BLUE CROSS OF NORTHEASTERN PA "BCNEPA" MEDICAL POLICY BULLETIN	**MANUAL:** MEDICAL POLICY
	REFERENCE NO.: MPO-490-0160
EFFECTIVE DATE October 1, 2014	**SUBJECT:** Not Medically Necessary Services

Blue Cross of Northeastern Pennsylvania ("BCNEPA") Medical Policy

Medical policy is not an authorization, certification, explanation of benefits or a contract. Benefits and eligibility are determined before medical policy and claims payment policy are applied. Policies are provided for informational purposes only and are developed to assist in administering plan benefits and do not constitute medical advice.

Treating providers are solely responsible for medical advice and treatment. Policies are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease.

Medical practices and information are constantly changing and BCNEPA may review and revise its medical policies periodically. Also, due to the rapid pace of changing technology and the advent of new medical procedures, BCNEPA may not have a policy to address every procedure.

In those cases, BCNEPA may review other sources of information including, but not limited to, current medical literature and other medical resources, such as Technology Evaluation Center Assessments (TEC) published by the Blue Cross Blue Shield Association. BCNEPA may also consult with health care providers possessing particular expertise in the services at issue.

I. DESCRIPTION:

A. Medically Necessary services or supplies are those services or supplies that are:

1. Appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease, or injury;

2. Provided for the diagnosis, or the direct care and treatment of the Member's condition, illness, disease, or injury;

3. In accordance with current standards of medical practice;

4. Not primarily for the convenience of the Member, or the Member's Provider; and

5. The most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an Inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an Outpatient.

B. Services or supplies not meeting all of the above criteria are considered not medically necessary.

II. BENEFIT POLICY STATEMENT:

BCNEPA makes decisions on coverage based on Policy Bulletins, benefit plan documents, and the member's medical history and condition. Benefits may vary based on product line, group or contract, therefore, Member benefits must be verified. In the event of a conflict between the Member's benefit plan document and topics addressed in Medical Policy Bulletins (i.e., specific contract exclusions), the Member's benefit plan document always supersedes the information in the Medical Policy Bulletins. BCNEPA determines medical necessity only if the benefit exists and no contract exclusions are applicable.

Benefits are determined by the terms of the Member's specific benefit plan document [i.e., the Fully Insured policy, the Administrative Services Only (ASO) agreement applicable to the Self-Funded Plan Participant, or the Individual Policy] that is in effect at the time services are rendered.

III. MEDICAL POLICY STATEMENT:

A. BCNEPA will not provide coverage for the following services and/or procedures as they are considered not medically necessary:

1. An adjustable cranial orthosis as a treatment of plagiocephaly or brachycephaly:

    a) When synostosis is not present.

2. Use of an adjustable cranial orthosis for synostosis:

    a) In the absence of cranial vault remodeling surgery.

3. Arthroscopic debridement and/or Lavage for treatment of osteoarthritis of the knee:

    a) When preoperative imaging does not demonstrate specific anatomic lesions (e.g. large meniscal tears, loose bodies).

4. Thermal capsulorrhaphy as a treatment of joint instability, including, but not limited to the shoulder, knee and elbow:

    a) Studies do not support the efficacy of this treatment, and

    b) There is a high rate of unsatisfactory results and complications, raising the potential for net harm.

5. Serology testing for H. pylori:

    a) It is no longer considered a current standard of medical practice by the American Gastroenterological Association and the American College of Gastroenterology because:

        - It has poor predictive value,
        - It leads to increased antibiotic resistance,

- It does not test for active infection,
- It leads to increased incidence of side effects of treatment,
- It does not confirm eradication, and
- It contributes to increased patient anxiety over implications of a positive test.

b) C-urea breath test or stool antigen tests are the preferred methods of testing because of superior positive predictive value.

6. Computer-assisted corneal topography:

a) To detect or monitor diseases of the cornea,

b) Quantitative measurement does not result in an intervention change that improves health outcomes.

B. BCNEPA will provide coverage for the following radiology services when medically necessary:

CT Colonography/Virtual Colonoscopy

1. CT colonography/virtual colonoscopy may be considered medically necessary when patients cannot tolerate an endoscopic colonoscopy. Examples include:

c) An incomplete standard endoscopic colonoscopy of the entire colon due to the inability to pass the colonoscope proximally; or

d) An obstructing neoplasm, spasm, redundant colon, extrinsic compression, or aberrant anatomy/scarring from prior surgery; or

e) Complications from previous standard colonoscopy; or

f) Increased sedation risk (e.g., COPD, previous anesthesia adverse reaction); or

g) Diverticulitis with increased risk of perforation.

2. CT colonography/virtual colonoscopy for all other clinical indications is considered not medically necessary.

2. CT colonography/virtual colonoscopy when used for the purpose of colon cancer screening is considered not medically necessary.

Magnetoencephalography/Magnetic Source Imaging

1. Magnetoencephalography/magnetic source imaging may be considered medically necessary:

    a) for the purpose of determining the laterality of language function, as a substitute for the Wada test, in patients being prepared for surgery for epilepsy, brain tumors, and other indications requiring brain resection;

    b) as part of the preoperative evaluation of patients with intractable epilepsy (seizures refractory to medical therapy) when standard techniques, such as MRI, are inconclusive;

    c) Magnetoencephalography/magnetic source imaging is considered not medically necessary for all other indications.

C. BCNEPA will provide coverage for the following surgical services when medically necessary:

Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux

1. Periureteral bulking agents may be considered medically necessary as a treatment of vesicoureteral reflux grades II–IV when medical therapy has failed and surgical intervention is otherwise indicated.

2. The use of bulking agents as a treatment of vesicoureteral reflux in other clinical situations is considered not medically necessary.

Total Ankle Replacement

1. Total ankle replacement using an FDA-approved device may be considered medically necessary in skeletally mature patients with moderate to severe ankle (tibiotalar) pain that limits daily activity and who have the following conditions:

    a) Arthritis in adjacent joints (i.e., subtalar or midfoot); OR

    b) Severe arthritis of the contralateral ankle; OR

    c) Arthrodesis of the contralateral ankle; OR

    d) Inflammatory (e.g., rheumatoid) arthritis

2. Absolute contraindications to ankle arthroplasty include any of the following:

    a) Extensive avascular necrosis of the talar dome;

    b) Compromised bone stock or soft tissue (including skin and muscle);

    c) Severe malalignment (e.g., > 15 degrees) not correctable by surgery;

    d) Active ankle joint infection;

e) Peripheral vascular disease;

f) Charcot neuroarthropathy.

3. Relative contraindications to ankle arthroplasty include:

a) Peripheral neuropathy;

b) Ligamentous instability;

c) Subluxation of the talus;

d) History of ankle joint infection;

e) Presence of severe deformities above or beneath the ankle.

4. Total ankle replacement is considered not medically necessary for all other indications.

Transanal Endoscopic Microsurgery (TEMS)

1. Transanal endoscopic microsurgery may be considered medically necessary for treatment of rectal adenomas, including recurrent adenomas that cannot be removed using other means of local excision.

2. Transanal endoscopic microsurgery may be considered medically necessary for treatment of clinical stage T1 rectal adenocarcinomas than cannot be removed using other means of local excision and that meet all of the following criteria:

a) Located in the middle or upper part of the rectum,

b) Well or moderately differentiated (G1 or G2) by biopsy,

c) Without lymphadenopathy, and

d) Less than 1/3 the circumference of the rectum

3. Transanal endoscopic microsurgery is considered not medically necessary for treatment of rectal tumors that do not meet the criteria noted above.

D. BCNEPA will provide coverage for the following therapy services when medically necessary:

Intraoperative Radiation Therapy

1. Use of intraoperative radiation therapy may be considered medically necessary in rectal cancer with positive or close margins with T4 lesions or recurrent disease.

2. Use of intraoperative radiation therapy is considered not medically necessary for all other oncologic applications.

IV. DEFINITIONS:

Generally Accepted Standards of Medical Practice: Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

V. CODING:

- **The identification of a code in this section does not denote coverage or separate reimbursement.**
- Covered procedure codes are dependent upon meeting criteria of the policy and appropriate diagnosis code.
- The following list of codes may not be all-inclusive, and are subject to change at any time.
- Benefits are determined by the terms of the Member's specific benefit plan document [i.e., the Fully Insured policy, the Administrative Services Only (ASO) agreement applicable to the Self-Funded Plan Participant, or the Individual Policy] that is in effect at the time services are rendered.

PROCEDURE CODES

0184T	52327	77424	86677	95966	S2300
27702	74261	77425	92025	95967	
27703	74262	77469	95965	S1040	

VI. SOURCES:

Blue Cross Blue Shield Association (BCBSA) Medical Policy Reference Manual. "Adjustable Cranial Orthoses for Positional Plagiocephaly and Craniosynostoses" (1.01.11), Section: DME, Issue: 5: 2014: 1-15. "Arthroscopic Debridement and Lavage as Treatment for Osteoarthritis of the Knee" (7.01.117), Section: Surgery, Issue: 12: 2012: 1-8. "Thermal Capsulorrhaphy as a Treatment of Joint Instability" (7.01.82), Section: Surgery, Issue: 6: 2014: 1-8. "Corneal Topography/Computer-Assisted Corneal Topography/Photokeratoscopy" (9.03.05), Section: Other/Vision, Issue: 4: 2014: 1-6. "Magnetoencephalography/Magnetic Source Imaging" (6.01.21), Section: Radiology, Issue: 9: 2012: 1-12. "Periureteral Bulking Agents as a Treatment of Vesicoureteral Reflux (VUR)" (7.01.102), Section: Surgery, Issue: 10: 2013: 1-12. "Total Ankle Replacement" (7.01.77), Section: Surgery, Issue: 8: 2013: 1-18. "Transanal Endoscopic Microsurgery (TEMS)" (7.01.112), Section: 11: 2012: 1-11. "Intraoperative Radiation Therapy" (8.01.08), Section: Therapy, Issue: 8: 2013: 1-18. "Virtual Colonoscopy/CT Colonography" (6.01.32), Section: Radiology, Issue: 5: 2013: 1-13.

Highmark Medical Policy: "Miscellaneous Services" Z-24, Effective Date: April 1, 2012. 1-17. "CT Colonography/Virtual Colonoscopy" (X-52), Section: Radiology, Issue Date: January 1, 2010: 1-4.

Patient Care Management Committee Minutes: November 17, 2011.

VII. APPROVALS:

Approved by Medical Director, Network Management & Provider Operations:

Signature: 
(John Viteritti, D.O.)

Date of Approval: September 17, 2014

HISTORY:

Medical Policy MPO-490-0160 Not Medically Necessary Services effective November 1, 2009.

Revision Dates: 12/01/09, 02/01/10, 04/01/10, 05/01/10, 07/01/10, 10/01/10, 12/01/10, 01/01/11, 02/01/11, 04/01/11, 06/01/11, 08/01/11, 10/01/11, 12/01/11, 02/01/12, 04/01/12, 06/01/12, 07/01/12, 10/01/12, 01/01/13, 02/01/13, 03/01/13, 06/01/13, 07/01/13, 08/01/13, 10/01/13, 11/01/13, 12/01/13, 01/01/14, 02/01/14, 05/01/14, 07/01/14, 08/01/14, 10/01/14

Policy developed by: Medical Policy Department