I. Policy

Capital BlueCross considers the following procedures and diagnostic lab tests to be of “Questionable Current Usefulness”, and are considered not medically necessary unless medical necessity can be established on an individual basis. The following list is not an all inclusive list. Capital Blue Cross will continually add any obsolete procedures or diagnostic tests:

- Amylase, blood isoenzymes, electrophoretic
- Anastomosis, arterial extracranial - intracranial (e.g., middle cerebral/cortical) arteries (when performed to treat or prevent cerebral ischemia in patients with arteriosclerotic disease in the carotid and middle cerebral arteries)
- Animal inoculation, small animal; with observation
- Animal inoculation, small animal; with observation and dissection
- Arsenic
- Bendien’s test for cancer and tuberculosis
- Bolen’s test for cancer
- Brain imaging, limited procedure; static
- Brain imaging, complete study static
- Calcium, feces, 24-hour quantitative
- Calcium saturation clotting time
- Capillary fragility test (Rumple-Leede)
- Cardiontegram (or omnicardiogram)
- Cellular therapy
- Cephalin flocculation
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- Cerebrospinal fluid flow, imaging (not including introduction of material); tomographic SPECT
- Chromium, blood
- Chymotrypsin, duodenal contents
- Circulation time, one test
- Clot retraction study (Bolen’s clot retraction test for cancer [CRT])
- Clot Retraction
- Coccygectomy, primary
- Collodial gold
- Congo red, blood
- Contrast or chain urethrocystography
- Craniectomy for implantation of neurostimulator electrodes, cerebellar; cortical (when performed for cerebral palsy)
- Craniectomy for implantation of neurostimulator electrodes, cerebellar; subcortical (when performed for cerebral palsy)
- Craniotomy for lobotomy, including cingulotomy (when performed for relief of mental disturbances)
- Cystotomy or cystotomy with cryosurgery, fulguration and/or insertion of radioactive material
- Cystourethroscopy with insertion of radioactive substance
- Cystourethroscopy with ejaculatory duct catheterization, with or without irrigation instillation, or duct radiography, exclusive of radiologic service
- Displacement therapy (Proetz type)
- Dynamic posturography
- Eustachian tube inflation; transnasal; with catheterization
- Excision coccygeal pressure ulcer, with coccygectomy; with flap closure
- Excision, coccygeal pressure ulcer, with coccygectomy; with primary suture
- Fascia lata graft; by incision and area exposure, complex or sheet (when performed to treat low back pain)
- Fascia lata graft; by stripper (when performed to treat low back pain)
- Gastric analysis, pepsin
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- Gastric analysis, tubeless
- Guanase, blood
- Hair analysis
- Heart catheterization by left ventricular puncture
- Hormones, adrenocorticotropic quantitative *animal* tests
- Hormones, adrenocorticotropic quantitative bioassay
- Incisional biopsy of the prostate
- Injection procedure and placement of chain for contrast and/or chain urethrocystography
- Interruption, partial or complete of femoral vein, by ligature, intravascular device; (when performed to treat post-phlebitis syndrome)
- Intestinal plication, complete (Noble type operation) (separate procedure)
- Master two step
- Mechanical fragility test, red blood cells
- MicroNutrient testing (formerly functional intracellular analysis [FIA])
- Mucoprotein, blood (seromucoid)
- Open biopsy or excision of internal mammary nodes
- Penile revascularization, artery, with or without vein graft
- Prostatotomy for external drainage of prostate abscess
- Radiation therapy for the following conditions: acne, psoriasis, the tineas, furunculosis, eczema, contact dermatitis, herpes zoster, plantar verruca, verruca vulgaris, keratosi, bursitis, tendonitis, spurs, pterygium (except Strontium 90 application), pinquecula, sclerosis (post fracture) and otitis media
- Rehfuss test for gastric acidity
- Serum glutamate dehydrogenase
- Serum seromucoid assay for cancer and other diseases
- Skin test, actinomycosis
- Skin test, brucellosis
- Skin test, cat scratch fever
- Skin test, lymphopathia venereum
Skin test, psittacosis
- Skin test, trichinosis
- Starch, feces, screening
- Sympathectomy, lumbar (when performed to treat hypertension)
- Sympathectomy, thoracolumbar (when performed to treat hypertension)
- Thymol turbidity, blood
- Transection or avulsion of phrenic nerve
- Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments
- Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; with prescaral sympathectomy (presacral neurectomy)
- Zinc sulphate turbidity, blood

**Cardiovascular tests**

- Phonocardiogram with or without ECG lead; with supervision during recording with interpretation and report (when equipment is supplied by the physician)
- Phonocardiogram: tracing only, without interpretation and report (e.g., when equipment is supplied by the hospital, clinic),
- Phonocardiogram; interpretation and report,
- Phonocardiogram with ECG lead, with indirect carotid artery and/or jugular vein tracing, and/or apex cardiogram; with interpretation and report,
- Phonocardiogram; without interpretation and report only,
- Vectorcardiogram (VCG), with or without ECG; with interpretation and report, and
- Vectorcardiogram; interpretation and report only.

**Cross-reference:**
NA
II. PRODUCT VARIATIONS

[N] = No product variation, policy applies as stated  
[Y] = Standard product coverage varies from application of this policy, see below 

| [N]  | Capital Cares 4 Kids | [N]  | Indemnity |
| [N]  | PPO                  | [N]  | SpecialCare |
| [N]  | HMO                  | [N]  | POS       |
| [N]  | SeniorBlue HMO       | [Y]  | FEP PPO* |
| [N]  | SeniorBlue PPO       |       |           |

* The FEP program dictates that all drugs, devices or biological products approved by the U.S. Food and Drug Administration (FDA) may not be considered investigational. Therefore, FDA-approved drugs, devices or biological products may be assessed on the basis of medical necessity.

III. DESCRIPTION/BACKGROUND

A procedure that is considered obsolete, outdated, or discredited is considered a Procedure of Questionable Current Usefulness (POQCU).

IV. RATIONALE

NA

V. DEFINITIONS

MEDICAL NECESSITY - Capital defines “medical necessity or medically necessary” to mean the following:

- Services or supplies that a physician exercising prudent clinical judgment would provide to a Plan Member for the diagnosis and/or the direct care and treatment of the Plan Member’s medical condition, disease, illness, or injury that are necessary; and
- In accordance with accepted standards of good medical practice; and
- Clinically appropriate for the Plan Member’s condition, disease, illness or injury; and
- Not primarily for the convenience of the Plan Member and/or Plan Member’s family, physician, or other health care provider; and
MEDICAL POLICY

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- Not more costly than alternative services or supplies at least as likely to produce equivalent results for the Plan Member’s condition, disease, illness or injury.

For these purposes, “generally accepted standards of good medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, national Physician Specialty Society recommendations and the views of Physicians practicing in relevant clinical areas and any other clinically relevant factors.

VI. BENEFIT VARIATIONS

The existence of this medical policy does not mean that this service is a covered benefit under the member's contract. Benefit determinations should be based in all cases on the applicable contract language. Medical policies do not constitute a description of benefits. A member’s individual or group customer benefits govern which services are covered, which are excluded, and which are subject to benefit limits and which require preauthorization. Members and providers should consult the member’s benefit information or contact Capital for benefit information.

VII. DISCLAIMER

Capital's medical policies are developed to assist in administering a member’s benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member’s benefit information, the benefit information will govern. Capital considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VIII. CODING INFORMATION

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.
Unless medical necessity has been established on an individual basis following plan review of related clinical documentation, the following procedures and laboratory tests of questionable current usefulness are not medically necessary; therefore not covered:

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HCPCS Code       Description
M0075        CELULAR THERAPY
P2028        CEPHALIN FLOCULATION, BLOOD
P2029        CONGO RED, BLOOD
P2031        HAIR ANALYSIS (EXCLUDING ARSENIC)
P2033        THYMOL TURBIDITY, BLOOD
P2038        MUCOPROTEIN, BLOOD (SEROMUCOID) (MEDICAL NECESSITY PROCEDURE)
S3904        MASTERS TWO STEP
S9025        OMNICARDIOGRAM/CARDIOINTEGRAM

Investigational; therefore not covered:

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### X. Policy History

| MP 4.009 | CAC 6/29/04  
|          | CAC 7/26/05  
|          | CAC 8/30/05  
|          | CAC 7/25/06  
|          | CAC 10/31/06 
|          | CAC 9/25/07  
|          | CAC 5/27/08  
|          | CAC 11/25/08 
|          | CAC 1/26/10 Added MicroNutrient testing to list of procedures and laboratory tests of questionable current usefulness.  
|          | CAC 4/26/11 Minor revision. Policy updated with additional obsolete procedures and tests.  
|          | CAC 7/30/13 Consensus review. References updated but no changes to the policy statements.  
|          | 12/23/2013- New 2014 code added to policy  
|          | CAC 3/25/14 Consensus. No change to policy statements. References updated. Deleted codes removed from policy |