Louisiana

Policy Notice 2001-02 *July 2001*

The Contractor Advisory Committee in Louisiana met in April and has reviewed and accepted several policies which were HCFA directed. Implementation dates appear on the last page of each policy. The policies attached are as follows:

Note: You may notice that the formatting of some of the medical policies in this Policy Notice may be different than other policies in the document. HCFA has instructed Medicare Services to create a new table format for any new medical policies that are implemented.

Please be sure to study these policies and forward them to the appropriate personnel. This policy notice is an official notice of coverage and implementation as specifically defined in each of them. If you have any questions, please contact the Medicare medical director at Medicare Services, P.O. Box 83860, Baton Rouge, LA 70884-3860.

Breast Reconstruction Following Mastectomy

Policy Number: LA-90-001

Description:

Reconstruction of the breast following a medically necessary mastectomy is considered a relatively safe and effective non-cosmetic procedure.

Policy Type:

Operational statement of national coverage policy

HCPCS Section & Benefit Category:

Surgery; Integumentary System
Medicine; Special Services and Reports

HCPCS Codes:

The following short descriptors are in accordance with the AMA copyright agreement. Please refer to the current CPT book for full descriptions.

19120 -	Removal of breast lesion
19140 -	Removal of breast tissue
19160 -	Removal of breast tissue
19162 -	Remove breast tissue, node
19180 -	Removal of breast
19182 -	Removal of breast
19200 -	Removal of breast
19220 -	Removal of breast
19240 -	Removal of breast

Reconstruction:

19316 -	Suspension of breast
19340 -	Immediate breast prosthesis
19342 -	Delayed breast prosthesis
19350 -	Breast reconstruction
19361 -	Breast reconstruction
19364 -	Breast reconstruction
19366 -	Breast reconstruction
19380 -	Revise breast reconstruction
19396 -	Design custom breast implant
99070 -	Special supplies
19396 -	Design custom breast implant

HCFA's National Policy:

Title XVIII of the Social Security Act, section 1862 (a) (7). This section excludes routine physical examinations and screening tests performed in the absence of signs or symptoms from coverage.

Title XVIII of the Social Security Act, section 1862 (a) (1) (A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act, section 1833 (e). This section prohibits Medicare payment of any claim which lacks the necessary information to process the claim.

Indications & Limitations Of Coverage And/Or Medical Necessity:

Reconstruction of the breast is a covered service following a medically necessary mastectomy. The mastectomy may be simple, modified, radical, subtotal, total, unilateral, or bilateral and coded to reflect the appropriate procedure.

Medicare payment may not be made for breast reconstruction for cosmetic reasons. (Cosmetic surgery is excluded from coverage under Section 1862(a)(10) of the Social Security Act).

ICD-9 Codes That Support Medical Necessity:

V10.3	Personal history of malignant neoplasm - breast
V45.71	Acquired absence of breast (10/1997)
173.5	Malignant neoplasm of skin of trunk (breast)
174.0-174.9	Malignant neoplasm of female breast
175.0, 175.9	Malignant neoplasm of male breast
198.81	Secondary malignant neoplasm of breast
198.2	Secondary malignant neoplasm of skin of breast
216.5	Benign neoplasm of skin of trunk (breast)
217	Benign neoplasm of breast
232.5	Carcinoma in-situ of skin of trunk (breast)
233.0	Carcinoma in-situ of breast
238.3	Neoplasm of uncertain behavior of breast
239.2	Neoplasm of uncertain behavior - bone, soft tissue, and skin
239.3	Neoplasms of uncertain behavior - breast

Reasons For Denial:

Statutorily excluded

Non-Covered ICD-9 Codes:

All others not listed above.

Sources Of Information:

CIA35-47

Coding Guidelines:

Utilize modifier 20 for microsurgical technique

This policy does not take precedence over the Correct Coding Initiative (CCI) and CCI does not interfere with Indications/Limitations or acceptable diagnoses specified.

Documentation Requirements:

Other Comments:

CAC Notes:

Start Date Of Comment Period:

Start Date Of Notice Period:

November 1997
December 22, 1990

Presented To CAC:

Original Effective Date:

December 22, 1990

Revision Date:

Providers' News:

LAB97-06
FY90-07

Electrocardiography, Rhythm

Policy Number: LA-2000-005

Contractor's Policy Number	LA 2000-005
Contractor Name	Louisiana - Arkansas B/S
Contractor Number	00528
Contractor Type	Carrier
LMRP Title	Electrocardiography, Rhythm
AMA CPT Copyright Statement	"CPT codes, descriptions, and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply."
HCFA National Coverage Policy	Title XVIII of the Social Security Act, section 1862 (a)(7). This section excludes routine physical examinations and screening tests performed in the absence of signs or symptoms from coverage. Title XVIII of the Social Security Act, section 1862 (a)(1)(A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary. Title XVIII of the Social Security Act, section 1833(e). This section prohibits Medicare payment of any claim which lacks the necessary information to process the claim.
Primary Geographic Jurisdiction	Louisiana
Secondary Geographic Jurisdiction	Not applicable
HCFA Region	Dallas
HCFA Consortium	Southern
Original Policy Effective Date	08/15/2001
Original Policy Ending Date	
Revision Effective Date	
Revision Ending Date	
LMRP Description	Rhythm electrocardiograms are limited electrocardiographic tracings, consisting of one to three leads of the standard twelve lead tracing. Rhythm electrocardiograms provide longer segments of their included leads and are useful for assessment of the cardiac rhythm.

Indications and Limitations of Coverage and/or Medical Necessity	Rhythm strips are most effectively used to detect or characterize a known or suspected arrhythmia or in the presence of an acute myocardial infarction. They are also used in graphically demonstrating the efficacy of antiarrhythmic drugs. Separately billable coverage of rhythm strips (codes 93040 - 93042) will be allowed only when the patient must be "hooked up" to an EKG machine, a tracing made and an interpretation with a written report completed. When the patient is on continuous monitoring, we would not expect to see the reading/interpretation of rhythm strips billed in addition to the appropriate E & M code. This will apply to all monitored units and emergency room care.
CPT/HCPCS Section & Benefit Category	Medicine
Type of Bill Code	Not applicable
Revenue Codes	Not applicable
CPT/HCPCS Codes	93040 Rhythm ECG with report 93041 Rhythm ECG, tracing 93042 Rhythm ECG, report
Not Otherwise Classified (NOC)	Not applicable
ICD-9 Codes that Support Medical Necessity	426.0 Atrioventricular block (complete) 426.10 Atrioventricular block, unspecified 426.11 First degree atrioventricular block 426.12 Mobitz (type) II atrioventricular block 426.13 Other second degree atrioventricular block 426.2 Left bundle branch hemiblock 426.3 Other left bundle branch block 426.4 Right bundle branch block 426.50 Bundle branch block, unspecified 426.51 Right bundle branch block and left posterior fascicular block 426.52 Right bundle branch block and left anterior fascicular block 426.53 Other bilateral bundle branch block 426.54 Trifascicular block 426.6 Other heart block 426.7 Anomalous atrioventricular excitation 426.81 Lown-Ganong-Levine syndrome 426.89 Other specified conduction disorders 426.9 Conduction disorder, unspecified 427.0 Paroxysmal supraventricular tachycardia 427.1 Paroxysmal ventricular tachycardia 427.2 Paroxysmal tachycardia, unspecified 427.31 Atrial fibrillation

	427.32 Atrial flutter 427.41 Ventricular fibrillation 427.42 Ventricular flutter 427.5 Cardiac arrest 427.60 Premature beats, unspecified 427.61 Supraventricular premature beats 427.69 Other premature beats 427.81 Sinoatrial node dysfunction 427.89 Other specified cardiac dysrhythmias 427.9 Cardiac dysrhythmia. Unspecified 780.2 Syncope and collapse 780.31 Febrile convulsions 780.39 Other convulsions 780.4 Dizziness and giddiness 785.0 Tachycardia, unspecified 785.1 Palpitations
Diagnosis that Support Medical Necessity	Not applicable
ICD-9 Codes that DO NOT Support Medical Necessity	Not applicable
Diagnosis that DO NOT Support Medical Necessity	Not applicable
Reasons for Denial	• Otherwise not covered • All other indications not listed in the "Indications and Limitations of Coverage" section of this Policy; • The medical record does not verify that the service described by the HCPCS code was provided; • The service does not follow the guidelines of this policy; and, • The service is considered: for routine screening.
Non-Covered ICD-9 Code(s)	All codes not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy.
Non-Covered Diagnosis	All codes not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy.
Coding Guidelines	This policy does not take precedence over the Correct Coding Initiative (CCI) and CCI does not interfere with Indications/Limitations or acceptable diagnoses specified.
Documentation Requirements	Documentation supporting the medical necessity should be legible, maintained in the patient's medical record and must be made available to Medicare upon request. The EKG tracing should be part of the record and available for review.
Utilization Guidelines	Not applicable

Other Comments	
Sources of Information and Basis for Decision	American College of Cardiology Position Statement 1991. "Recommended Guidelines for In-Patient Cardiac Monitoring of Adults for Detection of Arrhythmia. " *Journal of the American College of Cardiology 18:1431-1433.*
Advisory Committee Notes	Presented to CAC on December 13, 2000 with the Cardiology representative having no changes to the policy.
Start Date of Comment Period	11/27/2000
End Date of Comment Period	01/10/2001
Start Date of Notice Period	07/01/2001
Revision History	

Disclaimer: "This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from cardiology."

Epirubicin Hydrochloride

Policy Number: LA-2001-001

Contractor's Policy Number	LA 2001-001
Contractor Name	Louisiana - Arkansas B/S
Contractor Number	00528
Contractor Type	Carrier
LMRP Title	Epirubicin Hydrochloride
AMA CPT Copyright Statement	"CPT codes, descriptions, and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply."
HCFA National Coverage Policy	Title XVIII of the Social Security Act, section 1862 (a)(7). This section excludes routine physical examinations and screening tests performed in the absence of signs or symptoms from coverage. Title XVIII of the Social Security Act, section 1862 (a)(1)(A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary. Title XVIII of the Social Security Act, section 1833(e). This section prohibits Medicare payment of any claim which lacks the necessary information to process the claim.
Primary Geographic Jurisdiction	Louisiana
Secondary Geographic Jurisdiction	Not applicable
HCFA Region	Dallas
HCFA Consortium	Southern
Original Policy Effective Date	08/15/2001
Original Policy Ending Date	
Revision Effective Date	
Revision Ending Date	
LMRP Description	Epirubicin is an anthracycline glycoside antineoplastic antibiotic that is a semisynthetic derivative of daunorubicin.
Indications and Limitations of Coverage and/or Medical Necessity	Effective September 16, 1999, the FDA approved Epirubicin as an adjuvant therapy in patients with axillary-node tumor involvement following resection in primary breast cancer.

CPT/HCPCS Section & Benefit Category	Physician Services, Medicine, Drugs and Biologicals
Type of Bill Code	Not applicable
Revenue Codes	Not applicable
CPT/HCPCS Codes	J9180 Epirubicin HCl injection (01/01/2001) 96408 Chemotherapy, push technique
Not Otherwise Classified (NOC)	J9999 with a description of services (DOS 09/16/1999-12/31/2000)
ICD-9 Codes that Support Medical Necessity	174.0-174.9 Malignant neoplasm of female breast 175.0-175.9 Malignant neoplasm of male breast
Diagnosis that Support Medical Necessity	Not applicable
ICD-9 Codes that DO NOT Support Medical Necessity	Not applicable
Diagnosis that DO NOT Support Medical Necessity	Not applicable
Reasons for Denial	Non FDA approval; otherwise not covered
Non-Covered ICD-9 Code(s)	All codes not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy.
Non-Covered Diagnosis	All codes not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy.
Coding Guidelines	• Epirubicin is administered intravenously over 3-5 minutes. Therefore, an Intravenous push, 96408, will be allowed. • This policy does not take precedence over the Correct Coding Initiative (CCI) and CCI does not interfere with Indications/Limitations or acceptable diagnoses specified.
Documentation Requirements	Three Phase III studies from HCFA accepted literature must be submitted at the review level to justify any indications not listed above.
Utilization Guidelines	
Other Comments	
Sources of Information and Basis for Decision	USPDI: 2001 - pgs 1367, 3175; 2000 - pgs 3200; AHFS: 2001 - pgs 960; 2000 - pg 915; Medicare Carriers Manual, Section 2049.4C

Advisory Committee Notes	Presented to CAC on April 4, 2001. The radiation oncology representative questioned whether or not patients with non-axillary node involvement would be denied and Dr. Hickman stated that if they were denied, they would be reviewed individually. The oncology representative had no changes.
Start Date of Comment Period	03/17/2001
End Date of Comment Period	05/15/2001
Start Date of Notice Period	07/01/2001
Revision History	The 2000 Edition of the USPDI and AHFS compendia had the additional indications of lung carcinoma, lymphoma, hodgkin's and non-hodgkin's, gastric carcinoma and ovarian carcinoma. These were removed in the 2001 compendia update.

Disclaimer: "This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from oncology and radiation oncology."

Mylotarg (Gemtuzumab Ozogamicin)

Policy Number: LA-2001-002

Contractor's Policy Number	LA 2001-002
Contractor Name	Louisiana - Arkansas B/S
Contractor Number	00528
Contractor Type	Carrier
LMRP Title	Mylotarg (Gemtuzumab Ozogamicin)
AMA CPT Copyright Statement	"CPT codes, descriptions, and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply."
HCFA National Coverage Policy	Title XVIII of the Social Security Act, section 1862 (a)(7). This section excludes routine physical examinations and screening tests performed in the absence of signs or symptoms from coverage. Title XVIII of the Social Security Act, section 1862 (a)(1)(A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary. Title XVIII of the Social Security Act, section 1833(e). This section prohibits Medicare payment of any claim which lacks the necessary information to process the claim.
Primary Geographic Jurisdiction	Louisiana
Secondary Geographic Jurisdiction	Not applicable
HCFA Region	Dallas
HCFA Consortium	Southern
Original Policy Effective Date	08/15/2001
Original Policy Ending Date	
Revision Effective Date	
Revision Ending Date	MM/DD/YYYY
LMRP Description	Mylotarg is a chemotherapy agent using monoclonal antibody technology. It is composed of recombinant humanized IgG_4, kappa antibody conjugated with a cytotoxic antitumor antibiotic, calicheamicin, isolated from fermentation of a bacterium, Micromonospora echinospora sp. Calichensis. The antibody portion of mylotarg binds to the CD33 antigen.

Indications and Limitations of Coverage and/or Medical Necessity	Effective with date of service May 18, 2000, the FDA approved Mylotarg for the treatment of patients with CD33 positive acute myeloid leukemia in first relapse who are 60 years of age or older and who are not candidates for cytotoxic chemotherapy.
CPT/HCPCS Section & Benefit Category	Physician Services, Medicine, Drugs and Biologicals
Type of Bill Code	Not applicable
Revenue Codes	Not applicable
CPT/HCPCS Codes	96410 Chemotherapy,infusion method 96412 Chemo, infuse method add-on
Not Otherwise Classified (NOC)	J9999 with a description of mylotarg
ICD-9 Codes that Support Medical Necessity	205.00
Diagnosis that Support Medical Necessity	Not applicable
ICD-9 Codes that DO NOT Support Medical Necessity	Not applicable
Diagnosis that DO NOT Support Medical Necessity	Not applicable
Reasons for Denial	Non FDA approval; otherwise not covered
Non-Covered ICD-9 Code(s)	All codes not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy.
Non-Covered Diagnosis	All codes not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy.
Coding Guidelines	• Mylotarg is administered only by IV infusion over 2 hours (96410-96412). It should never be administered by rapid IV infusion , such as IV push or bolus. Therefore, an Intravenous push, 96408, will not be allowed. • This policy does not take precedence over the Correct Coding Initiative (CCI) and CCI does not interfere with Indications/ Limitations or acceptable diagnoses specified.

Documentation Requirements	• Submitted with the claim must be miscellaneous chemotherapy code J9999 with the description of mylotarg, the appropriate diagnosis, and amount administered. • Supporting documentation as to the medical necessity will need to be provided for patients receiving more than two treatment courses as studies have not been performed on more than 2 courses. A treatment course is defined as a total of 2 doses (9mg/m^2) with 14 days between the doses. • Three Phase III studies from HCFA accepted literature must be submitted at the review level to justify any indications not listed above.
Utilization Guidelines	Not applicable.
Other Comments	
Sources of Information and Basis for Decision	AHFS: : 2001 - p 987 USPDI: 2001- p 1595 Medicare Carrier's Manual, Section 2049.4C FDA approved package labeling
Advisory Committee Notes	Presented to CAC on April 4, 2001 with the oncology representative having no changes to the policy.
Start Date of Comment Period	03/17/2001
End Date of Comment Period	05/15/2001
Start Date of Notice Period	07/01/2001
Revision History	

Disclaimer: "This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from oncology."

Noninvasive Vascular Studies - Revision

Policy Number: LA-00-003

Description:

Noninvasive vascular studies utilize ultrasonic Doppler and physiologic principles to assess irregularities in blood flow in arterial and venous systems. The display may be a two dimensional image with spectral analysis and color flow or a plethysmographic recording.[1] A hard copy, or a soft copy convertible to a hard copy, provides a permanent record of the study performed and must be of a quality that meets accepted standards.[2] Contrast arteriography and phlebography are standard diagnostic techniques for evaluation of arterial and venous diseases. These techniques are invasive and involve additional expense, time, discomfort and risks to the patient. Reliable, valid and accurate noninvasive studies are necessary to offset this problem. It is the responsibility of the provider to ensure the quality of the noninvasive studies.

The accuracy of noninvasive vascular studies depends on the knowledge, skill and experience of the technologist and interpreter. Consequently, the providers of interpretations must be capable of demonstrating documented training and experience and maintain documentation for post-payment audit. Furthermore, effective January 1, 1997, (La. Part B Medicare Provider's News), all noninvasive vascular diagnostic studies must be either (1) performed by, or under the general supervision of, persons that have demonstrated minimum entry level competency by being credentialed in vascular technology, or (2) performed in laboratories accredited in vascular technology. Examples of appropriate personnel certification include the Registered Vascular Technologist (RVT) credential and the Registered Vascular Specialist (RVS) credential in Vascular Technology, and appropriate laboratory accreditation include the Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL) or the Ultrasound Practice Accreditation Commission of the American Institute of Ultrasound in Medicine. January 1, 2004, documentation of both RVT and facility accreditation will be required each January prior to billing electronically for that new year and with any and all submitted paper claims. Supervisory levels of diagnostic tests must be in accordance with Program Memorandum B-01-28.[16]

Noninvasive Vascular Studies include patient care required to perform the studies, supervision of the studies and interpretation of study results with copies for patient records of hard copy output or imaging when provided.[3]

As published in the Federal Register on November 22, 1996, diagnostic tests, to be covered, must be ordered by the practitioner that treats the patient. The treating physician is the practitioner responsible for the treatment of the patient and who orders the test to use the results in the management of the beneficiary's specific medical problem(s). Consulting physicians may also order tests.

It is the responsibility of the practitioner to ensure the medical necessity of procedures and to maintain a record of medical necessity for post-payment audit. The provider must maintain records either hand written or a verbal request (converted to a written document) by the ordering practitioner of medical necessity for post-payment audit.

Noninvasive vascular studies are medically necessary only if the outcome will potentially impact the clinical course of the patient. For example, if a patient is (or is not) going to proceed on to other diagnostic and/or therapeutic procedures regardless of the outcome of noninvasive studies, noninvasive vascular procedures are not medically necessary. This is, if it is obvious from the findings of the history and physical examination that the patient is going to proceed to angiography, then noninvasive vascular studies are not medically necessary. A baseline study may be allowed if used to document the extent of vascular disease.

A duplex scan includes a real-time scan (see CPT 4; Diagnostic Ultrasound). Consequently, billing for both a duplex scan and echography of the same body part represents unbundling and is not allowed. The use of simple hand-held or other Doppler device that does not produce hard copy output, or that does not permit analysis of bi-directional vascular flow, is considered part of the physical examination of the vascular system and is not separately reimbursable.[3]

Definitions

Duplex Scan: Implies an ultrasonic scanning procedure with display of both two-dimensional structure and motion with time and Doppler ultrasonic signal documentation with spectrum analysis and/or color flow velocity mapping or imaging. The color Doppler evaluation is considered to be part of the duplex examination and is not considered to be a separately reimbursable examination.

Physiologic Studies: Implies functional measurement procedures including Doppler ultrasound studies, blood pressure measurements, transcutaneous oxygen tension measurements, or plethysmography.

Plethysmography Implies volume measurement procedures including air, impedance, or strain gauge methods.

Policy Type:

Local Medical Necessity policy

HCPCS Section & Benefit Category:

Medicine; Non-Invasive Vascular Diagnostic Studies

HCPCS Codes:

The following short descriptors are in accordance with the AMA copyright agreement. Please refer to the current CPT book for full descriptions.

76936	Echo guide for artery repair
93875	Extracranial study
93880	Extracranial study
93882	Extracranial study
93886	Intracranial study
93888	Extracranial study
93922	Extremity study
93923	Extremity study
93924	Extremity study
93925	Lower extremity study
93926	Lower extremity study
93930	Lower extremity study
93931	Upper extremity study
93965	Extremity study
93970	Extremity study
93971	Extremity study
93975	Vascular study
93976	Vascular study
93978	Vascular study
93979	Vascular study
93980	Penile vascular study
93981	Penile vascular study
93990	Doppler flow testing

HCFA's National Policy:

Title XVIII of the Social Security Act, section 1862 (a) (7). This section excludes routine physical examinations and screening tests performed in the absence of signs or symptoms from coverage.

Title XVIII of the Social Security Act, section 1862 (a) (1) (A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Title XVIII of the Social Security Act, section 1833(e). This section prohibits Medicare payment of any claim which lacks the necessary information to process the claim.

Indications & Limitations Of Coverage And/Or Medical Necessity:

CEREBROVASCULAR EXAMINATION (CPT Codes 93875 through 93888)

Indications for Cerebrovascular Evaluations[4]

1. Cervical bruits
2. Amaurosis fugax.
3. Focal cerebral or ocular transient ischemic attacks (i.e., localizing symptoms, weakness of one side of the face, slurred speech, weakness of a limb). Visual transient ischemic attacks are defined as retinal or hemispheric visual field deficits and not temporary blurred vision.
4. Drop attacks or syncope are rare indications primarily seen with vertebro-basilar or bilateral carotid artery disease. Incoordination or limb dysfunction should be grouped with unilateral weakness of the face or extremities.
5. Symptomatic cardiovascular disease affecting other arterial beds (i.e.: coronary artery disease, peripheral arterial disease, aneurismal arterial disease.)
6. Vasculitis involving the extracranial carotid arteries.

Examples of Signs and Symptoms That Do Not Demonstrate Medical Necessity

1. Dizziness is not a typical indication unless associated with other localizing signs or symptoms. However, episodic dizziness with symptom characteristics typical of transient ischemic attacks may indicate medical necessity, especially when other more common sources (e.g., postural hypotension or transiently deceased cardiac output as demonstrated by cardiac event monitoring) have been previously excluded.
2. Headaches are not an indication for extracranial studies.

Acceptable Procedures for Reimbursement [6 7]

1. Duplex scan (93880 or 93882).
2. 93875 is of limited usefulness and should be reimbursed only when medical necessity is documented. Since duplex scanning of the carotid vessels is considered to be the most useful test for surgically correctable ischemic disease, only 93880 & 93882 will be generally reimbursed.
3. Transcranial Doppler (TCD) (see below) (93886 or 93888).

Multiple Cerebrovascular procedures can be allowed during the same encounter given the provider can demonstrate medical necessity on post-payment audit. Separate vertebral studies are rarely indicated, and will not be considered for reimbursement without additional documentation of medical necessity.[8]

Methods Not Acceptable For Reimbursement [6 7]

1. Pulse delay oculoplethysmography.
2. Carotid phonoangiography and other forms of bruit analysis are covered services but are included in the reimbursement for the office visit.
3. Periorbital photoplethysmography.

4. Thermography.
5. Photoelectric plethysmography.
6. Light reflection rheography. [9] [10]

Recommendations for Follow-up Studies [2]

1. Stenosis of 20-50% (diameter reduction), an annual study.
2. Stenosis of 50-79%, every six months.
3. Stenosis of 80-99%, surgery is usually recommended.
4. After carotid endarterectomy, repeat examinations are allowed at six weeks, six months, one year, and annually thereafter. During the first year, follow-up studies should be unilateral unless signs and symptoms provide indications for a bilateral procedure.

TRANSCRANIAL DOPPLER (TCD) (93886 or 93888)

The accuracy of TCD examinations depends on the knowledge, skill and experience of the technologist and interpreter. Consequently, the providers of TCD studies must be capable of demonstrating documented training and experience and maintain documentation for post-payment audit. An example of acceptable training and experience would be a physician and/or registered vascular technologist with documentation of attendance at a formal TCD training program that includes hands on experience and results in a certificate of proficiency, and with a minimum experience of 100 patient TCD examinations.

TCD is an allowed procedure and is of established value in: [9]

1. Detection and evaluation of the hemodynamic effects of severe stenosis or occlusion of the extracranial (greater than or equal to 60%) and major basal intracranial arteries (greater than or equal to 50%, diameter reduction).[11]
2. Detection and serial evaluation of cerebral vasospasm complicating subarachnoid hemorrhage.
3. Evaluation of invasive therapeutic interventions for cerebral arteriovenous malformations.
4. Evaluation of intracranial hemodynamic abnormality in-patients with suspected brain death.
5. Intraoperative and perioperative monitoring of intracranial flow velocity and hemodynamic patterns during carotid artery intervention. This is primarily a Medicare Part A procedure but the professional component could be reimbursed given it is provided during the operative procedure by a physician that is not a member of the operating team.
6. Evaluation of cerebral emobilization.
7. Detection and evaluation of intracranial vascolopathy in children with sickle cell disease (2 to 4 per year allowed).[12]

Examples of non-acceptable indications include: [9]

1. Evaluation of brain tumors.
2. Assessment of familial and degenerative diseases of the cerebrum, brainstem, cerebellum, basal ganglia and motor neurons.
3. Evaluation of infectious and inflammatory conditions.
4. Psychiatric disorders.
5. Epilepsy.

The following applications are in the research phase and are considered investigational:

1. Assessing patients with migraine.
2. Monitoring during cardiopulmonary bypass.
3. Monitoring during investigational interventions.
4. Evaluation of patients with dilated vasculopathies such as fusiform aneurysms.
5. Assessing autoregulation, physiologic, and pharmacological responses of cerebral arteries.

PERIPHERAL ARTERIAL EXAMINATIONS (CPT Codes 93922 through 93931)

Noninvasive peripheral arterial examinations, performed to establish the level and/or degree of arterial occlusive disease, are medically necessary if (1) significant signs and/or symptoms indicating a high likelihood of limb ischemia and (2) the patient is a candidate for invasive therapeutic procedures. A routine history and physical examination, which includes Ankle/Brachial Indices (ABI's), can readily document the presence or absence of ischemic disease in a majority of cases. It is not medically necessary to proceed beyond the physical examination for minor signs and symptoms such as hair loss, absence of a single pulse, relative coolness of a foot, shiny thin skin, or lack of toe nail growth unless related signs and/or symptoms are present which are severe enough to require possible invasive intervention.

An ABI (1) is not a reimbursable procedure in itself, and (2) should be abnormal (i.e., < 0.9 at rest) or must be accompanied by another appropriate indication before proceeding to more sophisticated or complete studies, except in patients with severe diabetes resulting in medical calcification as demonstrated by artifactually elevated ankle blood pressures.

Indications for Peripheral Arterial Evaluations[13]

1. Claudication of less than one block or of such severity that it interferes significantly with the patient's occupation or lifestyle.
2. Rest pain (typically including the forefoot), usually associated with absent pulses, which becomes increasingly severe with elevation and diminishes with placement of the leg in a dependent position.
3. Tissue loss defined as gangrene or pre-gangrenous changes of the extremity, or ischemic ulceration of the extremity occurring in the absence of pulses.
4. Aneurysmal disease.
5. Evidence of thromboembolic events.
6. Blunt or penetrating trauma (including complications of diagnostic and/or therapeutic procedures.)
7. For evaluation of dialysis access, see policy regarding CPT code 93990.
8. Evaluation of therapeutic outcome.

Examples of Signs and Symptoms that Do Not Indicate Medical Necessity

1. Continuous burning of the feet is considered to be a neurologic symptom.
2. "Leg pain, nonspecific" and "Pain in limb" as single diagnoses are too general to warrant further investigation unless they can be related to other signs and symptoms.
3. Edema rarely occurs with arterial occlusive disease unless it is in the immediate postoperative period, in association with another inflammatory process or in association with rest pain.
4. Absence of relatively minor pulses (i.e., dorsalis pedis or posterior tibial) in the absence of symptoms. The absence of pulses is not an indication to proceed beyond the physical examination unless it is related to other signs and/or symptoms.

Acceptable Procedures for Reimbursement [2 13]

1. Duplex Scan (93925, 93926, 93930, 93931).
2. Single level physiologic studies (i.e., Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement) (93922)
3. Segmental physiologic studies or with provocative functional maneuvers complete bilateral (segmental blood pressures, Doppler waveform analysis, volume plethysmography, TCO_2). (93923)
4. Physiologic studies at rest and following treadmill stress testing (93924).

A complete extremity physiologic study includes pressure measurements and an additional physiologic technique (e.g., Doppler ultrasound study or plethysmography). Transcutaneous oxygen tension

measurements are acceptable to evaluate healing potential in non-healing or difficult to heal wounds at a frequency of no greater than twice in any 60 day period.

Duplex scanning and physiologic studies may be reimbursed during the same encounter if the physiologic studies are abnormal and/or to evaluate vascular trauma, thromboembolic events or aneurismal disease, and if duplex imaging is likely to replace angiography studies (e.g.: therapy will be given based solely on the results of the Doppler imaging study given the provider can document medical necessity.)

Methods Not Acceptable for Reimbursement

1. Mechanical Oscillometry[6]
2. Inductance Plethysmography[6]
3. Capacitance Plethysmography[6]
4. Photoelectric Plethysmography[6]
5. ABI (considered part of the physical examination)

Post-intervention Follow-up Studies

Duplex post-intervention follow-up studies are typically limited in scope and unilateral in nature. Consequently, the "complete" duplex scan codes (i.e., 93925 or 93930) should seldom be used while the "unilateral or limited study" codes (i.e., 93926 or 93931) should typically be used.

1. In the immediate post-operative period, patients may be studied if re-established pulses are lost, become equivocal, or if the patient develops related signs and/or symptoms of ischemia with impending repeat intervention.
2. With regard to autogenously lower extremity vein bypass surgeries, a study can be performed at three month intervals during the first year, at six month intervals during the second year, and yearly thereafter. Follow-up studies are not medically necessary post-angioplasty in the absence of signs and/or symptoms of occlusive disease.[2]

In general, noninvasive studies of the arterial system are to be utilized when invasive correction is contemplated, but not to follow noninvasive medical treatment regimens. The latter may be followed with physical findings and/or progression or relief of signs and/or symptoms. Screening of the asymptomatic patient is not covered by Medicare.

PERIPHERAL VENOUS EXAMINATIONS (CPT Codes 93965 through 93971)

Indications for venous examinations are separated into two major categories: deep vein thrombosis and chronic venous insufficiency. Studies are medically necessary only if the patient is a candidate for anticoagulation, thrombolysis or invasive therapeutic procedures. Venous examinations may also be used to assess potency and quality of venous segments in patients with prior vein surgery, deep vein thrombosis, current or chronic indwelling venous catheters, or present or prior grafts.

Since the signs and symptoms of arterial occlusive disease and venous disease are so divergent, the performance of simultaneous arterial and venous studies during the same encounter should be rare. Consequently, a document clearly supporting the medical necessity of both procedures performed during the same encounter must be available for post-payment audit.

Deep Vein Thrombosis (DVT)

DVT is the most common vascular disorder that develops in hospitalized patients and can develop after trauma or prolonged immobility (sitting or bed rest). Unfortunately, the signs and/or symptoms of DVT are relatively non-specific and, due to the risk associated with pulmonary embolism (PE), objective testing is allowed in patients that are candidates for anticoagulation or invasive therapeutic procedures for the following indications:

1. Clinical signs and/or symptoms of DVT including edema, tenderness, inflammation, and/or erythema.

2. Clinical signs and/or symptoms of PE including hemoptysis. Chest pain, and/or dyspnea.
3. Unexplained lower extremity edema status post major surgical procedures.
4. High risk patients.

Bilateral limb edema in the presence of signs and/or symptoms of congestive heart failure, exogenous obesity and/or arthritis should rarely be an indication.

Chronic Venous Insufficiency

Chronic venous insufficiency may be divided into three categories: primary varicose veins, secondary varicose veins and post-thrombotic (post-phlebitic) syndrome. It is not medically necessary to study primary varicose veins. Objective tests of venous function may be indicated with ulceration, thickening or discoloration suspected to be secondary to venous insufficiency in order to confirm this diagnosis by documenting venous valvular incompetence prior to treatment.

Acceptable Procedures for Reimbursement [14]

1. Duplex Scan (93970 or 93971)
2. Doppler waveform analysis including responses to compressions and other maneuvers (93965).
3. Impedance Plethysmography (93965).
4. Air Plethysmography (93965).
5. Strain Gauge Plethysmography (93965)

Duplex exam of the venous system has replaced venography as the standard for detection of deep vein thrombosis and is the exam of choice in patients with suspected venous thrombosis. Plethysmography is less accurate and should not be routinely used. 93965 will be reimbursed only when medical necessity is documented.

Performance of both duplex scanning (93970 or 93971) and physiological tests (93965) of extremity veins during the same encounter is not medically necessary. Reimbursement of physiologic test will not be allowed after a duplex examination has been performed.

Methods Not Acceptable for Reimbursement[6]

1. Mechanical Oscillometry.
2. Inductance Plethysmography.
3. Capacitance Plethysmography.
4. Photoelectric Plethysmography.

Follow-up Studies

Frequency of follow-up studies will be carefully monitored for medical necessity and it is the responsibility of the provider to maintain documentation of medical necessity for post-payment audit.

Vein Mapping

Duplex scanning is sometimes performed to find a suitable vein for arterial reconstruction. Vein mapping with ultrasound imaging is covered if:

1. History of previous harvest or stripping of vein (V45.81)
2. Previous history of thrombophlebitis (451.0 or 997.2).
3. Severe varicose veins.
4. Assessment of arm veins for possible arteriovenous fistula.
5. Anomalies of peripheral vascular system (747.60-747.69)

HEMODIALYSIS ACCESS EXAMINATION (CPT Code 93990)

Limited coverage has been established for duplex scanning of hemodialysis access sites in patients with end stage renal disease (ESRD). These procedures are medically necessary only in the presence of signs or symptoms of impending failure of the access site and when the results may impact the clinical course of the patient. Furthermore, when services are provided by the ESRD physician of record, services are considered renal related and are, therefore, part of the physician's monthly capitated fee and are not separately reportable. Services performed by a Medicare approved ESRD facility are covered services under the composite rate of the facility and therefore not separately reimbursable.

If an intervention is contemplated, the duplex ultrasound examination can be used to identify the site of abnormality and as a guide to directing the therapeutic intervention.

Appropriate indications for Duplex Scan of Hemodialysis Access Sites include:

1. ICD-9-CM code 996.73: Complication (Complication NOS, occlusion NOS, embolism, fibrosis, hemorrhage, pain, stenosis, thrombosis) due to renal dialysis device, implant, and graft as demonstrated by clear documentation in the dialysis record of signs of chronic (i.e., 3 successive dialysis sessions) of abnormal function or a trend of abnormalities including:
   a. elevated venous pressure greater than 200 mmHg at a flow rate of 200 cc/min (on a 200 cc/min pump),[15]
   b. elevated recirculation time of 12% or greater [15], and
   c. Low urea reduction rate < 60%[15]
2. Low intra-access blood flow:
   - Absolute flow < 800 cc/min; or
   - Decrease flow (trended) > 25%
3. Elevated static venous pressure:
   - or equal to 0.5 intra-access/mean arterial pressure
   - or equal to 0.4 intra-access pressure/systolic blood pressure
   - 0.2 increase in trended intra-access pressure
4. Elevated dynamic venous pressure:
   - or equal to 125 mmHg at a blood flow rate of 200 cc/min using 15 gauge needles (If using different size needles, pressure threshold should be adjusted.
5. Abnormal physical examination of access:
   - Swelling of access extremity
   - Prolonged bleeding, following needle withdrawal with normal bleeding studies
6. Unexplained decreases in the measured amount of hemodialysis delivered (URR, Kt/V)
7. Difficult cannulation documented on three occasions.
8. Thrombus aspiration.
9. Shunt collapse suggesting poor arterial flow documented on three occasions.

Trend data is more important than any single value. Routine evaluation without evidence of signs and symptoms is considered screening and is not a covered service.

ULTRASOUND GUIDED REPAIR OF PSEUDOANEURYSM INCLUDES COMPRESSION OR THROMBIN INJECTION (CPT Code 76936 Ultrasound Guidance Procedure)

Diagnosis of pseudoaneurysm is primarily based on history and physical examination. Consequently, CPT code 76936 includes CPT codes 93926 through 93931 and these procedures are not separately reimbursable. The medical necessity of ultrasound guided repair of arteriovenous fistulae is not supported by a review of the current literature and is, therefore, not reimbursable.

Acceptable indications for reimbursement include:

1. Pulsatile mass indicating a pseudoaneurysm.

The patient must be at least three (3) day's status post invasive vascular procedure.

When performed in conjunction with the invasive procedure, 76936 is considered part of the invasive procedure and is not separately reportable.

VISCERAL VASCULAR STUDIES (CPT Codes 93975, 93976, 93978, 93979)

Appropriate ultrasound evaluation of the abdominal visceral and retroperitoneal vasculature requires duplex ultrasound (with the optional use of color Doppler). The examination requires, in addition to knowledge of vascular anatomy and pathophysiology, a thorough understanding of normal abdominal and pelvic anatomy as well as expertise in the technical requirements of ultrasound imaging.

INDICATIONS for ABDOMINAL, RETROPERITONEAL and PELVIC ORGANS (CPT Codes 93975 through 93976)

1. Hypertension
2. Stenosis of visceral artery (atherosclerotic, fibromuscular dysplasia, Vasculitis, functional)
3. Aneurysm of visceral artery
4. Portal hypertension, with or without ascites.
5. Thrombosis of visceral vein (renal, hepatic, mesenteric, portal or splenic)
6. Stenosis of visceral vein (rein, hepatic, mesenteric, portal or splenic)
7. Complications of internal (biological) (synthetic) prosthetic device, implant and graft:
    - Due to vascular implant and graft
    - Complications of transplanted organ
        - Kidney
        - Liver
        - Pancreas
9. Other specified transplant organ
10. Persons with a condition influencing their Health Status

    Organ or tissue replaced by transplant
        - Kidney
        - Liver
        - Pancreas

INDICATIONS for AORTA, INFERIOR VENA CAVA, ILIAC VASCULATURE or BYPASS GRAFTS (CPT Codes 93978 through 93979

1. Atherosclerosis of aorta
2. Atherosclerosis of the extremities with intermittent Claudication.
3. Atherosclerosis of other specified arteries.
4. Aortic aneurysm and dissection.
5. Aneurysm of iliac artery
6. Thromboangitis obliterans (Buerger's disease)
7. Peripheral vascular disease, unspecified.
8. Arterial embolism and thrombosis of abdominal aorta.
9. Arterial embolism and thrombosis of iliac artery
10. Phlebitis and thrombophlebitis of iliac vein
11. Venous embolism and thrombosis of vena cava
12. Venous embolism and thrombosis of renal vein.
13. Complications peculiar to certain specified procedures.

14. Other complications of internal (biological) (synthetic) prosthetic device, implant and graft:
    - Due to vascular implant or graft
15. Complications of transplanted organ:
    - Kidney
    - Liver

Unacceptable for Reimbursement

Routine imaging of the iliac veins is not medically necessary. Specific medical indications include:

- Possible propagation of a known thrombus; therefore, a consideration for placement of a vena cava filter device via the femoral approach.

Post Intervention Follow-up Studies

Abdominal aortic aneurysms > 4 cm in diameter may be followed with ultrasound every 6 months. Medical necessity will have to be provided for studies more frequently performed. Follow-up studies may be performed for the following procedures:

- Transjugular intrahepatic porto-caval shunt (TIPS)
- Renal Transplant
- Liver Transplant

PENILE VASCULAR STUDIES (CPT Codes 93980 through 93981)

Noninvasive vascular studies of the penile vessels include duplex imaging of the inflow and outflow vessels of the penis. The study includes duplex imaging and Doppler signal documentation with spectral analysis and/or color flow velocity mapping or imaging.

Indications for Penile Vascular Study:

1. Disorders of the penis, which may include priapism and vascular disorders of the penis.
2. Mechanical complications of genitourinary device, implant and graft.

ICD-9 Codes That Support Medical Necessity:

93875–93882	237.3	Paraganglion (includes Carotid Body)
	342.00-342.92	Hemiplegia and hemiparesis
	344.00-344.5	Quadriplegia and quadriparesis; paraplegia; diplegia of upper limbs; monoplegia of lower limb; monoplegia of upper limb; unspecified monoplegia
	344.81	Locked-in-state
	344.9	Paralysis, unspecified
	362.30-362.37	Retinal vascular occlusion
	362.84	Retinal Ischemia
	368.10-368.12	Subjective visual disturbance, unspecified; sudden vision loss; transient visual loss
	368.40-368.47	Visual field defects

	433.00-433.91	Occlusion and stenosis of precerebral arteries (includes: embolism, narrowing, obstruction, or thrombosis of basilar, carotid, vertebral arteries)
	434.00-434.91	Occlusion of cerebral arteries
	435.0-435.9	Transient cerebral ischemia (includes: Cerebrovascular insufficiency {acute} with transient focal neurological signs and symptoms; insufficiency of basilar, carotid and vertebral arteries; spasm of cerebral arteries)
	436	Acute, but ill-defined, Cerebrovascular disease
	437.0	Cerebral atherosclerosis
	437.1	Other generalized ischemic Cerebrovascular disease
	437.4-437.5	Cerebral arteritis; moyamoya disease
	437.7	Transient global amnesia
	438.0-438.9	Late effects of Cerebrovascular disease
	442.81-442.82	Other aneurysm: Artery of neck; subclavian artery
	446.0-446.7	Polyarteritis nodosa and allied conditions
	447.1	Stricture of artery
	447.6	Arteritis, unspecified
	780.2	Syncope & collapse
	780.4	Dizziness and giddiness
	781.2-781.4	Abnormality of gait; lack of coordination; transient paralysis of limb
	782.0	Disturbance of skin sensation
	784.3	Aphasia
	784.5	Other speech disturbance
	785.9	Other symptoms involving cardiovascular system
	900.00-900.9	Injury to blood vessels of head and neck
	901.1	Innominate and subclavian arteries
	996.1	Mechanical complication of other vascular device, implant, & graft (carotid artery bypass graft)
	996.70-996.79	Other complication of internal (biological) (synthetic) prosthetic device, implant, and graft
	997.00-997.09	Central nervous system complications, not elsewhere classified
	998.11-998.13	Hemorrhage or hematoma or seroma complicating a procedure
	V15.1	Personal history of surgery to heart and great vessels
93886–93888	348.5	Cerebral edema

	430	Subarachnoid hemorrhage
	433.00-433.91	Occlusion and stenosis of precerebral arteries
	434.00-434.91	Occlusion of cerebral arteries
	435.0-435.9	Transient cerebral ischemia
	437.0	Cerebral atherosclerosis
	437.1	Other generalized CV disease
	437.4-437.5	Cerebral arteritis; Moyamoya disease
	852.00-852.09	Subarachnoid hemorrhage following injury w/o mention of open intracranial wound
	852.10-852.19	Subarachnoid hemorrhage following injury with open intracranial wound
93922–93931	250.70-250.73	Diabetes with peripheral circulatory disorder
	353.0	Brachial plexus disorders, including thoracic outlet syndrome
	435.2	Subclavian steal syndrome
	440.0	Atherosclerosis of aorta
	440.21-440.29	Atherosclerosis of native arteries of the extremities
	440.30-440.32	Atherosclerosis of bypass graft of the extremities
	441.00-441.9	Aortic aneurysm and dissection
	442.0	Other aneurysm; Of artery of upper extremity
	442.2-442.3	Other aneurysm: Of iliac arteries; Of artery of lower extremity
	442.82	Other aneurysm; Of subclavian artery
	443.0-443.9	Other peripheral vascular disease
	444.0-444.9	Arterial embolism and thrombosis
	446.5	Giant Cell Arteritis
	446.7	Takayasu's disease
	447.0-447.2	Arteriovenous fistula, acquired; Stricture of artery; Rupture of artery
	447.6	Arteritis, unspecified
	707.10-707.19	Ulcer of lower extremity, except decubitus
	708.8	Chronic ulcer of other specified sites (chronic ulcer {neurogenic trophic})
	710.1	Systemic sclerosis
	728.71	Plantar fascial fibromatosis
	785.4	Gangrene
	903.00-903.9	Injury to blood vessels of upper extremity

	904.0-904.9	Injury to blood vessels of lower extremity and unspecified sites
	996.1	Mechanical complication of other vascular device, implant, and graft (involving: aortic {bifurcation} graft {replacement} surgically created arteriovenous fistula or shunt, balloon {counter pulsation} device {intra-aortic})
	996.74	Complications Due to vascular implant and graft
	997.2	Peripheral vascular complications, not elsewhere classified
	998.11-998.13	Hemorrhage or hematoma or seroma complicating a procedure
	998.2	Accidental puncture or laceration during a procedure
	V42.0	Organ or tissue replaced by transplant; Kidney
	V43.4	Organ or tissue replaced by other means; Blood vessel
	V58.49	Other specified aftercare following surgery
93965, 93970-93971	415.11-415.19	Pulmonary embolism and infarction
	451.0-451.9	Phlebitis and thrombophlebitis
	453.1	Thrombophlebitis migrans
	453.9	Other venous embolism and thrombosis; Of unspecified site
	454.0-454.2	Varicose veins of lower extremities: With ulcer; With Inflammation; With ulcer and inflammation
	459.1-459.2	Postphlebitis syndrome; Compression of vein
	459.81-459.89	Other specified disorders of circulatory system
	671.20-671.24	Superficial thrombophlebitis
	671.30-371.33	Deep phlebothrombosis, antepartum
	671.40-671.44	Deep phlebothrombosis, postpartum
	671.90	Unspecified venous complication
	671.94	Unspecified venous complication
	695.9	Unspecified erythematous condition
	707.10-707.19	Ulcer of lower limbs, except decubitus
	727.51	Synovial cyst of popliteal space
	729.5	Pain in limb
	729.81	Swelling of limb
	747.60	Anomaly of the peripheral vascular system, unspecified site
	747.63	Upper limb vessel anomaly
	747.64	Lower limb vessel anomaly

	747.69	Anomalies of other specified sites of peripheral vascular system
	782.2-782.3	Localized superficial swelling, mass, or lump; Edema
	785.4	Gangrene
	786.00-786.02	Dyspnea and respiratory abnormalities: Respiratory abnormality, unspecified; hyperventilation; Orthopnea
	786.06	Dyspnea and respiratory abnormalities; Tachypnea
	786.09	Dyspnea and respiratory abnormalities; Other
	786.3	Hemoptysis
	786.52	Painful respiration
	786.59	Chest pain; Other
	794.2	Non-specific abnormal results of function studies; Pulmonary
	903.00-903.9	Injury blood vessels of upper extremity
	904.0-904.9	Injury to blood vessels of lower extremity and unspecified sites
	996.1	Mechanical complication of other vascular device, implant, and graft (involving: surgically created arteriovenous fistula or shunt; dialysis catheter; umbrella
	996.70	Complications Due to unspecified device, implant and graft
	996.74	Complications Due to vascular implant and graft
	996.79	Complications Due to other internal prosthetic device, implant and graft
	997.2	Peripheral vascular complications
	998.2	Accidental puncture or laceration during a procedure
	999.2	Other vascular complications
	V12.51-V12.52	Personal history of venous thrombosis and embolism; thrombophlebitis
	V45.81	Other postsurgical status - Aortocoronary bypass status
93990	996.1	Mechanical complication of other vascular device, implant, and graft (involving: surgically created arteriovenous fistula or shunt; dialysis catheter; umbrella device, vena cava)
	996.62	Infection and inflammatory reaction Due to vascular device, implant and graft
	996.73-996.74	Complications Due to: renal dialysis device, implant & graft; vascular implant & graft
93975-93979	401.0-401.9	Essential hypertension
	402.00-402.01	Hypertensive heart disease; Malignant w/o or with congestive heart failure

	440.1	Atherosclerosis; Of renal artery
	440.8	Atherosclerosis Of other unspecified arteries
	442.1	Other aneurysm; Of renal artery
	442.83-442.84	Other aneurysm: splenic artery; Other visceral artery
	447.3-447.4	Hyperplasia of renal artery; Celiac artery compression syndrome
	452	Portal Vein Thrombosis
	453.0	Budd Chiari Syndrome
	453.3	Other venous embolism and thrombosis; Of renal vein
	453.9	Other venous embolism and thrombosis; unspecified site
	557.0-557.9	Vascular insufficiency of intestine
	572.3	Portal Hypertension
	593.81	Vascular disorders of kidney
	789.5	Ascites
	996.74	Complications Due to vascular implant and graft
	996.81-996.82	Complications of transplanted: Kidney; Liver
	996.86	Complications of transplanted Pancreas
	996.89	Complications of transplanted organ; other specified transplant organ
	V42.0	Organ or tissue replaced by transplant; Kidney
	V42.7	Organ or tissue replaced by transplant; Liver
	V42.83	Organ or tissue replaced by transplant; Pancreas
	V42.89	Organ or tissue replaced by transplant; Other organ or tissue
93978-93979	440.0	Atherosclerosis of aorta
	440.21	Atherosclerosis of the extremities with intermittent claudication
	440.8	Atherosclerosis of other specified arteries
	441.00	Dissection of aorta; Unspecified site
	441.02	Dissection of aorta; abdominal
	441.1-441.5	Aneurysm: Thoracic ruptured; Thoracic w/o mention of rupture; Abdominal ruptured; Abdominal w/o mention of rupture; Abdominal unspec. site, ruptured.
	441.9	Aortic aneurysm of unspecified site without mention of rupture
	442.2	Other aneurysm; Of the iliac artery
	443.1	Thromboangitis obliterans (Buerger's disease)
	443.9	Peripheral vascular disease, unspecified

	444.0	Arterial embolism and thrombosis; of abdominal aorta
	444.81	Arterial embolism and thrombosis; iliac artery
	451.81	Phlebitis and thrombophlebitis of iliac vein
	453.2-453.3	Other venous embolism and thrombosis of: Vena cava; Renal vein
	996.74	Complications Due to vascular implant and graft
	996.81-996.82	Complications of transplanted: Kidney; Liver
93980-93981	607.3	Priapism (painful erection)
	607.82	Vascular disorder of penis
	607.89	Other disorders of corpus cavernosum or penis
	996.30	Mechanical complication of genitourinary device, implant, and graft; Unspecified device, implant and graft
	996.31	Mechanical complication of genitourinary device, implant, and graft; Due to urethral (indwelling) catheter
	996.39	Mechanical complication of genitourinary device, implant, and graft; Other

Reasons For Denial:

There is no literature to support the efficacy of this procedure for any indications other than those listed above.

Non-Covered ICD-9 Codes:

All codes not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy.

Sources Of Information:

1. New York State Medicare Local Medical Review Policy for Noninvasive Vascular Diagnostic Studies. 1999
2. Transamerica Occidental Life Insurance Company Payment Safeguard Administrator Proposed Local Medical Review Policy for the state of California for Noninvasive Vascular Studies.
3. Non-Invasive Vascular Diagnostic Studies. In Physicians' Current Procedural Terminology. 1995
4. ICAVL Essentials and Standards for Accreditation in Noninvasive Vascular Testing; Part II, Vascular Laboratory Operations, Cerebrovascular Testing. 1995, 2000.
5. Medicare Part B for Kansas/Nebraska/Western Missouri for Noninvasive Vascular Studies.
6. Strandness DE, Andros G, Baker JD, Berstein EF. Vascular laboratory utilization and payment: Report of The Ad Hoc Committee of the Western Vascular Society. J Vasc Surg 1992; 16:163-169.
7. Assessment: Transcranial Doppler. Report of the American Academy of Neurology, Therapeutics and Technology Assessment Subcommittee. Neurology 1990; 40:680-681.
8. Medicare Services of Missouri Draft Policy for Non-invasive Vascular Studies.
9. Medicare Carrier Manual, Appendix, Coverage Issues – iagnostic Services, Coverage Issue 50-6.
10. Federal Register, Volume 57, Number 25, Friday, November 20, 1992.

11. Chimowitz MI, Kokkinos J, Strong J, Brown MB, Levine SR, Silliman S, Pessin MS, Weichel E, Sila CA, Furlan AJ, Kargman DE, Sacco RL, Wityk RJ, Ford G, Fayad PB. The Warfarin-Aspirin Symptomatic Intracranial Disease Study. Neurology 1995; 45:1488-1493.
12. Adams RJ, McKie VC, Hsue L, et al: Prevention of a first stroke by transfusions in children with Sickle Cell Anemia and abnormal results on Transcranial Doppler Ultrasonography. New England Journal of Medicine. 1998; 339:5-11.
13. ICAVL Essentials and Standards for Accreditation in Noninvasive Vascular Testing; Part II, Vascular Laboratory Operations, Peripheral Arterial Testing. 1995. 2000
14. CAVL Essentials and Standards for Accreditation in Noninvasive Vascular Testing; Part II, Vascular Laboratory Operations, Peripheral Venous Testing. 1995. 2000
15. Program Memorandum AB-00-44.
16. Program Memorandum B-01-28.

Coding Guidelines:

This policy does not take precedence over the Correct Coding Initiative (CCI) and CCI does not interfere with Indications/Limitations or acceptable diagnoses specified.

Documentation Requirements:

Other Comments:

CAC Notes:

This policy does not reflect the sole opinion of the carrier or Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee, which includes representatives from all recognized specialties within the state.

Start Date Of Comment Period:

November 17, 2000

Start Date Of Notice Period:

July 2001

Presented To CAC:

December 2000

Original Effective Date:

August 01, 2001

Revision Date:

Providers' News:

Pulmonary Function Testing

Policy Number: LA-2001-003

Contractor's Policy Number	LA 2001-003
Contractor Name	Louisiana - Arkansas B/S
Contractor Number	00528
Contractor Type	Carrier
LMRP Title	Pulmonary Function Testing
AMA CPT Copyright Statement	"CPT codes, descriptions, and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply."
HCFA National Coverage Policy	Title XVIII of the Social Security Act, section 1862 (a)(7). This section excludes routine physical examinations and screening tests performed in the absence of signs or symptoms from coverage. Title XVIII of the Social Security Act, section 1862 (a)(1)(A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary. Title XVIII of the Social Security Act, section 1833(e). This section prohibits Medicare payment of any claim which lacks the necessary information to process the claim.
Primary Geographic Jurisdiction	Louisiana
Secondary GeographicJurisdiction	Not applicable
HCFA Region	Dallas
HCFA Consortium	Southern
Original Policy Effective Date	08/15/2001
Original Policy Ending Date	
Revision Effective Date	
Revision Ending Date	
LMRP Description	Pulmonary function tests describe a wide array of measurements designed to evaluate the status of structural components of the lung. They include, but are not limited to, spirometry, diffusion capacity studies, lung volumes and gas diffusion studies. This policy is intended to outline the clinically appropriate indications and applications that would meet Medicare coverage.

Indications and Limitations of Coverage and/or Medical Necessity	Indications: The evaluation of lung function is indicated to determine: • The presence of lung disease or abnormality of lung function • The extent of abnormalities and the causative disease process • The extent of disability due to abnormal lung function • The progression of the disease • The type of disease or lesion • A course of therapy in the treatment of the particular condition To determine a course of therapy in the treatment of the particular condition. Limitations: For the purposes of medical reviews, the carrier expects the provider to follow a thoughtful, purposeful sequence in his/her selection of tests. The Carrier maintains an algorithm as a useful guide that may be considered in medical necessity reviews. The Medicare program specifically excludes screening testing. Examples of screening also include, but are not limited to, the following: • An asymptomatic patient, with or without high risk of lung disease • Studies as part of a routine exam • Studies as part of an epidemiological survey Procedure code 94150, vital capacity, is a "bundled" service, which means that there is no separate reimbursement for this code. CPT codes 94014, 94015, and 94016 are not covered since their clinical efficacy has not been established. **A. Spirometry** Indications: Spirometry makes up the most commonly applied section of PFTs. The general indications are as follows: Diagnostic: • To evaluate symptoms, signs or abnormal laboratory tests ➢ Symptoms: unexplained dyspnea, wheezing, orthopnea, cough, phlegm production ➢ Signs: unexplained diminuitive breath sounds, overinflation, cyanosis, chest deformity, unexplained crackles

- Abnormal laboratory tests: hypoxemia, hypercapnia, polycythemia, abnormal chest radiographs

- To measure the effect of systemic disease on pulmonary function (e.g. neuromuscular disease, connective tissue disease)
- To assess preoperative risk
- To assess prognosis (lung transplant, etc.)

Monitoring:

- To assess therapeutic interventions:
- Bronchodilator therapy
- Steroid treatment for asthma, interstitial lung disease, etc.
- Other (antibiotics in cystic fibrosis, etc.)
- To monitor for adverse reactions to drugs with known pulmonary toxicity

Limitations:

Post-bronchodilator spirometry is used to rule out a reversible component to a patient's bronchospasm and to determine if the patient is a candidate for bronchodilator therapy. Claims for code 94060 will be subject to medical review according to the following:

The initial use of bronchospasm evaluation (94060) is covered when at least one of the following conditions is present:

1. There are clinical signs or symptoms consistent with bronchospasm,
2. Spirometry without bronchodilator is abnormal
3. Reversibility of bronchospasm in response to bronchodilator therapy, or lack thereof has not yet been demonstrated.

If reversibility of bronchospasm (bronchodilator responsiveness) has already been either ruled out or demonstrated, repeat pre and post-bronchodilator study (94060) will be covered only when there is a significant clinical change in the patient's functional respiratory status necessitating an adjustment or augmentation of bronchoactive medications and this is documented in the patient's medical record.

B. Lung Volumes

The absolute lung volumes or capacities cannot be measured by spirometry. They are total lung capacity (TLC), residual volume (RV), and functional residual capacity (FRC). Measurement of these volumes or capacities is indicated when the vital capacity is reduced. Lung volumes may also be indicated to distinguish restrictive disease from chronic obstructive disease (COPD), to evaluate bullous diseases and to elucidate the date from other lung functions and to assess therapeutic interventions such as lobectomy and

	chemotherapy. **C. Diffusion Capacity (DLCO)** Diffusion capacity measurement is often indicated when spirometry and lung volume studies reveal restrictive disease. DLCO is used to distinguish between chest wall and interstitial disease. Diffusion capacity is also useful in quantifying the degree of parenchymal destruction in COPD and assessing pulmonary vascular diseases and interstitial diseases, even if vital capacity is normal. **D. Lung Compliance** Lung compliance measures the elastic recoil or stiffness of the lungs. It is more invasive than other PFTs, because the patient is required to swallow an esophageal balloon. Compliance studies are performed only when all other PFTs give equivocal results, or the results require confirmation by additional data. **E. Cardiopulmonary Exercise Testing** Pulmonary stress testing is done in two (2) forms. The simple pulmonary stress testing (code 94620) is a test that allows quantification of work load and heart rate activity, while measuring the degree of oxygen desaturation. This test is undertaken to measure the degree of hypoxemia or desaturation that occurs with exertion. It is also used to optimize titration of supplemental oxygen for the correction of hypoxemia A more complex protocol involves the measurements of oxygen uptake, CO2 production, and O2. This is defined by code 94621. Indications for this protocol include the following: • To distinguish between cardiac and pulmonary causes of dyspnea • To determine the need for and dose of ambulatory oxygen • To assist in developing a safe exercise prescription for patients with cardiovascular or pulmonary disease • To predict the morbidity of lung resection • To titrate optimal settings in selected patients who have physiologic pacemakers
CPT/HCPCS Section & Benefit Category	Medicine
Type of Bill Code	Not applicable
Revenue Codes	Not applicable
CPT/HCPCS Codes	94010 Breathing capacity test 94060 Evaluation of wheezing 94070 Evaluation of wheezing 94150 Vital capacity test 94200 Lung function test (MBC/MVV)

	94240 Residual lung capacity 94250 Expired gas collection 94260 Thoracic gas volume 94350 Lung nitrogen washout curve 94360 Measure airflow resistance 94370 Breath airway closing volume 94375 Respiratory flow volume loop 94400 CO2 breathing response curve 94450 Hypoxia response curve 94620 Pulmonary stress test/simple 94621 Pulm stress test/complex 94680 Exhaled air analysis, o2 94681 Exhaled air analysis, o2/co2 94690 Exhaled air analysis 94720 Monoxide diffusing capacity 94750 Pulmonary compliance study 94770 Exhaled carbon dioxide test 95070 Bronchial allergy tests 95071 Bronchial allergy tests
Not Otherwise Classified (NOC)	Not applicable
ICD-9 Codes that Support Medical Necessity	**A. CPT codes 94010, 94060, 94200, 94240, 94375, 94720** 011.00-011.96 Pulmonary tuberculosis 012.00-012.86 Other respiratory tuberculosis 031.0 Diseases due to other mycobacteria, pulmonary 039.1 Thoracic actinomycosis 045.00-045.03 Acute poliomyelitis 114.0 Primary coccidioidomycosis (pulmonary) 116.0 Blastomycosis 117.1 Sporotrichosis 117.5 Cryptococcosis 135 Sarcoidosis 138 Poliomyelitis, late effects 162.0-162.9 Malignant neoplasm of trachea, bronchus, and lung 163.0-163.9 Malignant neoplasm of pleura 164.0-164.9 Malignant neoplasm of thymus, heart, and mediastinum 165.0-165.9 Malignant neoplasm of other and ill-defined sites within the respiratory system and intrathoracic organs 197.0 Secondary malignant neoplasm, lung 212.3 Benign neoplasm of bronchus and lung 212.4 Benign neoplasm of pleura 212.5 Benign neoplasm of mediastinum 228.1 Pulmonary lymphangioma, any site 231.2 Carcinoma in situ, bronchus and lung 235.7 Neoplasm of uncertain behavior, trachea, bronchus, & lung

	239.1	Neoplasms of unspecified nature of the respiratory system
	277.00-277.01	Cystic fibrosis
	277.8	Histiocytosis
	289.0	Polycythemia, secondary
	335.20	Amyotrophic lateral sclerosis
	344.00-344.09	Quadriplegia and quadriparesis
	344.1	Paraplegia
	344.89	Other specified paralytic syndrome
	357.0	Guillain-Barre Syndrome
	358.0	Myasthenia gravis
	359.1	Hereditary progressive muscular dystrophy
	415.11-415.19	Pulmonary embolism and infarction
	416.0-416.9	Chronic pulmonary heart disease
	428.0-428.9	Heart failure
	466.0	Acute bronchitis
	466.11-466.19	Acute bronchiolitis
	490	Bronchitis, not specified as acute or chronic
	491.0	Simple chronic bronchitis
	491.1	Mucopurulent chronic bronchitis
	491.20-491.21	Obstructive chronic bronchitis
	492.0-492.8	Emphysema
	493.00-493.91	Asthma
	494	Bronchiectasis
	495.0-495.9	Extrinsic allergic alveolitis
	496	Chronic airway obstruction, not elsewhere classified (COPD)
	500	Coal workers' pneumoconiosis (anthracosilicosis, anthacosis, black lung disease, miners' asthma)
	501	Asbestosis
	502	Pneumoconiosis due to other silica or sillicates (pneumoconiosis due to talc, silicotic fibrosis of lung, silicosis)
	503	Pneumoconiosis due to other inorganic dust (aluminosis, bauxite, berylliosis, graphite fibrosis, siderosis, stannosis)
	504	Pnuemonopathy due to inhalation of other dust (byssinosis, cannabinosis, flax-dressers disease)
	505	Pneumoconiosis, unspec.
	508.1	Chronic and other pulmonary manifestations due to radiation (fibrosis of lung)
	511.0	Pleurisy without mention of effusion or current tuberculosis
	515	Post inflammatory pulmonary fibrosis
	516.3	Idiopathic pulmonary fibrosis
	517.2	Lung involvement in systemic sclerosis
	517.8	Lung involvement in other diseases classified elsewhere
	518.0	Pulmonary collapse

	518.81 Acute respiratory failure 518.89 Chronic pulmonary vascular occlusive disease 519.1 Other diseases of trachea and bronchus, nec 519.4 Disorders of diaphragm 519.8 Other diseases of respiratory system, nec 710.0 Systemic lupus erythematosus 714.81 Rheumatoid lung 737.10 Kyphosis (acquired) (postural) 737.30 Scoliosis \and kyphoscoliosis], idiopathic 754.2 Certain congenital musculoskeletal deformities of spine 754.81 Pectus excavatum 780.50-780.57 Sleep disturbances 782.5 Cyanosis 786.00-786.09 Dyspnea and respiratory abnormalities 786.1 Stridor 786.2 Cough 790.91 Abnormal arterial blood gases 793.1 Nonspecific abnormal findings in lung field 799.0 Asphyxia (hypoxemia, hypoxia, pulse oximetry showing desaturation) 909.5 Late effect of adverse effect of drug, medicinal or biological substance 987.0-987.9 Toxic effect of other gases, fumes, or vapors 998.81 Emphysema (subcutaneous) (surgical) resulting from a procedure V12.6 Personal history of diseases of respiratory system V42.1 Heart transplant V42.6 Lung transplant **B. CPT 94070** 493.00-493.91 Asthma equivalent/hx of asthma with normal spirometry 518.89 Bronchial allergy/hypersensitivity 786.2 Unexplained cough **C. CPT 94620, 94621** 786.00-786.09 Dyspnea and respiratory abnormalities **D. CPT 94250, 94260, 94350, 94360, 94370, 94400, 94450, 94680, 94681, 94690, 94750, and 94770** These procedures are payable with any diagnosis from sections A, B or C.
Diagnosis that Support Medical Necessity	Not Applicable
ICD-9 Codes that DO NOT Support Medical Necessity	Not applicable

Diagnosis that DO NOT Support Medical Necessity	Not applicable
Reasons for Denial	A claim submitted without a valid ICD-9-CM diagnosis code will be returned as an incomplete claim under 1833(e). A claim submitted without one of the ICD-9-CM diagnosis codes listed in the "ICD-9-CM Diagnosis Codes That Support Medical Necessity" section of this policy will be denied under 1862(a)(1)(A). A claim for services rendered in any place of service other than those indicated as payable in the "Coding Guidelines" section of this policy will be denied. A claim for (these services), submitted without the UPIN number of the referring/ordering physician or qualified non-physician practitioner, will be returned as an incomplete claim under 1833 (e).
Non-Covered ICD-9 Code(s)	All codes not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy. V70.0 Routine general medical examination at a health care facility V70.6 Health examination in population surveys V70.7 Examination for normal comparison or control in clinical research V76.0 Special screening for malignant neoplasms of respiratory organs V81.3 Special screening for chronic bronchitis and emphysema V72.82 Preoperative respiratory examination
Non-Covered Diagnosis	All codes not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy.
Coding Guidelines	1. Use code 94010 to indicate repeat spirometries performed to evaluate a patient's response to newly established treatments, monitor the course of asthma/COPD, or evaluate patients continuing with symptomatology after initiation of treatment. 2. The appropriate combination of tests may be coded if proper clinical indication exists: a. Codes 94060, 94070, 94200, 94375, 94620 & 94621 may not be billed with code 94010. b. Codes 94010, 94070, 94200, 94375, 94620, 94621 and 94770 may not be billed with code 94060. c. Code 94070 may not be billed with codes 94010, 94060, 94200, 94375, 94620, 94621 and 94770. d. Code 94360 and 94750 may not be billed with code 93720 (plethysmography, total body.) e. Code 94761 (noninvasive ear or pulse oximetry) may not be billed with code 94620.

	3. Use modifier TC when reporting the technical component of the service. The technical component is payable in office (11) or an Independent Diagnostic Testing Facility (use place where service was rendered). 4. Use modifier 26 to report the professional component of the service. The professional component may be billed in office (11), inpatient hospital (21), outpatient hospital (22), emergency room (23) skilled nursing facility (31), nursing facility (32), comprehensive inpatient rehabilitation facility (61), and comprehensive outpatient rehabilitation facility (62). 5. Report these procedure codes without a modifier if the global service is being performed. The global service is payable in office (11), and IDTF (independent diagnostic testing facility) (use place where service was rendered), if all components of the service are done in the IDTF itself. Claims for components done in facilities other than the IDTF must be submitted to the respective carrier or intermediary responsible for that jurisdiction. 6. This policy does not take precedence over the Correct Coding Initiative (CCI) and CCI does not interfere with Indications/Limitations or acceptable diagnoses specified.
Documentation Requirements	Documentation supporting the medical necessity, such as ICD-9-CM diagnosis codes, must be submitted with each claim. Claims submitted without such evidence will be denied as not medically necessary. All providers of pulmonary function tests should have on file a referral (a prescription) with clinical diagnoses and requested tests. Indications for the studies should be clearly described in the clinical records and available for review. All equipment and studies should meet minimum standards outlined by the American Thoracic Society. Spirometry studies, in particular, require a minimum of three attempts that must meet minimum acceptability criteria. All studies require an interpretation, with a written report. Computerized reports must have a physician's signature, attesting to its accuracy. Documentation must be available to Medicare upon request.
Utilization Guidelines	Not applicable.
Other Comments	For services that exceed the accepted standard of medical practice and may be deemed not medically necessary, the provider/supplier must provide the patient with an acceptable advance notice of Medicare's possible denial of payment. A waiver of liability should be signed when a provider/supplier does not want to accept financial responsibility for the service.

Sources of Information and Basis for Decision	New York Medicare carrier policy Respiratory Care: A Guide to Clinical Practice, 3rd Edition, Editors George G. Burton, John E Hodgkins, Jeffrey Ward, Lippincott 1991 American Thoracic Society Standardization of Spirometry, 1994 Update Spirometry: Quantitative Test Criteria and Test Acceptability, Henry Golundmeyer, Am Rev Respir 1987, 136, 449-452 National Guideline Clearinghouse, "Exercise testing for evaluation of hypoxemia and/or desaturation" Respir. Care 1992 August National Guideline Clearinghouse, "Spriometry, 1996 Update", Respir Care 1996 July American Thoracic Society, "Single-breath Carbon Monoxide Diffusing Capacity (Transfer Factor)," July 1995 Manual of Pulmonary Function Testing, Gregg Ruppel, Mosey 1975 Pulmonary Function Testing In Ontario: Patterns of Practice and Policy Implications, Chan B, Anderson G, Naylor CD ICES Working Paper #036 Florida Medicare carrier policy
Advisory Committee Notes	Presented to CAC on April 04, 2001. The Internal Medicine representative requested the addition of bronchial provocation and CPT codes 95070 and 95071 were added. The Physiatry representative requested the addition of spinal cord injuries and ICD-9 codes 344.00-344.09 and 344.1 were added.
Start Date of Comment Period	03/17/2001
End Date of Comment Period	05/15/2001
Start Date of Notice Period	07/01/2001
Revision History	

Disclaimer: "This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from internal medicine and psychiatry."

Rh_0 Immune Globulin, Human (Injection and Infusion)

Policy Number: LA-97-001

Description:

A specific polyclonal immune globulin preparation that contains IgG antibodies against the Rh_0 (D) antigen on red blood cells.

Policy Type:

Local medical necessity policy

HCPCS Section & Benefit Category:

Drugs and Biologicals

HCPCS Codes:

The following short descriptors are in accordance with the AMA copyright agreement. Please refer to the current CPT book for full descriptions.

J2790	Rho d immune globulin inj
J2792	Rho(D) immune globulin h, sd (Eff. 01/01/1999)
J3490-	Drugs unclassified injectio (with the description of WinRho (SD or SDF)) (prior to 12/31/1998)
90384	Rh ig, full-dose, im (Eff. 01/01/1999) (Non-covered service, per MFSDB)
90385	Rh ig, minidose, im (Eff. 01/01/1999)
90386	Rh ig, iv (Eff. 01/01/1999) (Non-covered service, per MFSDB)

HCFA's National Policy:

Title XVIII of the Social Security Act, section 1862 (a) (7). This section excludes routine physical examinations.

Title XVIII of the Social Security Act, section 1862 (a) (1) (A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary.

Indications & Limitations Of Coverage And/Or Medical Necessity:

1. Adults with Chronic thrombocytopenic purpura (ITP), children with chronic or acute ITP, and children and adults with ITP secondary to HIV infection.
2. Rh exposure

ICD-9 Codes That Support Medical Necessity:

287.3	Thrombocytopenic purpura (ITP)
999.7	Rh Incompatibility reaction

Reasons For Denial:

There is no literature to support the efficacy of this procedure for any indications other than those listed above.

Non-Covered ICD-9 Codes:

All others not mentioned above.

Sources Of Information:

Package insert with FDA approved labeling.

Coding Guidelines:

This policy does not take precedence over the Correct Coding Initiative (CCI) and CCI does not interfere with Indications/Limitations or acceptable diagnoses specified.

Documentation Requirements:

Three Phase III studies from HCFA accepted literature (specified in Program Memorandum AB-94-2) must be submitted at the review level to justify any indications not listed above.

Other Comments:

CAC Notes:

Start Date Of Comment Period:

Start Date Of Notice Period:

July 1999
August 1997

Presented To CAC:

December 2000

Original Effective Date:

Revision Date:

Providers' News:

LA PN 99-01
LAB 97-05

Sacral Nerve Stimulation for the Treatment of Urge Urinary Incontinence

Policy Number: LA 2000-004

Contractor's Policy Number	LA 2000-004
Contractor Name	Louisiana - Arkansas B/S
Contractor Number	00528
Contractor Type	Carrier
LMRP Title	Sacral Nerve Stimulation for the Treatment of Urge Urinary Incontinence
AMA CPT Copyright Statement	"CPT codes, descriptions, and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply."
HCFA National Coverage Policy	Title XVIII of the Social Security Act, section 1862 (a)(7). This section excludes routine physical examinations and screening tests performed in the absence of signs or symptoms from coverage. Title XVIII of the Social Security Act, section 1862 (a)(1)(A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary. Title XVIII of the Social Security Act, section 1833(e). This section prohibits Medicare payment of any claim which lacks the necessary information to process the claim.
Primary Geographic Jurisdiction	Louisiana
Secondary GeographicJurisdiction	Not applicable
HCFA Region	Dallas
HCFA Consortium	Southern
Original Policy Effective Date	April 15, 2001
Original Policy Ending Date	
Revision Effective Date	
Revision Ending Date	
LMRP Description	Sacral nerve stimulation is defined as the implantation of a permanent device that modulates the neural pathways controlling bladder function. This treatment is one of several alternative modalities for patients with urge urinary incontinence who have not

	responded to more conservative treatment for a least six months. Such measures might include behavioral and pharmacological treatments that were ineffective or not well tolerated. This treatment involves electrical stimulation of the sacral nerves in the lower region of the spine via a totally implantable system. System components include a lead, an implantable pulse generator, and an extension that connects the lead to the pulse generator. It is expected that the physician performing this service has completed a training course in the use and implantation of the device.
Indications and Limitations of Coverage and/or Medical Necessity	Sacral nerve stimulation is a covered service for patients who meet the following criteria: a) urge incontinence is not due to a neurologic condition; b) who have failed six months of previous conservative treatments; c) who have had a successful peripheral nerve evaluation test; d) the device used is FDA approved for this purpose.
CPT/HCPCS Section & Benefit Category	Surgery
Type of Bill Code	Not applicable
Revenue Codes	Not applicable
CPT/HCPCS Codes	64575 Implant neuroelectrodes 64585 Revise / remove neuroelectrode 64590 Implant neuroreceiver 64595 Revise / remove neuroreceiver 95970 Analyze neurostim, no prog 95971 Analyze neurostim, simple A4290 Sacral nerve stim test lead
Not Otherwise Classified (NOC)	Not applicable
ICD-9 Codes that Support Medical Necessity	788.31 Urge incontinence
Diagnosis that Support Medical Necessity	Not applicable
ICD-9 Codes that DO NOT Support Medical Necessity	Not applicable
Diagnosis that DO NOT Support Medical Necessity	Not applicable

Reasons for Denial	Sacral nerve stimulation will be denied for any patient not meeting the criteria in the Indications and Limitations section of this policy. Sacral nerve stimulation will be denied for any type of incontinence except urge incontinence that is not associated with a neurologic condition. Otherwise not covered
Non-Covered ICD-9 Code(s)	All codes not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy.
Non-Covered Diagnosis	All codes not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy.
Coding Guidelines	CPT codes 64575 and 64585 are mutually exclusive. If it is necessary to remove a neurostimulator electrode on the same day it was implanted, attach modifier –59 to the latter code. CPT codes 64590 and 64595 are mutually exclusive. If it is necessary to remove a neurostimulator generator on the same day it was implanted, attach modifier –59 to the latter code. This policy does not take precedence over the Correct Coding Initiative (CCI) and CCI does not interfere with Indications/Limitations or acceptable diagnoses specified.
Documentation Requirements	The required criteria list in Indications and Limitations of Coverage must be documented in the medical record for audit purposes.
Utilization Guidelines	Not applicable
Other Comments	
Sources of Information and Basis for Decision	1. Sacral Nerve Stimulation for the Treatment of Refractory Urinary Urge Incontinence. Schmidt, RA, Jones, U, Oleson, KA, et. al. Unpublished as of December, 1998. Submitted paper made available by Medtronic. 2. Sacral Nerve Root Neuromodulation: an Effective Treatment for Refractory Urge Incontinence. Shaker, HS, Hassouna, M. J. Urol., 1998; 159:1516-1519.

Advisory Committee Notes	Presented at the April 7, 1999 CAC meeting and pended awaiting CMD Steering Committee recommendations due to lack of urological representation. Presented at the August 11, 1999 meeting by urological guests. Item was pended at the request of the neurological representative for further research. Presented at the December 08, 1999 meeting and addressed by new urology representative who recommended waiting one year for more data. Presented at the December 13, 2000 and accepted.
Start Date of Comment Period	03/22/1999
End Date of Comment Period	12/13/2000
Start Date of Notice Period	07/01/2001
Revision History	

Disclaimer: "This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from urology and neurology."

Stereotactic Radiosurgery/Fractionated Stereotactic Radiotherapy

Policy Number: LA 2001-004

Contractor's Policy Number	LA 2001-004
Contractor Name	Louisiana - Arkansas B/S
Contractor Number	00528
Contractor Type	Carrier
LMRP Title	Stereotactic Radiosurgery/Fractionated Stereotactic Radiotherapy
AMA CPT Copyright Statement	"CPT codes, descriptions, and other data only are copyright 1999 American Medical Association (or such other date of publication of CPT). All Rights Reserved. Applicable FARS/DFARS Clauses Apply."
HCFA National Coverage Policy	Title XVIII of the Social Security Act, section 1862 (a)(7). This section excludes routine physical examinations and screening tests performed in the absence of signs or symptoms from coverage. Title XVIII of the Social Security Act, section 1862 (a)(1)(A). This section allows coverage and payment for only those services that are considered to be medically reasonable and necessary. Title XVIII of the Social Security Act, section 1833(e). This section prohibits Medicare payment of any claim which lacks the necessary information to process the claim.
Primary Geographic Jurisdiction	Louisiana
Secondary Geographic Jurisdiction	Not applicable
HCFA Region	Dallas
HCFA Consortium	Southern
Original Policy Effective Date	08/15/2001
Original Policy Ending Date	
Revision Effective Date	
Revision Ending Date	
LMRP Description	Stereotactic radiosurgery involves the delivery of a single high dose of radiation to usually a small defined volume of tissue. Fractionated stereotactic radiotherapy delivers a prescribed dose of radiation in a series of small doses over multiple treatments to frequently larger and/or multiple sites. The target(s) is localized by stereotactic

	methods and treatment is delivered by radiation beams over multiple arcs and planes or by use of static fields. Otherwise inaccessible areas can be treated and vital parts of the brain and normal tissue can be spared as dose specifications (isocenter and target volume) can be made. A variety of methods have been developed to provide a reference system for the localization study to determine the target coordinates and include both fixed frame and frameless systems, removable frame systems, and rigid masks. In one frameless system, three small gold filled titanium screws are placed in the skull and CT scans or angiography are obtained to localize the lesion and depict the tumor in three dimensions. Treatment can be repeated any number of times as the target is calculated from the position of the gold markers. Regardless of the number of sessions, these procedures consist of the following components: • Head position stabilization - (fixed or frameless system) • Imaging for localization (CT and/or MRI and/ or angiography, etc.) • Computer assisted tumor localization • Treatment planning - number of isocenters, number, placement and • Length of arcs, beam size and weight, etc. • Isodose distributions, dosage prescription and calculation • Setup and quality assurance testing • Simulation of prescribed arcs or fixed portals • Stereotactic intervention or treatment itself.
Indications and Limitations of Coverage and/or Medical Necessity	Stereotactic Radiosurgery/Fractionated Stereotactic Radiotherapy: Indications for stereotactic radiosurgery include: • Disabling symptomatology in trigeminal neuralgia and Parkinson's Disease which has become refractive to medical treatment. However, this type procedure is not allowed for pallidotomy to treat Parkinsonism (refer to "Stereotactic Pallidotomy" LMRP) • Primary central nervous system malignancies, generally under 4 cm. • Primary and secondary tumors of the skull base or nasopharyngeal malignancies • Benign brain tumors such as meningiomas and acoustic neuromas • Arteriovenous malformations and hemangiomas, not suited for other treatment modalities • Boost treatment for larger lesions that have been treated initially with external beam radiation therapy or surgery (ex.,

	grade III and IV gliomas, oligodendrogliomas, sarcomas, and chordomas) • Metastatic brain lesions, generally <4 in number, with exceptions for very slow growing malignancies. • Patients with excellent performance status whose systemic disease is controlled and who otherwise have long survival expectations • Relapse in a previously irradiated field with a time interval of at least 6 months from treatment of intracranial disease to recurrence
CPT/HCPCS Section & Benefit Category	Radiology; Surgery
Type of Bill Code	Not applicable
Revenue Codes	Not applicable
CPT/HCPCS Codes	20660 Apply,remove fixation device 61793 Focus radiation beam 61795 Brain surgery using computer 70552 Mri brain w/dye 70460 Ct head/brain w/dye 76355 CAT scan for localization 76370 CAT scan for therapy guide 76375 3d/holograph reconstr add-on 77261-77263 Radiation therapy planning 77280-77295 Set radiation therapy field 77300 Radiation therapy dose plan 77305-77315 Radiation therapy dose plan 77321 Radiation therapy port plan 77332-77334 Radiation treatment aid(s) 77336 Radiation physics consult 77370 Radiation physics consult 77412-77416 Radiation treatment delivery 77417 Radiology port film(s) 77427 Radiation tx management, x5 77432 Stereotactic radiation trmt 77470 Special radiation treatment
Not Otherwise Classified (NOC)	Not applicable
ICD-9 Codes that Support Medical Necessity	146.0-146.9 Malignant neoplasm of oropharynx 147.0-147.9 Malignant neoplasm of nasopharynx 160.3 Malignant neoplasm of ethmoidal sinus 191.0-191.9 Malignant neoplasm of brain 192.0-192.1 Malignant neoplasm of unspecified parts of nervous system 192.3 Malignant neoplasm of spinal meinges

	194.3 Malignant neoplasm of pituitary gland & craniopharyngeal duct 194.4 Malignant neoplasm of pineal gland 198.3-198.4 Secondary malignant neoplasm of brain and spinal cord 198.89 Secondary malignant neoplasm of other specified sites 225.0-225.2 Benign neoplasm of brain; up to cerebral meninges 227.3 Benign neoplasm of pituitary gland and craniopharyngeal duct 227.4 Craniopharyngeal neoplasms 227.6 Glomus jugulare 228.2 Hemangioma of intracranial structures 234. Neoplasms of uncertain behavior of pituitary gland and craniopharyngeal duct 237.5 Neoplasms of uncertain behavior of brain and spinal cord 237.1 Pineal gland neoplasm 237.3 Glomus neoplasm 239.6-239.7 Neoplasms of unspecified nature of brain, endocrine glands and other parts of nervous system 332.0 Parkinson's Disease 333.1 Essential tremors 350.1 Trigeminal neuralgia 747.81 Anomalies of cerebrovascular system
Diagnosis that Support Medical Necessity	Not applicable
ICD-9 Codes that DO NOT Support Medical Necessity	Not applicable
Diagnosis that DO NOT Support Medical Necessity	Not applicable
Reasons for Denial	Otherwise not covered This procedure is not indicated for: • Patients with a projected life span of less than 6 months and who have metastatic disease unless a justification acceptable to the Carrier is supplied. • Patients with wide-spread cerebral or extra-cranial metastases not responsive to systemic therapy • For pallidotomy for Parkinson's Disease
Non-Covered ICD-9 Code(s)	All codes not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy.

Non-Covered Diagnosis	All codes not listed in the "ICD-9 Codes That Support Medical Necessity" section of this policy.
Coding Guidelines	1. Consult current correct coding guidelines for applicable specific code combinations or reductions in payment due to specific codes billed. 2. The appropriate ICD-9 diagnosis code(s) must be submitted with each claim. 3. Stereotactic radiosurgery/radiotherapy can be performed in a properly licensed free-standing facility in addition to a hospital. 4. Gamma Knife Pallidotomy is never covered and will be denied. 5. All the components for these radiosurgery procedures have current CPT codes which need to be billed. 6. As these procedures often utilize a collegial approach, each provider must bill for the exact component performed. 7. As the services are collegial in nature with different specialties providing individual components of the treatment, assistants will not be reimbursed. 8. HCFA regulations do not permit modifiers 62 (co-surgeon) and 66 (team surgeons) for CPT 61793. 9. It is inappropriate for the same provider to bill the surgery codes (61793, 61795) in conjunction with the radiation codes (77xxx series). 10. CPT 61793 and 61795 are appropriate billings for the entire procedures described and should NOT be billed for each fraction of treatment. 11. CPT code 77432 is intended for a single session of treatment. However, if fractionated treatment is delivered, this code should be billed for the first session and after that CPT code 77427 should be billed for each additional five fractions of treatment. 12. Fractionated services of more than one session should follow the billing as outlined in item 11, that is, after the first treatment during which 77432 would be billed, then additional sessions would be billed under the weekly management code of 77427 which would be for each five fractions comprising one week of treatment. However, since a week of treatment has also bee defined as over three, then should the number of treatments be an odd number the weekly management code of 77427 would be billed for three to five fractions whereas no additional billing would be allowed for one to two additional fractions after the initial treatment that was billed under 77432.

	13. Billing for treatment planning, field setting, dosimetry, etc. should be done only once per treatment regime and not for each session unless the geometry or dose is modified. 14. It is appropriate to bill 20660 for the use of any type of stabilizing mask. However, for continuing radiation treatment a thermal plastic mask should be billed under 77334 which is the radiation oncology code for molds. 15. Services for continuing medical radiation physics consultation (77336) for hospital inpatients or outpatients are covered by Part A. In a free-standing radiation therapy center, the technical component may be billed for non-hospital patients whether the radiation physicist is employed by or contracts with the center. 16. CPT code 77370 is a technical only code similar to 77336 (see #15 above). It is not billable to Part B for hospital inpatients or outpatients. 17. CPT code 70552, one of CPT CT codes 70460, 76355, 76370) and 76375 (an add-on code) are appropriate for imaging services for which both MRI and CT are required for 3d reconstruction of both images together (image fusion).
Documentation Requirements	1. The patient's record must support the medical necessity and frequency of treatment. Medical records should include not only the standard history and physical but also the patient's functional status and a description of current performance status such as Karnofsky Performance Status. All documentation must be available upon request of the carrier. 2. ICD-9 code documentation supporting the medical necessity of this item, must be submitted with each claim. Claims submitted without such evidence will be denied as being not medically necessary. 3. No special requirements are necessary with electronic claims submission. If it is suspected that the claim will be denied, submit appropriate documentation (e.g., a history and physical exam and a cover letter describing the need for and the use of this test and its frequency) with a hard-copy claim.
Utilization Guidelines	Not applicable
Other Comments	
Sources of Information and Basis for Decision	1. Missouri local medical review policies 2. Adler, Joseph J., "Linear accelerator-based stereotaxic radiosurgery for brain metastases; the influence of number of lesions on survival" Journal of Clinical Oncology, April 1996,

	1085-92. 3. Alexander, E., et al., "Stereotactic radiosurgery for the definitive, Noninvasive treatment of brain metastases" Journal of National Cancer Inst., January 4, 1995, 34-40. 4. Friedman JH., et al., "Gamma knife pallidotomy in advanced Parkinson's disease", Annals of Neurology, April 1996, 535-8. 5. Gildengerg, Philip, MD., Ph,D., "Stereotactic Surgery; Applications in Neurologic Disease, Seminars in Neurology, volume 9, September 1989. 6. Kirkeby, OJ., "Fractionated stereotactic radiation therapy for intracranial arteriovenous malformations", Stereotactic and Functional Neurosurgery, 1996, 10-4. 7. Souhami, L., et al., "Fractionated stereotactic radiation therapy for intracranial tumors", Cancer, November 15, 1991, 2101-8.
Advisory Committee Notes	Presented at the April 4, 2001 meeting addressing the issue of stereotactic surgery versus open procedures.
Start Date of Comment Period	03/17/2001
End Date of Comment Period	05/15/2001
Start Date of Notice Period	07/01/2001
Revision History	

Disclaimer: "This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from radiation oncology and the PRO."

Urine, Bacterial Culture

Policy Number: LA-96-002

Description:

Analysis of the urine.

Policy Type:

Local medical necessity policy

HCPCS Section & Benefit Category:

Pathology and Laboratory

HCPCS Codes:

The following short descriptors are in accordance with the AMA copyright agreement. Please refer to the current CPT book for full descriptions.

87086	Urine culture/colony count
87087	Urine bacteria culture (deleted 12/31/2000)
87088	Urine bacteria culture

HCFA's National Policy:

Title XVIII of the Social Security Act, section 1862 (a)(7). This section excludes physical examinations.

Title XVIII of the Social Security Act, section 1862 (a) (1) (A). This section allows coverage and payment for only those services are considered to be medically reasonable and necessary.

Indications & Limitations Of Coverage And/Or Medical Necessity:

A urine culture will be considered medically necessary if one of the following criteria is met:

a. A patient's urinalysis is abnormal suggesting urinary tract infection, e.g., hematuria (599.7), pyuria (599.0), proteinuria (791.0);

b. A patient has clinical symptoms indicative of a possible urinary tract infection;

c. The urine culture is being done to follow-up on a previously treated urinary tract infection to confirm the effectiveness of the therapy; or

d. The patient is being evaluated for fever of unknown origin (780.6) or suspected septicemia (038._).

ICD-9 Codes That Support Medical Necessity:

038.0-038.9, 580.0-580.9, 581.0-581.9, 582.0-582.9, 583.0-583.9, 584.5-584.9, 585, 586, 587, 588.0-588.9, 589.0-589.9, 590.0-590.9, 591, 592.0-592.9, 593.0-593.9, 594.0-594.9, 595.0-595.9, 596.0-596.9, 597.0-597.89, 598.0-598.9, 599.0-599.9, 600.0, 600.1, 600.2, 600.3, 600.9, 600 (deleted 01/01/2001), 601.0-601.9, 602.0-602.9, 603.0-603.9, 604.0-604.99, 605, 606.0-606.9, 607.607.9, 608.0-608.9, 780.6, 788.0-788.9, 790.7, 791.0, 791.7

Reasons For Denial:

When the claim lacks diagnosis documentation to support the medical necessity:

- For screening or as part of a routine examination; V72.84 is a screening diagnosis and is not covered (08/15/2001).
- Components for the panels may not be billed separately on the same date of service as a panel test.

Non-Covered Diagnosis Codes:

All others not listed above.

Sources Of Information:

1. Palmetto Government Benefits
2. Diagnostic Tests Handbook, Springhouse Corporation, 1987, pp. 409-1 0. 1996 CPT Book, American Medical Association.
3. Other Carrier's Local Medical Review Policies.

Coding Guidelines:

This policy does not take precedence over the Correct Coding Initiative (CCI) and CCI does not interfere with INDICATIONS/LIMITATIONS or acceptable diagnoses specified.

Documentation Required:

Documentation supporting the medical necessity of this item, such as ICD-9 codes, must be submitted with each claim. Claims submitted without such evidence will be denied as not being medically necessary.

Other Comments:

CAC Notes:

This policy does not reflect the sole opinion of the carrier or Carrier Medical Director. Although the final decision rests with the carrier, this policy was developed in cooperation with the Carrier Advisory Committee, which includes representatives from all recognized specialty societies within the state.

Start Date Of Comment Period:

May 29, 1996

Start Date Of Notice Period:

February 2001
August 15, 1996

Presented To CAC:

June 1996

Original Effective Date:

September 15, 1996

Revision Date:

Providers' News:

MCB 2001-01
LA 96-04

Medicare Provider News Policy Notice is published three times a year by Medicare Services. It provides billing and coverage information to providers whose patients are covered under Medicare Part B.

Medicare Provider News serves as legal notice to providers concerning responsibilities and requirements imposed upon them by Medicare law, regulations and guidelines.

Editor: Scott Thier, Missouri

Medicare Services
P.O. Box 83860
Baton Rouge, LA 70884-3860
A HCFA Contracted Carrier

ATTN: BILLING MANAGER