Ranibizumab (Lucentis™) for Intravitreal Injection (08.00.74)

### COVERED: ACCORDING TO CERTAIN CRITERIA

Ranibizumab (Lucentis™) is a recombinant, humanized, immunoglobulin G1 kappa (IgG1 kappa) monoclonal antibody fragment that was developed for ophthalmic intravitreal injection. It is a vascular endothelial growth factor A (VEGF-A) antagonist that works by binding to and inhibiting the action of VEGF-A. VEGF-A is a substance that binds to certain cells to stimulate new blood vessel formation and growth (angiogenesis or neovascularization). When VEGF-A is bound to ranibizumab (Lucentis™), it cannot stimulate neovascularization; therefore, new blood vessel formation and vascular leakage are reduced.

In neovascular/exudative (wet) age-related macular degeneration (AMD), VEGF-A induces abnormal neovascularization and increases vascular permeability and leakage, which appear to contribute to the progression of the disease. The proliferation of

abnormal, leaky blood vessels eventually damages the area of the eye responsible for central vision (known as the macula) and may lead to blindness.

Ophthalmic intravitreal injection of ranibizumab (Lucentis™) is considered medically necessary and, therefore, covered for individuals who have neovascular (wet or exudative) AMD.

All other uses of ranibizumab (Lucentis™) are considered experimental/investigational and, therefore, not covered because their safety and/or efficacy cannot be established by a review of the available published literature.

## Billing Guidelines

Intravitreal injection of ranibizumab (Lucentis™) must be reported with both of the following codes:

- 67028: Intravitreal injection of a pharmacologic agent
- J3590: Unclassified biologicals

Ranibizumab (Lucentis™) is supplied in a single dose vial and is administered only by ophthalmic intravitreal injection, no more than once monthly per affected eye.

## Scanning Computerized Ophthalmic Diagnostic Imaging (07.13.06c)

### COVERED: ACCORDING TO CERTAIN CRITERIA

Glaucoma commonly causes a spectrum of related eye and vision changes, including erosion of the optic nerve and the associated retinal nerve fibers, and loss of peripheral vision. A diagnosis of glaucoma seldom is made based on a single clinical observation, but instead relies upon analysis of an assemblage of clinical data. Careful reliance upon all available clinical data can allow for early treatment and prevent unnecessary end-stage therapies.

Compared with visual field testing and/or disc photos, scanning computerized ophthalmic diagnostic imaging allows earlier detection of glaucomatous damage to the nerve fiber layer or optic nerve. It also provides a more precise method of observing the optic nerve head, which allows for earlier and more efficient treatment efforts.

Because scanning computerized ophthalmic diagnostic imaging provides details about the microscopic

anatomy of the retina and the vitreo-retinal interface, this technique is also valuable for the evaluation of individuals with retinal disease, diabetic retinopathy, and macular abnormalities.

Scanning computerized ophthalmic diagnostic imaging is considered medically necessary and, therefore, covered for the following:

- Up to one test per year for mild glaucomatous damage or suspected glaucoma, as demonstrated by any of the following:
  - Intraocular pressure (IOP) greater than or equal to 22 mm Hg, as measured by applanation
  - Symmetric or vertically elongated enlargement of optic nerve cup, neural rim intact, cup-disc ratio greater than 0.4 or cup-disc asymmetry
  - Focal optic disc notch
  - Optic disc hemorrhage or history of optic disc hemorrhage
  - Nasal step peripheral to 20 degrees, small paracentral, or arcuate scotoma
  - Mild constriction of visual field isopters
- Up to two tests per year for moderate glaucomatous damage, as demonstrated by any of the following:
  - Enlarged optic nerve cup with neural rim remaining but sloped or pale, cup-disc ratio greater than 0.5 but less than 0.9
  - Definite focal optic disc notch with thinning of the neural rim
  - Definite glaucomatous visual field defects (e.g., arcuate defect, nasal step, paracentral scotoma) or general depression
- Advanced glaucomatous damage, as demonstrated by any of the following:
  - Diffuse enlargement of optic nerve cup, with cup-disc ratio greater than or equal to 0.9
  - Wipe-out of all or a portion of the neural retinal rim
  - Severe generalized constriction of isopters (i.e., Goldmann 14e, less than 10 degrees of fixation)
  - Absolute visual field defects to within 10 degrees of fixation
  - Severe generalized reduction of retinal sensitivity

- Loss of central visual acuity, with temporal island remaining
- Up to four tests per year for individuals with retinal disorders to determine either of the following:
  - The safety of cessation of therapy
  - The need for ongoing therapy

Scanning computerized ophthalmic diagnostic imaging for any other condition is considered experimental/investigational and, therefore, not covered.

Scanning computerized ophthalmic diagnostic imaging is not the preferred study for advanced glaucomatous damage. It is more appropriate to perform visual field testing late in the course of glaucoma, when the nerve fiber layer has been extensively damaged and visual field testing is more likely to detect small changes.

If bilateral studies are reported, the documentation maintained by the provider must demonstrate medical necessity for the test to be performed in each eye.

## Treatment of Twin-Twin Transfusion Syndrome (TTTS) (11.00.14a)

### COVERED: ACCORDING TO CERTAIN CRITERIA

Twin-twin transfusion syndrome (TTTS) occurs in cases of monozygotic monochorionic (one placenta) twins. Though not fully understood, twins with TTTS share a single placenta that contains blood vessels that abnormally connect the fetuses to each other. As a result, the twin donating the blood can experience growth retardation, anemia, and oligohydramnios (reduced amniotic fluid). The twin receiving the blood can experience polyhydramnios (excessive amniotic fluid) and vascular engorgement, leading to congestive heart failure and hydrops fetalis (excessive accumulation of serous fluid in the tissues and body cavities).

Treatment options for TTTS include serial amnioreduction and fetoscopic laser photocoagulation of the placental vessels that join the fetuses. Serial amnioreduction is a variant of amniocentesis in which amniotic fluid is repeatedly removed in order to restore normal fluid volume. In fetoscopic laser photocoagulation, the abnormal connection of the placental vessels is identified endoscopically under ultrasound guidance and ablated using a laser. This separates the two fetal circulations, correcting the

underlying abnormality. The alternative to prenatal intervention is conservative management, which is associated with a fetal mortality rate between 90 percent and 100 percent.

Randomized controlled studies of serial amnioreduction and fetoscopic laser photocoagulation are difficult to undertake because of the limited numbers of candidates available at centers that provide the procedure and because of the ethical issues involved in withholding treatment to candidates in control groups in which perinatal mortality can reach 90 percent. When compared to serial amnioreduction, fetoscopic laser photocoagulation has resulted in fewer reports of neurologic morbidity in surviving children.

Serial amnioreduction, fetoscopic laser photocoagulation of placental vessels, or serial amnioreduction combined with fetoscopic laser photocoagulation is considered medically necessary and, therefore, covered when provided as a treatment for TTTS when all of the following criteria are met:

- Gestational age of less than 25 weeks
- Ultrasonographic examination showing a single, monochorionic placenta
- Severe oligohydramnios (reduced amniotic fluid [deepest pool less than 1 cm]) or anhydramnios (absence of amniotic fluid) of the donor twin
- Massive polyhydramnios (excessive amniotic fluid) of the recipient twin (vertical pool of amniotic fluid 8-18 cm)
- Donor appearing as a stuck twin fixed to the uterine wall by the intertwin membrane
- Donor showing signs of oliguria, with either a very small, or empty, bladder
- Recipient showing signs of polyuria, with a distended bladder
- Fetuses discordant in size (15 percent to 25 percent)
- Umbilical artery Doppler ultrasonography revealing the absence or reversal of end-diastolic velocities as a sign of markedly increased placental resistance

## **Vagus Nerve Stimulation (11.15.16d)**

### **COVERED: ACCORDING TO CERTAIN CRITERIA**

Seizures are considered paroxysmal disorders (i.e., characterized by abnormal cerebral neuronal discharge) and can occur with or without a loss of consciousness. Seizures can be classified as having either a generalized or a partial onset.

Epilepsy is diagnosed in individuals with a predisposition for recurrent, unprovoked seizures. Seizures that are not completely controlled by medical therapy are referred to as medically refractory seizures. Vagus nerve stimulation (VNS) has been evaluated as an alternative treatment for individuals with medically refractory partial-onset seizures or for whom surgery is not recommended or has failed.

The VNS system is composed of a generator, electrodes, and an external programming device that is used to change stimulation settings. The generator is surgically implanted in the upper left area of the chest. One or more leads are threaded under the skin to connect to the electrodes that are attached to the vagus nerve. Once implantation is completed, the generator is programmed to stimulate the vagus nerve at regular intervals, thereby reducing seizure activity.

The basic principles of VNS when used as a treatment for epilepsy are that vagal visceral afferents (nerves that convey impulses from sense organs and other receptors to the brain or spinal cord) have a diffuse central nervous system projection, and the activation of these pathways has a widespread effect upon neuronal excitability. The exact mechanism of VNS neuronal excitability is not fully known.

Although VNS has been approved by the FDA to treat depression, current published literature does not support the use of VNS for this purpose. In addition, clinical trials for the use of VNS for treatment-resistant depression (TRD) do not demonstrate the effectiveness of VNS on health outcomes in an investigational setting, nor do these trials demonstrate improved health outcomes with the use of VNS when compared to other treatment modalities for TRD.

## **Seizures**

VNS is considered medically necessary and, therefore, covered for the treatment of individuals who have medically refractory partial-onset seizures and for whom surgery is not recommended or has failed.

## **Treatment-resistant Depression**

VNS for TRD is considered not medically necessary and, therefore, not covered because the available published literature does not support its use in the diagnosis or treatment of this illness.

VNS for any diagnosis other than medically refractory partial-onset seizures is considered not medically necessary and, therefore, not covered because the available published literature does not support its use in the diagnosis or treatment of illness or injury.

# Claim Payment Policy

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## **Computer Analysis and Generation of Automated Data in Conjunction with Diagnostic Studies is Not Eligible for Separate Reimbursement (06.00.01b)**

The results of diagnostic studies may be computer analyzed and generated by an automated system. Examples of studies for which computer analysis and generation of automated data may be available include, but are not limited to:

- Electrocardiogram (ECG)
- Cardiovascular stress test (without radiopharmaceutical injection)
- Rhythm ECG
- Electromyogram (EMG)
- Urea breath test, carbon-14 (C-14)
- Cardiac blood pool imaging
- Apnea monitoring
- Ambulatory ECG monitoring
- Non-invasive peripheral arterial test and pulse volume recording
- Papanicolaou (Pap) smears

The Company considers the computer analysis and generation of automated data to be integral parts of a covered, diagnostic study and, therefore, not eligible for separate reimbursement consideration.

Computer analysis and generation of automated data reported independently of a diagnostic procedure (same or different provider) or with a noncovered diagnostic procedure are not eligible for separate reimbursement.

# Experimental/Investigational Policy

## Correlated Audioelectric Cardiography (07.02.15b)

### NOT COVERED: CONSIDERED EXPERIMENTAL/ INVESTIGATIONAL

Traditionally, a 12-lead electrocardiogram (EKG) is performed to detect and diagnose heart conditions. EKG is a diagnostic tool that graphically traces the electric current generated by heart muscle during a heartbeat, and then records it with an electrocardiograph. However, the EKG does not detect heart sounds, which can be additional indicators of heart disease. Correlated audioelectric cardiography (COR) simultaneously records 12-lead EKG and heart sounds data through acoustic sensors placed on the chest. Theoretically, these recordings can then be analyzed by a computer to provide a diagnostic tool for detecting serious cardiac conditions.

A review of the available published literature revealed one clinical trial on a small number of individuals that focused on the capacity of COR technology to perform its proposed function. However, the outcomes did not provide any data regarding either the diagnostic performance of COR compared with the traditional EKG or its impact on diagnosing individuals in the clinical setting. Although it has been suggested that COR may assist in evaluating individuals in the emergency room, further studies are needed to determine the efficacy of COR in the clinical setting.

COR is considered experimental/investigational and, therefore, not covered because the efficacy of this device cannot be established by a review of the available published literature.

## Intestinal Rehabilitation Program (07.05.03b)

### NOT COVERED: CONSIDERED EXPERIMENTAL/ INVESTIGATIONAL

Short bowel syndrome is a condition caused by the loss of intestinal surface as a result of extensive resection, trauma, Crohn's disease, mesenteric artery thrombosis, or other etiology. It leads to malabsorption of nutrients and fluids, and, as a result, affected individuals usually require lifelong total parenteral nutrition (TPN). In short bowel syndrome, some adaptation (e.g., lengthening and dilation) of the remaining intestinal length can

occur, but individuals with less than 60 cm of functional jejunum or ileum usually require TPN for the rest of their lives.

Specialized inpatient and outpatient intestinal rehabilitation programs have been investigated as a nonsurgical alternative to lifelong TPN for individuals with short bowel syndrome. Intestinal rehabilitation is a comprehensive program of dietary modification, glutamine supplementation, growth hormone therapy, extensive counseling and education, and physical therapy. The goal of an intestinal rehabilitation program is to eliminate or reduce the need for TPN by increasing adaptation of the remaining bowel.

Currently, there is no one best way to define an intestinal rehabilitation program, as the components of different programs may vary. The few studies that have been conducted on intestinal rehabilitation are of limited value because there has been no comparative analysis of the components of the various programs, nor has there been follow-up data. Furthermore, the optimal treatment settings have not yet been determined.

An intestinal rehabilitation program is considered experimental/investigational and, therefore, not covered because the safety and/or efficacy of the service cannot be established by a review of the available published literature.

## Transcutaneous Electrical Joint Stimulation (05.00.68a)

### NOT COVERED: CONSIDERED EXPERIMENTAL/ INVESTIGATIONAL

Osteoarthritis (OA) and rheumatoid arthritis (RA) are characterized by progressive destruction of the joints. Both disorders result in pain, stiffness, and limited motion with gradual loss of function. Traditional treatments include anti-inflammatory drugs and other medications that often result in unwanted side effects. Transcutaneous electrical joint stimulation (TEJS) has been suggested as a noninvasive, nonsurgical alternative to drug therapy.

The TEJS device is intended to relieve joint pain and to reduce the loss of function associated with OA of the knee and RA of the hand. It is theorized that the pulsed electrical current stimulates the proliferation of chondrocytes and enhances cartilage repair.

The TEJS device is a portable, rechargeable, battery-operated unit that delivers low amplitude and low frequency pulsed electrical current to the joint tissue. It consists of a signal generator, electrode pads, and a wrap that holds the pads in place.

One randomized controlled trial evaluating the effect of the TEJS device on individuals with OA was found in peer-reviewed literature. Although the device was being studied as an alternative to present treatment modalities, individuals in the trial continued their medication regimes during treatment, making it difficult to determine the impact of TEJS on their symptoms. In addition, the low number of participants (n=71) does not allow assessment of health effect, particularly in a large population.

The TEJS device is considered experimental/investigational and, therefore, not covered because the safety and/or efficacy of this service cannot be established by a review of the available published literature.

## **Transvaginal and Transurethral Radiofrequency Tissue Remodeling for Urinary Stress Incontinence (11.17.07b)**

### **NOT COVERED: CONSIDERED EXPERIMENTAL/ INVESTIGATIONAL**

Urinary stress incontinence is the involuntary loss of urine from the urethra due to an increase in intra-abdominal pressure. When conservative therapy fails, surgical options are considered, including various types of bladder suspension procedures, which attempt to reduce bladder neck and urethra hypermobility by tautening the endopelvic fascia (paravaginal tissue or paraurethral tissue).

Recently, radiofrequency energy has been investigated as a technique to shrink and stabilize the endopelvic fascia to provide greater support for the urethra and bladder neck in individuals with urinary stress incontinence. Published literature regarding radiofrequency techniques for stress urinary incontinence is limited and inadequate to provide scientific conclusions regarding the safety and long-term efficacy of these procedures.

Transvaginal radiofrequency bladder neck suspension as a treatment of urinary stress incontinence is considered experimental/investigational and, therefore, not covered because the safety and/or efficacy of this service cannot be established by a review of the available published literature.

Transurethral radiofrequency tissue remodeling as a treatment of urinary stress incontinence is considered experimental/investigational and, therefore, not covered because the safety and/or efficacy of this service cannot be established by a review of the available published literature.

# More Information

## 30-Day advance policy change notifications available online

To better communicate policy changes to providers, advance notification articles regarding changes to medical policies are now published on [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy). These notification articles will be available at least 30 days in advance of the proposed changes to policy.

Please follow these instructions to read notifications:

1. Visit [www.ibx.com/medpolicy](http://www.ibx.com/medpolicy).
2. Select *Accept and Go to Medical Policy Online*.
3. Select the *Commercial and Other Medicare Advantage policies* link.
4. Select *News & Announcements* from the Medical Policy column on the left sidebar.
5. Select links to 30-day notice articles.

Another new enhancement to the *News and Announcements* section is a listing of recently published policies to the website ordered by month. These listings are updated daily, so please check back frequently to view what's new.

## Physician volunteers needed to assist in developing medical policies

Independence Blue Cross (IBC) is currently recruiting physicians to join its Policy Committee Advisory Panel. This panel is responsible for evaluating the scientific evidence and local standards of care addressed in the Company's medical policies.

Medical policies are research-based documents that allow IBC to evaluate the medical necessity of services, devices, biologics, and procedures for its members. In addition, medical policies provide guidelines for obtaining benefits and reimbursement in accordance with a member's plan. As a volunteer consultant on the Policy Committee Advisory Panel, you will evaluate

proposed medical policies based on your area(s) of expertise. As such, your contributions will significantly impact the care of patients in your region.

At this time, IBC is seeking physician consultants in the following specialties:

- Neurosurgery
- Orthopedics
- Urology
- Vascular Surgery
- Physical Medicine and Rehabilitation
- Rheumatology
- Cardiology
- Gastroenterology
- Pain Medicine

To qualify as a member of the Policy Committee Advisory Panel, you must:

- Maintain board certification for each specialty or subspecialty for which you wish to consult.
- Maintain an active clinical practice in each specialty or subspecialty for which you wish to consult.
- Understand and agree to adhere to our confidentiality statement.
- Maintain a high ethical standard, evidenced by the absence of any IBC investigation into personal or group claims practices.
- Complete and sign a Conflict of Interest Statement and Confidentiality Agreement prior to becoming a member of the advisory panel.

If you meet the above criteria and are interested in sharing your expertise as a member of the Policy Committee Advisory Panel, please submit your curriculum vitae to:

Gerald W. Peden, M.D., M.A.  
 Senior Medical Director  
 Claim Payment Policy Department  
 Independence Blue Cross  
 1901 Market Street  
 Philadelphia, PA 19103-1480

## Contact Provider Services

Provider Services	Philadelphia Area	Outside Philadelphia
HMO Policies/Procedures/Eligibility/Claims	215-567-3590	1-800-227-3119
PPO Policies/Procedures/Claims	215-567-3694	1-800-332-2566



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