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## TECHNICAL ASSESSMENTS . . .

### Magnetic Resonance Spectroscopy (MRS) (Policy Number 200235)

**Applicable Code(s): CPT: 76390**

Magnetic Resonance Spectroscopy (MRS) is a noninvasive technique that can be used to measure the concentrations of different low molecular weight chemicals. The technique is based on the same physical principles as Magnetic Resonance Imaging (MRI), i.e., the detection of energy exchange between external magnetic fields and specific nuclei within atoms. The primary difference between MRI and MRS is that in MRI, the emitted radio-frequency is based on the spatial position of the nuclei, while MRS detects the chemical composition of the scanned tissue.

MRS has been used to study brain tumors, strokes, seizure disorders, Alzheimer's disease, depression and other diseases affecting the brain, as well as the metabolism of other organs. The role of MRS in the diagnosis and therapeutic planning has not however been established to demonstrate improved clinical outcomes by adequate clinical studies of neurological diseases.

76390      Magnetic Resonance Spectroscopy

The consensus of opinion among experts regarding Magnetic Resonance Spectroscopy (MRS) is that studies and/or clinical trials to date do not demonstrate that MRS is equivalent or superior to currently accepted standard means of diagnosis and treatment. Medical Mutual considers **MRS** to be investigational, and **NOT** eligible for reimbursement.

The provider will be able to bill the subscriber for charges.

### Screening Whole Body CT Scan (Policy Number 200229)

**Applicable Code(s): CPT: 76499**

Whole body, computed tomography (CT) examines the thorax, abdomen and pelvis. Screening whole body CT is performed in asymptomatic individuals to allow early detection of disease as for example, lung cancer, colon cancer, or heart disease.

76499      Unlisted diagnostic radiologic procedure

The consensus of opinion among experts regarding Screening Whole Body CT Scans is that studies and/or clinical trials to date do not demonstrate that whole body scanning in asymptomatic individuals is equivalent or superior to currently accepted standard means of treatment. Medical Mutual considers whole body CT scanning in asymptomatic individuals to be investigational, and **NOT** eligible for reimbursement.

The provider will be able to bill the subscriber for charges.

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Payment is subject to the patient's eligibility and benefits pursuant to the terms of the contract. Nothing in this newsletter should be construed as granting benefits or coverage beyond the scope of the patient's benefits as described in applicable contracts, booklets, and certificates of coverage.



## Did you know?

Medical Mutual offers programs that provide education and support for our members who have been diagnosed with certain chronic diseases or who are currently pregnant. If you have diagnosed members with any of the following conditions, please contact Medical Mutual to enroll your patients in the appropriate Health Management program

Asthma/COPD  
(Breathe Easy®)

**1-888-224-6906**

Congestive Heart Failure  
(Heart Sense™)

**1-877-726-2715**

Heart Disease  
(Cardiac Rehabilitation)

**1-800-258-3175**

Pregnancy (BabyLink®)  
**1-866-833-BABY (2229)**

Diabetes  
(DiabetesAdvantage™)

**1-800-861-4826**

Mental Health Issues  
Behavioral Health

**1-800-258-3186**

## Bilaminate Skin Substitute (Apligraf) (Policy Number 200233)

**Applicable Codes: 15000, 15342, and 15343**

**HCPC Code: J7340**

Graftskin (Apligraf) is a manufactured human fibroblast - derived dermal substitute, designed to mimic human skin. It is composed of fibroblasts, extracellular matrix and a bioabsorbable scaffold. Fibroblasts are derived from human neonatal foreskins and are dispersed in a bovine-derived collagen matrix. The cell proliferates to fill the matrix to create a three-dimensional human skin substitute.

Graftskin has 2 FDA-approved indications:

- Treatment of venous ulcers that have not responded to conventional ulcer therapy
- Treatment of full-thickness neuropathic diabetic foot ulcers which extend through the dermis but without exposure of tendon, muscle, capsule or bone and are unresponsive to standard medical therapy.

CPT Codes:

- |       |  |
|-------|--|
| 15000 | Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues); first 100 sq. cm or one percent of body area of infants and children |
| 15342 | Application of bilaminate skin substitute/neodermis; 25 sq. cm   |
| 15343 | each additional 25 sq. cm (list separately in addition to code for primary procedure)  |

HCPC Code:

- |       |  |
|-------|--|
| J7340 | Dermal and epidermal, tissue of human origin, with or without bioengineered or processed elements, with metabolically active elements, per square centimeter |
|-------|--|

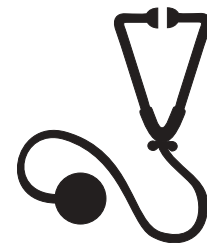
Medical Mutual has determined that Bilaminate Skin Substitute (Apligraf) is considered medically necessary and eligible for reimbursement for the following conditions:

**Venous stasis ulcers:** Non-infected partial or full-thickness skin ulcers due to venous insufficiency of greater than two (2) months duration that have failed to respond to documented conservative measures.

- Apligraf is indicated for use in addition to standard therapeutic compression.
- Measurements of the initial ulcer size, the size of the ulcer following cessation of conservative management, and the size at the beginning of skin substitute treatment must be documented.
- The ulcer must be free of infection and underlying osteomyelitis, and treatment of the underlying disease must be provided and documented in conjunction with bilaminate skin substitute.

**Neuropathic diabetic foot ulcers:** Full-thickness neuropathic diabetic foot ulcers of greater than three weeks duration that have failed to respond to documented conservative measures.

- Treatment with Apligraf is covered for ulcers that extend through the dermis, but that are without tendon, muscle, capsule or bone exposure, and are located on the plantar, medial or lateral area of the foot, excluding the heel.
- Apligraf is indicated for use with standard diabetic foot ulcer care, including a non-weight-bearing regimen and optimal metabolic control and nutrition.
- Measurements of the initial ulcer size, the size of the ulcer following cessation of conservative management, and the size at the beginning of skin substitute treatment must be documented.



## We value your opinion . . .

The Care Management Department regularly reviews and revises Corporate Medical Policies. Written comments regarding an existing policy may be directed to:

**Medical Mutual**  
**CC 01-5B-3979**  
**Attn: Medical Policy**  
**Committee**  
**2060 E. Ninth Street**  
**Cleveland, OH**  
**44115-1355**

## Did you know?

The Food and Drug Administration on December 12, 2002 approved Pediarix™, the new combination vaccine that contains Diphtheria and Tetanus Toxoids and Acellular Pertussis Adsorbed, Hepatitis B and Inactivated Poliovirus Vaccine. The vaccine is recommended for the primary series at 2, 4, and 6 months of age. This new combination vaccine can save up to 6 injections.

**Current Procedural Terminology (CPT) code 90723 is the correct code to submit for reimbursement when this vaccine is administered.**

- The ulcer must be free of infection and underlying osteomyelitis, and treatment of the underlying disease must be provided and documented in conjunction with bilaminate skin substitute treatment.

Limitations of coverage are as follows:

- For venous stasis ulcers and neuropathic diabetic foot ulcers, the safety and effectiveness of Apligraf have not been established for patients receiving greater than 5 device applications. Use of the skin substitute is, therefore, limited to five (5) separate applications to any given ulcer
- For venous stasis ulcers, reapplication of Apligraf may be considered for areas where the product is not completely adherent, but is generally not necessary until six (6) weeks have elapsed after initial application.

**CPT Codes 15000, 15342, and 15343 and HCPC Code J7340** are considered eligible for reimbursement providing that the medical criteria outlined in this policy have been met in the presence of the following clinical conditions which are frequently associated with medically accepted indications for Apligraf:

- Diabetes with other specified manifestations
- Varicose veins of lower extremities with ulcer
- with ulcer and inflammation
- Venous (peripheral)insufficiency, unspecified
- Ulcer of lower limb, unspecified

If a valid diagnosis is missing, this service will deny as not diagnostically related. The participating provider will be required to write off the charges.

### Dental Guidelines (Policy Number 200236)

#### GUIDELINES

1. All services rendered may be subject to review for medical necessity and, ultimately to contract specifications and/or limitations of the participant's certificate.
2. Under participant contract, multiple or bilateral surgeries on the same date of service are paid at a rate of 100% or the Usual and Customary Rate (UCR), or fee for the major procedure, 50% of the UCR for the second and third procedures, and 25% of the UCR for each additional procedure.
3. All major surgeries and some minor procedures are subject to time limitations. For major surgical procedures, a time period of 30 (thirty) days must elapse before Medical Mutual will initiate payment starting at 100% and continue as listed above.
4. If additional major surgical procedures are done within 30 (thirty) days that could have been done on the original date of service (as determined by Medical Mutual), payment will be made as if those procedures had been performed on the same date. Adequate documentation must accompany any request for additional payment for subsequent procedures done during this 30-day period.

Dental procedures, which may be considered medically necessary, include the following:

1. Intraoral abscesses which extend beyond the dental alveolus. These abscesses may require immediate attention in an acute phase, which would preclude pre-authorization.
2. Extraoral abscesses.
3. Cellulitis and osteitis which is clearly exacerbating and directly affecting a medical condition currently under treatment.
4. Removal of teeth and tooth fragments in order to treat and repair facial trauma resulting from an accident injury.
5. Myofacial pain dysfunction syndrome.



## Did you know?

If you have inquiries regarding specific claims, complete the Provider Action Request Form and submit to:

**Provider Inquiry Unit  
Medical Mutual  
P.O. Box 94917  
Cleveland, OH  
44101-4917**

## Did you know?

Medical Mutual has added reimbursement for the first prenatal care visit.

As of January 1, 2003, Medical Mutual implemented a separate and distinct reimbursement for the first prenatal care visit, which should be performed within the first 12 weeks of pregnancy.

This payment will be in addition to the routine global obstetrical allowance. Payment is allowable for any woman that began prenatal visits in 2003. Only one prenatal risk assessment visit is allowable per physician, nurse midwife or group practice per patient.

**Please utilize the Health Care Procedure Coding System (HCPCS) H1000 Prenatal Care at Risk Assessment to report the initial prenatal care visit, if the visit is performed within the first 12 weeks of pregnancy.**

6. Total or complete ankyloglossia.
7. Cleft palate
8. The prosthetic replacement of either the maxilla or the mandible due to the reduction of body tissue associated with traumatic injury (e.g., impact, gun shot wound), in addition to services related to treating neoplasms or iatrogenic dental trauma.
9. TMJ appliances are reimbursable, but are subject to certain limitations. Appliances are limited to one (1) appliance and twelve (12) related office visits per calendar year. A second appliance may be approved only if; 1) the appliance is accidentally broken, or 2) the patient needs both an upper and lower appliance.

**Note:** Dental care may be required to prepare an individual for medical treatment of disease, or to treat an individual for dental trauma directly resulting from medically necessary treatment of an injury or disease.

1. Necessary dental care when performed in preparation for or as a result of in-line radiation therapy for oral or facial cancer is subject to Medical Review.
2. Treatment of gingival hyperplasia, with or without periodontal disease, as a direct result of prolonged therapy with Dilantin (diphenylhydantoin) or related compounds is subject to Medical Review.
3. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, and roof and floor of the mouth, when such conditions require a pathological (histological) examination and performed by an eligible provider.
4. Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
5. Treatment of oral or facial cancer.
6. External (extra-oral) incision and drainage of cellulitis.
7. Surgery of accessory sinuses, salivary glands, or ducts.
8. Reduction of dislocations and the excision of the temporomandibular joints, when surgery is a necessary part of the reduction.
9. Mandibular bone grafts performed for causes other than orthodontia or dental support. (example – 21215 is appropriate in some cases, but in most cases use D4263 and D4264)
10. Removal of a foreign body which is hazardous to the patient's health, which is reaction producing or complicates a primary medical condition. (e.g. pin removal – 20680)
11. Intrinsic and traumatic diseases of the temporomandibular joint which require surgery such as rheumatoid arthritis and osteoarthritis.
12. Surgical treatment of the temporomandibular joint.

The following procedures are considered dental and not usually considered under medical benefits except where specified.

1. Dental care which is routine, preventive, restorative, prosthodontic, periodontic does not qualify as adjunctive dental care.
2. The adding or modifying of bridge work and dentures.
3. Orthodontia, except when directly required in the result of trauma to the teeth and supporting structures caused by medically necessary treatment of an injury.
4. The treatment of generally poor dental health (dental caries) due to certain systemic causes (e.g., congenital syphilis, malabsorption syndromes, rickets, etc.) is excluded from medical coverage.
5. Orthopedic appliances utilized for treatment of temporomandibular joint disorder (TMJ).



6. Extraction of unerupted or partially erupted, malposed teeth with or without the attached follicular or development tissues, are not considered medically necessary except when indicated in preparation for, or as a result of, dental trauma caused by the medically necessary treatment of an injury or illness.
7. Mandibular staple implants are not considered medically necessary because their primary purpose is dental in nature, unless the cause is accident, mandibular bone loss greater than 10 mm or cancer related.
8. Any oral surgical procedure that falls within the cosmetic, reconstructive or plastic surgery definition.
9. Surgical preparation of the mouth for dentures is not considered medically necessary except when performed as an integral part of the treatment of dental trauma.

**Air Ambulance Transport  
(Policy Number 200231)**

**Applicable Code(s): A0430, A0431, A0435, and A0436**

**Revenue Code(s): 540, 545**

A rotary or fixed wing aircraft designed and equipped to transport critically ill and/or injured individuals.

- A0430 Ambulance Service, conventional air services, transport one way, (fixed wing)
- A0431 Ambulance service, conventional air services, transport, one way, (rotary wing)
- A0435 Fixed wing mileage, per statute mile
- A0436 Rotary wing air mileage, per statute mile

Revenue Code(s):

- 540 Ambulance-general classification
- 545 Air ambulance

Medical Mutual has determined air ambulance transport by critical care personnel to the nearest medical and/or trauma center is medically necessary for life-threatening injuries or conditions in accordance with the following guidelines:

1. Initial transport from the scene/field by air ambulance is appropriate for the following circumstances:
  - A treatment center is unavailable within 30 miles;
  - OR
  - Regardless of distance in mileage from the scene/field to the nearest treatment center, if any of the following situation(s) and medical appropriateness criteria are met;
2. Transportation from one facility to the nearest medical and/or trauma center due to the inability of the first facility to provide industry standard of care for the medical condition and/or injury of the individual, is considered medically necessary in any of the following;
  - A. Individual is a candidate for therapeutic regimen with limited time for initiation after onset of symptoms which cannot be initiated at a local facility, and the time frame restriction cannot be met by ground ambulance transport;
  - B. Individual requires at a minimum, a nurse and/or physician to render critical care to be safely transferred to a facility with a higher level of care;
  - C. Transport by land ambulance would be unsafe due to the severity of the individual's illness/injury, and transport would be significantly delayed due to road/traffic conditions, i.e. traffic congestion, blocked roads, weather conditions, such as ice or snow resulting in hazardous driving conditions;
  - D. Area is inaccessible to ground traffic

**Did you know?**

Medical Policy Highlights can be viewed from our corporate web site ([www.medmutual.com](http://www.medmutual.com)) under Provider Services. A free copy of Acrobat Reader (required for viewing) has also been made available from this site.

**Did you know?**

Anesthesia charges for a vaginal delivery epidural, cannot be billed in addition to anesthesia charges for a cesarean delivery. In the event of an emergency cesarean section delivery, all anesthesia charges **MUST** be combined under the charge for the cesarean section.

**Did you know?**

Effective January 1, 2003, Medical Mutual reimburses for both the newborn exam and circumcision when performed on the same date of service.



## Did you know?

The following is clarification of information that appeared in the September 2002, Volume 7, Issue 2, Medical Policy Highlights. We apologize for any inconvenience this may have caused.

Concurrent medical care for the same patient on the same date of service, performed by different providers regardless of diagnosis is reimbursable **providing** the patient **has not** had a major surgical procedure within the previous 42 days.

Surgical procedures are subject to global pricing reimbursement. Global reimbursement includes all visit(s) or service(s) performed by **any** provider for a diagnosis related to the surgical procedure. Major and minor procedures are subject to the following global guidelines:

### Major Procedures –

Visits or services 1 day prior, and up to 42 days after a major procedure are included in the global reimbursement for the major surgical procedure.

### Minor Procedures –

Visits or services on the same day as a minor procedure are included in the global reimbursement for the minor surgical procedure.

- 3. Transportation from one facility to the nearest medical and/or trauma center due to the inability of the first facility to provide industry standard of care for the medical condition and/or injury of the individual. Criteria one and two above must also be met.

### Trauma Criteria –

The mechanism of trauma only (unaccompanied by anatomic or physiologic symptoms resulting from the injury) is **NOT** sufficient criteria to establish medical necessity of air ambulance transport. An individual **MUST** display anatomic and/or physiologic indications as a result of the trauma/injury to substantiate the medical necessity of air ambulance transport. **Currently Medical Mutual will allow all claims for air ambulance transport from the accident scene to process without review according to individual subscriber benefits. Medical Mutual will retrospectively monitor air ambulance claims for medical appropriateness as defined in this policy.**

Transport by land ambulance of trauma victim would take more than 30 minutes,

**AND**

Individual meets at **least one** of the following criteria –

- Penetration injury in any body part between mid-thigh and head; or
- Amputation or near amputation requiring rapid transport for reimplantation;
- Scalping injury or “degloving” injury; or
- Burns of greater than 10% of body surface, or major burns (2<sup>nd</sup> or 3<sup>rd</sup> degree) of face, hands, feet, or perineum; or
- New paralysis of extremities as a result of the trauma; or
- Transport requires immobilization and smooth rapid transit due to worsening motor sensory status; or
- Orofacial trauma requiring the placement of an airway; or
- Blunt thoracic or abdominal injury with respiratory compromise or hemodynamic instability; or
- Systolic blood pressure < 90mmHg; or
- Major electrical or chemical burn (2<sup>nd</sup> or 3<sup>rd</sup> degree); or
- Inhalation injury with demonstration of hypoxia requiring intubation, or impending airway obstruction; or
- Near drowning – individual must require intubation due to respiratory compromise; or
- Two (2) or more proximal long bone fractures, if associated with vascular compromise of limb or hemodynamic instability; or
- Open fracture of long bone **only if** nearest facility is greater than 30 miles; or
- Multiple orthopedic injuries, especially pelvic injuries if associated with vascular compromise or hemodynamic instability; or
- Champion Trauma score of 12 or less; or
- Glasgow Coma Score of 10 or less.

### Non-Trauma Criteria –

Transport by land ambulance of non-trauma victim would take more than 30 minutes,

**AND**

Individual must meet at **least one** of the following criteria –

- Individual requires Advanced Life Support, (any airway breathing or circulation support, such as an airway bag valve mask, intubation, IV bolus fluid, IV pressor medications, or any treatment required to sustain the life of the individual) during transport; or
- Individual has systolic blood pressure less than 90, and/or respiratory rate less than 10, or greater than 35, and/or pulse rate less than 60 or greater than 120, **and** these parameters cannot be stabilized at the transporting hospital; or



## Did you know?

Removal of skin tags is **NOT** considered cosmetic

Please add this newsletter to the Publications Section of your Medical Mutual Professional Provider Manual

## Did you know?

Removal of skin tags is **NOT** considered a cosmetic procedure

- Individual is currently hospitalized, experiencing shock, sepsis, organ failure, or other condition requiring critical care available only at another institution; or
- Individual has cardiac disease and is experiencing a progressively downhill course, is unstable, and requires treatment/measures not available at referring facility; or
- Individual experiencing severe neurological illness, and
  - a. is a candidate for thrombolytic therapy for acute stroke where the onset of stroke is less than 2 hours prior to stroke symptoms and the individual did not wake up with deficit, or is a candidate for intracerebral TPA given within 6 hours of onset of deficit; or
  - b. status epilepticus; or
  - c. acute cerebral hemorrhage, requiring emergency surgery.
- Individual is neonate or perinate requiring emergency critical care for;
  - a. acute airway compromise requiring intubation; or
  - b. acute cardiovascular compromise due to cardiac arrhythmia requiring intravenous medication, and/or IV fluid bolus, and/or IV pressor medication; or
  - c. status epilepticus.
- High risk obstetrical individual with life threatening problem of mother or fetus, but delivery is not imminent, and;
  - a. mother with penetrating wound to abdomen; or
  - b. mother with tetanic contraction and concern of abruptio placenta; or
  - c. mother with painless third trimester bleeding , with concern of placenta previa, and contractions beginning.
  - d. fetal bradycardia or late deceleration and concern of fetal hypoxia.

### **In the Event Individual Expires**

If the individual meets any of the above listed criteria categories for air ambulance transport, but expires during transport, or before being loaded into the air ambulance, reimbursement will be allowed. The pronouncement of death may be at the time the aircraft is in transit to pick-up the individual, or after the aircraft arrives on the scene. No reimbursement will be allowed in the following circumstance;

- The pronouncement of death is received **prior** to the aircraft taking off to pick-up the individual and the dispatcher has reasonable opportunity to notify the pilot to abort the flight, including as the aircraft taxis but **BEFORE** becoming airborne.

Reimbursement of medically appropriate air ambulance transport is provided for “base” and “loaded” mileage only; that is from the point of pickup to drop off destination. No reimbursement is allowed for mileage billed from point of takeoff to the scene of pickup. All charges for services, (i.e., physician/nurse services, monitoring of medication, and/or equipment supervision), and/or supplies utilized during transport (i.e., oxygen, gloves, dressings, IV tubing, medications, etc.) are considered included in the global reimbursement for air ambulance.

Air ambulance services are considered **not medically necessary** in any of the following circumstances:

- Air ambulance is dispatched and the individual does not use the service (with the exception of pronouncement of death in criteria listed above); or
- Air ambulance is utilized only as a convenience, or provided only for individual or family preference; or
- Air transportation of a donor organ to a Medical Mutual subscriber; or
- Air transportation of a transplant recipient to the medical facility where the transplant is to be performed.

**Predetermination is required for all non-emergency air ambulance transport.**

***COMING IN FUTURE ISSUES:***

- FMA Translator**
- Chelation Therapy**
- Automatic Internal Cardiac Defibrillator (AICD)**
- Synvisc and Hyalgan Injections**

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