CMS National Coverage Policy
Title XVIII of the Social Security Act, §1862 (a)(1)(A) allows coverage and payment for only those services that are considered to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Printed on 12/13/2012. Page 1 of 11
Title XVIII of the Social Security Act, §1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

21 CFR Chapter 1, Subchapter H, Part 888 orthopedic devices, arthroscope

42 CFR §482.24 documentation for medical records

CMS Manual Systems, Pub 100-08, Medicare Integrity Manual, Chapter 6, §6.5.2

CMS Manual Systems, Pub 100-08, Medicare Integrity Manual, Chapter 13, §3.4.1.3

Indications and Limitations of Coverage and/or Medical Necessity

Joint replacement surgery has been performed on millions of people over the past several decades and has proved to be an important medical advancement in the field of orthopedic surgery. The hip and knee are the two most commonly replaced joints. The knee is the largest joint in the body and includes the lower end of the femur, the upper end of the tibia and the patella. The knee joint has three compartments, the medial, the lateral and the patellofemoral. The surfaces of these compartments are covered with articular cartilage and are bathed in synovial fluid. The bones of the knee joint work together, allowing the knee to function smoothly. The hip is a large weight bearing joint made up of two components: a ball (femoral head) and socket (acetabulum). These components are covered with articular cartilage and are bathed in synovial fluid produced by a synovial membrane.

The most common reason for total knee replacement surgery is arthritis of the knee joint. Types of arthritis include,

- osteoarthritis,
- rheumatoid arthritis and
- traumatic arthritis (arthritis which occurs as a result of injury).

Arthritis causes a severe limitation in the activities of daily living, including difficulty with walking, squatting, and climbing stairs. Pain is typically most severe with activity and patients often have difficulty getting mobilized when seated for a long time. Other findings include chronic knee inflammation or swelling not relieved by rest, knee stiffness, lack of pain relief after taking non-steroidal anti-inflammatory medications and failure to achieve symptom improvement with other conservative therapies such as steroid injections and physical therapy.

Osteonecrosis and malignancy are additional reasons to proceed with total knee replacement surgery. The use of TKR in patients with malignancy must be weighed against considerations of life expectancy and possible alternative procedures to relieve pain. The goal of total knee replacement surgery is to relieve pain and improve or increase patient function.

Total hip replacement surgery is most often performed due to severe pain caused by osteoarthritis of the hip joint. Rheumatoid arthritis, traumatic arthritis, malignancy involving the hip joint and osteonecrosis of the femoral head are also causes for hip replacement surgery. The use of THR in patients with malignancy must be weighed against considerations of life expectancy and possible alternative procedures to relieve pain. The pain from the damaged joint usually limits activities of daily living, such as walking, bathing and cooking. The pain can also cause disruption of sleep due to the inability to lie on the hip while in bed. Pain relief not achieved by taking non-steroidal anti-inflammatory medications and failure to achieve symptom improvement with other conservative therapies such as physical therapy, activity modification and (in some patients) assistive device use are reasons for proceeding with a total hip replacement. The goal of total hip replacement surgery is to relieve pain and improve or increase patient function. Occasionally, there may be a need to perform a reoperation on a previous total hip or total knee replacement. This is often referred to as a revision total knee or revision total hip. Circumstances that lead to the need for a revision total hip or knee are continued disabling pain, continued decline in function which can be attributed to failure of the primary joint replacement. Failure can be due to infection involving the joint, substantial bone loss in the structures supporting the prosthesis, fracture, aseptic loosening of the components and wear of the prosthetic components.

**Total Knee Arthroplasty (TKA)**

**Indications**
Palmetto GBA will consider total knee replacement surgery medically necessary when one or more of the following criteria* are met:

Advanced joint disease demonstrated by:

- Radiographic supported evidence or when conventional radiography is not adequate, magnetic resonance imaging (MRI) supported evidence (subchondral cysts, subchondral sclerosis, periarticular osteophytes, joint subluxation, joint space narrowing, avascular necrosis); and
- Pain or functional disability from injury due to trauma or arthritis of the joint; and
- If appropriate, history of unsuccessful conservative therapy (non-surgical medical management) that is clearly addressed in the pre procedure medical record. (If conservative therapy is not appropriate, the medical record must clearly document why such approach is not reasonable); or
- Failure of a previous osteotomy; or
- Distal femur fracture; or
- Malignancy of the distal femur, proximal tibia, knee joint or adjacent soft tissues; or
- Failure of previous unicompartmental knee replacement; or
- Avascular necrosis of the knee; or
- Proximal tibia fracture

*See Documentation Requirements section for additional information

Non surgical medical management is usually but not always implemented prior to scheduling total joint surgery. Non-surgical treatment as clinically appropriate for the patient’s current episode of care typically includes one or more of the following:

- anti-inflammatory medications, analgesics,
- flexibility and muscle strengthening exercises,
- supervised physical therapy [Activities of daily living (ADLs), diminished despite completing a plan of care],
- assistive device use,
- weight reduction as appropriate, or
- therapeutic injections into the knee as appropriate.

In some circumstances, for example, if the patient has bone on bone articulation, severe deformity, or pain and significant disabling interference with activities of daily living, the surgeon may determine that nonsurgical medical management would be ineffective or counterproductive, and that the best treatment option, after explaining the risks, is surgical. If medical management is deemed inappropriate, the medical record should indicate the rationale for and circumstances under which this is the case.

Indications for Replacement/Revision of Total Knee Arthroplasty

- Loosening of one or more components, or
- Fracture or mechanical failure of one or more component, or
- Infection, or
- Treatment of periprosthetic fracture of distal femur, proximal tibia or patella, or
- Progressive or substantial periprosthetic bone loss, or
- Bearing surface wear leading to symptomatic synovitis, or
- Implant or knee misalignment, or
- Knee stiffness/arthrofibrosis, or
- Tibiofemoral instability, or
Extensor mechanism instability

**Total Hip Arthroplasty (THA)**

Palmetto GBA will consider total hip replacement surgery medically necessary when one or more of the following criteria* are met:

Advance joint disease demonstrated by:

- Radiographic supported evidence or when conventional radiography is not adequate, magnetic resonance imaging (MRI) supported evidence (subchondral cysts, subchondral sclerosis, periarticular osteophytes, joint subluxation, joint space narrowing, avascular necrosis); and
- Pain or functional disability from injury due to trauma or arthritis of the joint; and
- If appropriate, history of unsuccessful conservative therapy (non-surgical medical management) that is clearly addressed in the pre procedure medical record. *(If conservative therapy is not appropriate, the medical record must clearly document the rationale for why such approach is not reasonable)*; or
- Malignancy of the joint involving the bones or soft tissues of the pelvis or proximal femur; or
- Avascular necrosis (osteonecrosis of femoral head); or
- Fracture of the femoral neck; or
- Acetabular fracture; or
- Non-union or failure of previous hip fracture surgery; or
- Mal-union of acetabular or proximal femur fracture

*See Documentation Requirements for additional information

Non-surgical medical management is usually but not always implemented prior to scheduling total joint surgery. Non-surgical treatment as clinically appropriate for the patient’s current episode of care typically includes one or more of the following:

- anti-inflammatory medications or analgesics,
- flexibility and muscle strengthening exercises,
- supervised physical therapy [Activities of daily living (ADLs) diminished despite completing a plan of care],
- assistive device use,
- weight reduction as appropriate, or
- therapeutic injections into the hip as appropriate

**Indications for Replacement/Revision of Total Hip Arthroplasty**

- Loosening of one or both components; or
- Fracture or mechanical failure of the implant; or
- Recurrent or irreducible dislocation; or
- Infection; or
- Treatment of a displaced periprosthetic fracture; or
- Clinically significant leg length inequality not amenable to conservative management; or
- Progressive or substantial bone loss; or
- Bearing surface wear leading to symptomatic synovitis or local bone or soft tissue reaction
- Clinically significant audible noise; or
- Adverse local tissue reaction

**Limitations**

Palmetto GBA will not consider a total knee replacement or total hip replacement medically necessary when the following contraindications are present:
Active infection of the hip or knee joint or active systemic bacteremia

Active skin infection (exception recurrent cutaneous staph infections) or open wound within the planned surgical site of the hip or knee

Rapidly progressive neurological disease except in the clinical situation of a concomitant displaced femoral neck fracture

Absence or relative insufficiency of abductor musculature

Any process that is rapidly destroying bone

neurotrophic arthritis

This local coverage determination (LCD) is only addressing medical necessity criteria for performing total hip and knee replacement surgery. With respect to knee replacement surgery, there is a form of knee joint replacement surgery called unicompartmental knee replacement. This is typically done for patients with osteoarthritis of the knee in which the damage is contained to one compartment of the knee. The indications outlined in this LCD are not to be applied for unicompartmental knee replacement surgery. Failed previous unicompartmental joint replacement is an indication for performing a total knee arthroplasty.

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

011x Hospital Inpatient (Including Medicare Part A)
085x Critical Access Hospital

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

0360 Operating Room Services - General Classification

CPT/HCPCS Codes

Total Hip Replacement

27130 ARTHROPLASTY, ACETABULAR AND PROXIMAL FEMORAL PROSTHETIC REPLACEMENT (TOTAL HIP ARTHROPLASTY), WITH OR WITHOUT AUTOGRRAFT OR ALLOGRAFT

27132 CONVERSION OF PREVIOUS HIP SURGERY TO TOTAL HIP ARTHROPLASTY, WITH OR WITHOUT AUTOGRRAFT OR ALLOGRAFT

27134 REVISION OF TOTAL HIP ARTHROPLASTY; BOTH COMPONENTS, WITH OR WITHOUT AUTOGRRAFT OR ALLOGRAFT

27137 REVISION OF TOTAL HIP ARTHROPLASTY; ACETABULAR COMPONENT ONLY, WITH OR WITHOUT AUTOGRRAFT OR ALLOGRAFT

Printed on 12/13/2012. Page 5 of 11
27138 REVISION OF TOTAL HIP ARTHROPLASTY; FEMORAL COMPONENT ONLY, WITH OR WITHOUT ALLOGRAFT

Total Knee Replacement
27445 ARTHROPLASTY, KNEE, HINGE PROSTHESIS (EG, WALLDIUS TYPE)
27447 ARTHROPLASTY, KNEE, CONDYLE AND PLATEAU; MEDIAL AND LATERAL COMPARTMENTS WITH OR WITHOUT PATELLA RESURFACING (TOTAL KNEE ARTHROPLASTY)
27486 REVISION OF TOTAL KNEE ARTHROPLASTY, WITH OR WITHOUT ALLOGRAFT; 1 COMPONENT
27487 REVISION OF TOTAL KNEE ARTHROPLASTY, WITH OR WITHOUT ALLOGRAFT; FEMORAL AND ENTIRE TIBIAL COMPONENT

ICD-9 Codes that Support Medical Necessity
ICD-9CM diagnosis codes for Total Hip Arthroplasty
170.7 MALIGNANT NEOPLASM OF LONG BONES OF LOWER LIMB
171.3 MALIGNANT NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE OF LOWER LIMB INCLUDING HIP
213.7 BENIGN NEOPLASM OF LONG BONES OF LOWER LIMB
215.3 OTHER BENIGN NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE OF LOWER LIMB INCLUDING HIP
696.0 PSORIATIC ARTHROPATHY
714.0 RHEUMATOID ARTHRITIS
714.1 FELTY’S SYNDROME
714.30 CHRONIC OR UNSPECIFIED POLYARTICULAR JUVENILE RHEUMATOID ARTHRITIS
714.31 ACUTE POLYARTICULAR JUVENILE RHEUMATOID ARTHRITIS
714.32 PAUCIARTICULAR JUVENILE RHEUMATOID ARTHRITIS
714.33 MONOARTICULAR JUVENILE RHEUMATOID ARTHRITIS
714.4 CHRONIC POSTRHEUMATIC ARTHROPATHY
715.15 OSTEOARTHRITIS LOCALIZED PRIMARY INVOLVING PELVIC REGION AND THIGH
715.25 OSTEOARTHRITIS LOCALIZED SECONDARY INVOLVING PELVIC REGION AND THIGH
715.35 OSTEOARTHRITIS LOCALIZED NOT SPECIFIED WHETHER PRIMARY OR SECONDARY INVOLVING PELVIC REGION AND THIGH
715.95 OSTEOARTHRITIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED INVOLVING PELVIC REGION AND THIGH
716.15 TRAUMATIC ARTHROPATHY INVOLVING PELVIC REGION AND THIGH
716.55 UNSPECIFIED POLYARTHROPATHY OR POLYARTHRITIS INVOLVING PELVIC REGION AND THIGH
716.65 UNSPECIFIED MONOARTHRITIS INVOLVING PELVIC REGION AND THIGH
716.85 OTHER SPECIFIED ARTHROPATHY INVOLVING PELVIC REGION AND THIGH
718.55 ANKYLOSIS OF JOINT OF PELVIC REGION AND THIGH
718.65 UNSPECIFIED INTRAPELVIC PROTRUSION OF ACETABULUM PELVIC REGION AND THIGH
718.85 OTHER JOINT DERANGEMENT NOT ELSEWHERE CLASSIFIED INVOLVING PELVIC REGION AND THIGH
719.35 PALINDROMIC RHEUMATISM INVOLVING PELVIC REGION AND THIGH
719.45 PAIN IN JOINT INVOLVING PELVIC REGION AND THIGH
731.0 OSSEITIS DEFORMANS WITHOUT BONE TUMOR
733.14 PATHOLOGICAL FRACTURE OF NECK OF FEMUR
733.42 ASEPTIC NECROSIS OF HEAD AND NECK OF FEMUR
733.82 NONUNION OF FRACTURE
733.96 STRESS FRACTURE OF FEMORAL NECK
754.30 CONGENITAL DISLOCATION OF HIP UNILATERAL
755.63 OTHER CONGENITAL DEFORMITY OF HIP (JOINT)
808.0 CLOSED FRACTURE OF ACETABULUM
808.1 OPEN FRACTURE OF ACETABULUM
820.00 FRACTURE OF UNSPECIFIED INTRACAPSULAR SECTION OF NECK OF FEMUR CLOSED
820.01 FRACTURE OF EPIPHYSIS (SEPARATION) (UPPER) OF NECK OF FEMUR CLOSED
820.02 FRACTURE OF MIDCERVICAL SECTION OF FEMUR CLOSED
820.03 FRACTURE OF BASE OF NECK OF FEMUR CLOSED
820.09 OTHER TRANSCERVICAL FRACTURE OF FEMUR CLOSED
820.10 FRACTURE OF UNSPECIFIED INTRACAPSULAR SECTION OF NECK OF FEMUR OPEN
820.11 FRACTURE OF EPIPHYSIS (SEPARATION) (UPPER) OF NECK OF FEMUR OPEN
820.12 FRACTURE OF MIDCERVICAL SECTION OF FEMUR OPEN
820.13 FRACTURE OF BASE OF NECK OF FEMUR OPEN
820.19 OTHER TRANSCERVICAL FRACTURE OF FEMUR OPEN
820.20 FRACTURE OF UNSPECIFIED TROCHANTERIC SECTION OF FEMUR CLOSED
820.21 FRACTURE OF INTERTROCHANTERIC SECTION OF FEMUR CLOSED
820.22 FRACTURE OF SUBTROCHANTERIC SECTION OF FEMUR CLOSED
820.30 FRACTURE OF UNSPECIFIED TROCHANTERIC SECTION OF FEMUR OPEN
820.31 FRACTURE OF INTERTROCHANTERIC SECTION OF FEMUR OPEN
820.32 FRACTURE OF SUBTROCHANTERIC SECTION OF FEMUR OPEN
820.8 FRACTURE OF UNSPECIFIED PART OF NECK OF FEMUR CLOSED
820.9 FRACTURE OF UNSPECIFIED PART OF NECK OF FEMUR OPEN
996.41 MECHANICAL LOOSENING OF PROSTHETIC JOINT
996.42 DISLOCATION OF PROSTHETIC JOINT
996.43 BROKEN PROSTHETIC JOINT IMPLANT
996.44 PERI-PROSTHETIC FRACTURE AROUND PROSTHETIC JOINT
996.45 PERI-PROSTHETIC OSTEOLYSIS
996.46 ARTICULAR BEARING SURFACE WEAR OF PROSTHETIC JOINT
996.47 OTHER MECHANICAL COMPLICATION OF PROSTHETIC JOINT IMPLANT

V43.64* HIP JOINT REPLACEMENT
*ICD-9-CM code V43.64 should not be used as a primary diagnosis code when billing for a total hip replacement. It should be used in conjunction with a diagnosis code found in group 996.41-996.47.

ICD-9 CM diagnosis codes for Total Knee Arthroplasty

170.7 MALIGNANT NEOPLASM OF LONG BONES OF LOWER LIMB
171.3 MALIGNANT NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE OF LOWER LIMB INCLUDING HIP
213.7 BENIGN NEOPLASM OF LONG BONES OF LOWER LIMB
215.3 OTHER BENIGN NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE OF LOWER LIMB INCLUDING HIP

714.0 RHEUMATOID ARTHRITIS
715.16 OSTEOARTHROSIS LOCALIZED PRIMARY INVOLVING LOWER LEG
715.26 OSTEOARTHROSIS LOCALIZED SECONDARY INVOLVING LOWER LEG
715.36 OSTEOARTHROSIS LOCALIZED NOT SPECIFIED WHETHER PRIMARY OR SECONDARY INVOLVING LOWER LEG
715.96 OSTEOARTHROSIS UNSPECIFIED WHETHER GENERALIZED OR LOCALIZED INVOLVING LOWER LEG
716.16 TRAUMATIC ARTHROPATHY INVOLVING LOWER LEG
718.56 ANKYLOSIS OF LOWER LEG JOINT
718.86 OTHER JOINT DERANGEMENT NOT ELSEWHERE CLASSIFIED INVOLVING LOWER LEG
719.46 PAIN IN JOINT INVOLVING LOWER LEG
733.43 ASEPTIC NECROSIS OF MEDIAL FEMORAL CONDYLE
996.41 MECHANICAL LOOSENING OF PROSTHETIC JOINT
996.42 DISLOCATION OF PROSTHETIC JOINT
996.43 BROKEN PROSTHETIC JOINT IMPLANT
996.44 PERI-PROSTHETIC FRACTURE AROUND PROSTHETIC JOINT
996.45 PERI-PROSTHETIC OSTEOLYSIS
996.46 ARTICULAR BEARING SURFACE WEAR OF PROSTHETIC JOINT
996.47 OTHER MECHANICAL COMPLICATION OF PROSTHETIC JOINT IMPLANT
996.66 INFECTION AND INFLAMMATORY REACTION DUE TO INTERNAL JOINT PROSTHESIS

V43.65* KNEE JOINT REPLACEMENT
*ICD-9-CM code V43.65 should not be used as a primary diagnosis code when billing for a total hip replacement. It should be used in conjunction with a diagnosis code found in group 996.41-996.47.

Diagnoses that support medical necessity

ICD-9 Codes that DO NOT Support Medical Necessity

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

Back to Top

General Information

Printed on 12/13/2012. Page 7 of 11
Documentations Requirements

In order to qualify for coverage of both Medicare Part A inpatient services and Part B provider services the medical record must contain documentation that fully supports the medical necessity and justification of the procedure performed and must be made available to Palmetto GBA upon request. When the documentation does not meet the criteria for the service(s) rendered or the documentation does not establish the medical necessity for the service(s), such service(s) will be denied as not reasonable and necessary under Section 1862(a)(1)(A) of the Social Security Act.

A history and physical, discharge summary, physician progress notes and an operative report are typically in the hospital record for the procedures in this LCD. Other relevant information addressing coverage criteria related to the patient’s episode of care prior to the hospitalization, should be included in the hospital record (see below). Failure to include this information in the hospital record may result in denial of coverage for Part A services and trigger a review of the Part B provider claim to determine whether the Part B service rendered was reasonable and necessary.

When the procedure is indicated for advanced joint disease, the following should be documented in the medical record:

- Arthritis of the knee or hip supported by X-ray or MRI. The X-ray or MRI should demonstrate one of the following:
  - subchondral cysts,
  - subchondral sclerosis,
  - periarticular osteophytes,
  - joint subluxation,
  - joint space narrowing,
  - avascular necrosis or
  - bone on bone articulations

- Pain or functional disability at the hip or knee. For example, documented pain that interferes with ADLs (functional disability), or pain that is increased with initiation of activities or pain that increases with weight bearing.
- Unsuccessful conservative therapy (non-surgical medical management) if appropriate. The documentation should demonstrate a history of a reasonable attempt at conservative therapy as appropriate for the patient in their current episode of care. For example, documented trial of NSAIDs or contraindication to such therapy and/or documented supervised physical therapy. Documentation should support that ADLs are diminished due to pain and/or disability despite non-surgical medical management.
- For patients with significant conditions or co-morbidities, the risk/benefit of non-cardiac surgery, such as TKA or THA should be appropriately addressed in the medical record.

Medical record documentation for other TKA and THA indications outlined in the LCD should include the following, when indicated:

- Supporting evidence (e.g., pathology reports and referral from an Oncologist for a malignancy of the joint or X-ray of a fracture).
- Pain at the hip or knee when indicated as a reason for the procedure (e.g., for revision/replacement TKA/THA). For example, documented pain that interferes with ADLs (functional disability), pain that is increased with initiation of activities or pain that increases with weight bearing.
- For patients with significant conditions or co-morbidities, the risk/benefit of non-cardiac surgery, such as TKA or THA should be appropriately addressed in the medical record.
• When infection is the reason for revision TKA or THA surgery, laboratory and/or pathology reports must be in the medical record and all documentation regarding treatment of the infection and a physician note indicating that it is appropriate to proceed with surgery should be in the medical record as well.

In the instance that the patient is undergoing a bilateral knee or hip replacement, all criteria listed above would apply to the bilateral surgery when indicated. The medical record should also support the medical necessity for performing a bilateral THA or TKA.

The treating physician must discuss the significant benefit and risks with the patient. In order to meet Medicare’s reasonable and necessary (R&N) threshold for coverage of a procedure, the physician’s documentation for the case should clearly support both the diagnostic criteria for the indication (standard test results and/or clinical findings as applicable) and the medical need (the procedure does not exceed the medical need and is at least as beneficial as existing alternatives & the procedure is furnished with accepted standards of medical practice in a setting appropriate for the patient’s medical needs and condition). Lack of compelling arguments for an exception in the supporting documentation, the hospital (FISS claim) and physician services (MCS claim) can be denied.

If in certain circumstances the patient does not meet all of the required criteria outlined in the local coverage determination (LCD) for a procedure, but the treating physician feels that the procedure is covered, the documentation must clearly outline the patient’s episode of care that supports the major procedure and must clearly address the reason(s) for coverage. For example, if clinical findings (or lack of) for an indication are not consistent with the LCD criteria, it should be directly addressed in the pre procedure documentation. For example, if certain conservative measures are not necessary or appropriate for a given patient, it should be directly noted in the pre procedure documentation. The clinical judgment of the treating physician is always a consideration if clearly addressed in the pre procedure record and if consistent with the episode of care for the patient as documented in patient records and claim history.

When reviewing claims for procedures with DRGs, the CMS Online Manual, Pub 100-08, Chapter 6, §6.5.2 states the following:

Review of the medical record must indicate that inpatient hospital care was medically necessary, reasonable, and appropriate for the diagnosis and condition of the beneficiary at any time during the stay. The beneficiary must demonstrate signs and/or symptoms severe enough to warrant the need for medical care and must receive services of such intensity that they can be furnished safely and effectively only on an inpatient basis.

Appendices N/A

Utilization Guidelines It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters they may be subject to review for medical necessity.

The devices/implants utilized for total knee and total hip replacement surgeries are regulated by the FDA as medical devices. The devices used should be class II or class III devices that meet the requirements outlined in CFR 21, Chapter 1, subchapter H, Part 888 (http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.cfm?CFRPart=888)

The CMS Manual System, Pub. 100-08, Program Integrity Manual, Chapter 13, Section 5.1 (http://www.cms.hhs.gov/manuals/downloads/pim83c13.pdf) outlines that “reasonable and necessary” services are “ordered and/or furnished by qualified personnel.” Services will be considered medically reasonable and necessary only if performed by appropriately trained providers. This training and expertise must have been acquired within the framework of an accredited residency and/or fellowship program in the applicable specialty/subspecialty or must reflect extensive continued medical education activities. If these skills have been acquired by way of continued medical education, the courses must be comprehensive, offered or sponsored or endorsed by an academic institution in the United States and/or by the applicable specialty/subspecialty society in the United States, and designated by the American Medical Association (AMA) as Category 1 Credit.

Sources of Information and Basis for Decision
Ackerman, I. et.al. (2011). Decline in health-related quality of life reported by more than half of those waiting for joint replacement surgery: a prospective cohort study. BMC Musculoskeletal Disorders 12:108


InterQual® 2011 Procedures Adult Criteria, Total Joint Replacement, Knee and Hip & Removal and Replacement, Total Joint Replacement Knee and Hip. McKesson Corporation.


Advisory Committee Meeting Notes 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 include representatives from the affected provider community.

Contractor Advisory Committee meeting dates:
South Carolina-01/08/2013
North Carolina-01/08/2013
Virginia-01/08/2013
West Virginia-01/08/2013

Start Date of Comment Period 01/08/2013
End Date of Comment Period 02/25/2013
Start Date of Notice Period
Revision History Number
Revision History Explanation
Reason for Change Other

Related Documents
This LCD has no Related Documents.

LCD Attachments
There are no attachments for this LCD.

Draft Contact
Barbara Beeler, MD

Printed on 12/13/2012. Page 10 of 11
Local Coverage Determination (LCD) for Infrared Coagulation (IRC) of Hemorrhoids (L31554)

Contractor Information
Contractor Name
Palmetto GBA opens in new window
Contractor Number
11501
Contractor Type
MAC - Part A

LCD Information
Document Information
LCD ID Number
L31554

LCD Title
Infrared Coagulation (IRC) of Hemorrhoids

Contractor's Determination Number
J11A-11-010-L

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Original Determination Effective Date
For services performed on or after 01/24/2011

Original Determination Ending Date

Revision Effective Date
For services performed on or after 09/27/2012

Revision Ending Date

Language quoted from CMS National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the LCD Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act, §1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

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

42 CFR §409 et al are the Medicare Program Prospective Payment System for Hospital Outpatient Services Final Rule published in the FR Vol.65, No.68, April 7, 2000.

CMS Internet only manuals 100-02, Medicare Claims Processing Manual, chapter 15,§26.0-260.53

Printed on 12/5/2012. Page 1 of 7
Abstract

Hemorrhoids account for significant morbidity in the United States population. Approximately 4% of the general population and 50% of Americans over the age of 50 years are symptomatic. Engorgement or enlargement of these normal fibrovascular cushions is thought to be caused by increased pressure in the anal canal. Common sources of pressure that may contribute to hemorrhoids include constipation, straining with defecation, diarrhea, sitting or standing for long periods, obesity, heavy lifting, pregnancy, and childbirth.

A precise definition of hemorrhoids does not exist because the exact nature of the condition is not completely understood. Recent concepts of the pathophysiology of hemorrhoids have revealed that hemorrhoids are not varicosities; instead they are vascular cushions composed of arterioles, venules, and arteriolar-venular communications that slide down or prolapse, become congested and enlarged, and bleed. Three cushions lie in the following constant sites: left lateral; right anterolateral; and right posterolateral. Smaller discrete secondary cushions may be present between the main cushions. These cushions are present at birth and represent a normal anatomic feature of the anal canal. Therefore, the term “hemorrhoids” should refer to symptomatic abnormalities of the normal vascular hemorrhoidal tissue of the anal canal. In the absence of symptoms, the presence of even very large cushions is not an indication for treatment.

Hemorrhoids can be divided into those originating above the dentate line (internal) and those originating below the dentate line (external). This anatomic “border” is of special interest because external pain fibers end at the dentate line and most people have no sensation above this line. External hemorrhoids are rarely symptomatic unless thrombosed. Internal hemorrhoids are classified by history, symptomatology, and physical examination. They are graded as follows:

- Grade I – bleeding without prolapse;
- Grade II – prolapse with spontaneous reduction;
- Grade III – prolapse with manual reduction;
- Grade IV – incarcerated, irreducible prolapse.

Initial treatment for chronic symptoms of hemorrhoidal disease should be conservative, and typically includes lifestyle changes such as a high fiber diet, additional fiber supplements, and increased water intake. If symptoms persist in spite of conservative therapy in patients with Grade I, II, or III disease, local treatment is appropriate in the form of infrared coagulation (IRC), local sclerosing injection, or rubber band ligation (RBL). Operative treatment is reserved for symptomatic patients with Grade III or IV hemorrhoids.

The underlying goal of nonsurgical therapy is fixation of the hemorrhoidal cushion. The most common methods currently being employed are injection sclerotherapy, rubber band ligation, and infrared photocoagulation. A number of studies have demonstrated that IRC and RBL demonstrate comparable efficacy. However, treatment options are individualized as RBL is more likely to be associated with pain and potential complications, whereas IRC may require additional treatment sessions for recurrence of symptoms. The choice of treatment should be individualized based on patient preference and operator experience.
Infrared photocoagulation is indicated for the outpatient treatment of Grade I and II internal hemorrhoids. IRC may occasionally be utilized for Grade III internal hemorrhoids. Photocoagulation relies on tissue coagulation by infrared radiation, with tissue destruction limited to the depth of 3 mm. Many studies have demonstrated that IRC relieves symptoms with success rates comparable to alternatives. Further, the ease and rapidity of administration without side effects are considered by some authors to outweigh the possible need for repeat IRC treatments. This local coverage determination discusses medically necessary indications and limitations for infrared coagulation (IRC) of hemorrhoids.

**Indications and Limitations:**

Initial treatment for chronic symptoms of hemorrhoidal disease should include conservative treatment and typically begins with lifestyle changes such as a high fiber diet, fiber supplements, and increased water intake. At least six weeks may be required for significant improvement. Conservative treatment should continue even if a procedure is required.

Infrared coagulation is considered reasonable and necessary for patients with symptomatic Grade I or Grade II internal hemorrhoids that have not responded to conservative treatment. The most common symptoms are bleeding and prolapse. IRC may occasionally be utilized for symptomatic Grade III internal hemorrhoids.

Although IRC has thus far shown to have less morbidity than RBL, most studies also show that additional treatment is more likely to be required in some patients, particularly those with Grade II or III hemorrhoids. Payment will only be allowed for a physician or group once per patient per global period (90 days), no matter how many IRC treatment sessions occur. In addition, if IRC treatment has not satisfactorily resolved symptoms, then another method of treatment should be used. Payment for IRC will not be made more than twice per patient in the initial treatment episode subject to the 90-day global period restriction episode. (For subsequent treatment, please see the next paragraph.) Please see the IRC Supplemental Instructions Article (SIA) for additional coding and billing guidelines.

If the hemorrhoids recur and require treatment beyond conservative therapy, payment for IRC or another non-operative or operative treatment may be made. The medical literature has scant information regarding the long-term outcome for IRC. However, 80 – 90% of patients having rubber band ligation have reported themselves cured or greatly improved five years after rubber band ligation. Therefore, Medicare would not expect to see requests for repeat IRC payment until years after the initial treatment period and for only a minority of patients.

**Other Comments:**

Limitation of liability and refund requirements apply when denials are likely, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.

For outpatient settings other than CORFs, references to "physicians" throughout this policy include non-physicians, such as nurse practitioners, clinical nurse specialists and physician assistants. Such non-physician practitioners, with certain exceptions, may certify, order and establish the plan of care as authorized by State law. [See Sections 1861(s)(2) and 1862(a)(14) of Title XVIII of the Social Security Act; 42 CFR, Sections 410.74, 410.75, 410.76 and 419.22; 58 FR 18543, April 7, 2000.]

**Coding Information**

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

011x Hospital Inpatient (Including Medicare Part A)
012x Hospital Inpatient (Medicare Part B only)
013x Hospital Outpatient
Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

All revenue codes billed on the inpatient claim for the dates of service in question may be subject to review.

0360 Operating Room Services - General Classification
0361 Operating Room Services - Minor Surgery
0369 Operating Room Services - Other OR Services
0510 Clinic - General Classification
0517 Clinic - Family Practice Clinic
0519 Clinic - Other Clinic
0520 Free-Standing Clinic - General Classification
0521 Free-Standing Clinic - Clinic Visit by Member to RHC/FQHC
0523 Free-Standing Clinic - Family Practice Clinic
0529 Free-Standing Clinic - Other Freestanding Clinic

CPT/HCPCS Codes

46930 DESTRUCTION OF INTERNAL HEMORRHOID(S) BY THERMAL ENERGY (EG, INFRARED COAGULATION, CAUTERY, RADIOFREQUENCY)

ICD-9 Codes that Support Medical Necessity
It is the responsibility of the provider to code to the highest level specified in the ICD-9-CM (e.g., to the fourth or fifth digit). The correct use of an ICD-9-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

455.2 INTERNAL HEMORRHOIDS WITH OTHER COMPLICATION

Diagnoses that Support Medical Necessity
Not applicable

ICD-9 Codes that DO NOT Support Medical Necessity
Not applicable

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity
Not applicable

General Information

Documentations Requirements
The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.
Additional documentation specific to the treatment of internal hemorrhoids with infrared coagulation (IRC) as it is covered by Medicare includes a history and physical findings supporting a diagnosis of symptomatic Grade I, Grade II or Grade III hemorrhoids; any prior treatments for hemorrhoids and patient response; the type of conservative treatments utilized, symptoms response, and time allowed for the resolution of symptoms; and the grade of hemorrhoid (Grade I, II or III) being treated.

The medical record must also contain documentation that supports the medical necessity for repeat IRC (Please see “Indications for and Limitations of Coverage and/or Medical Necessity”). Documentation should reflect that a reasonable amount of time has elapsed to prove failure from the first treatment. This documentation includes, but is not limited to relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

Documentation must be legible and maintained in the patient’s medical record and be made available to the AB MAC upon request.

Appendices Not applicable

Utilization Guidelines For CPT code 46930—Destruction of internal hemorrhoid(s) by thermal energy (e.g. infrared coagulation, cautery, radiofrequency,), only one unit of service should be submitted no matter how many sites are treated per session.

Sources of Information and Basis for Decision


Walker AJ, Leister RJ, Nicholls RJ, Mann CV. A prospective study of infrared coagulation, injection and rubber band ligation in the treatment of hemorrhoids. *Int J Colorectal Dis*. 1990;5(2):113-116. Advisory Committee Meeting Notes 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, including include representatives from the provider community.

Contractor Advisory Committee meeting dates:

South Carolina -
North Carolina -
Virginia –
West Virginia –

Start Date of Comment Period

End Date of Comment Period

Start Date of Notice Period 12/09/2010

Revision History Number Revision #2, 09/27/2012

Revision History Explanation Revision #2,9/27/2012


Society for the surgery of the Alimentary Tract Inc.Surgical management of hemorrhoids. SSAT Patient Care Guidelines 2004. Available at www.ssat.com/cgi-bin/hemorr.cgi. Accessed 4/18/2007. These sections were deleted. This revision becomes effective 09/27/2012.

Revision #1, 5/16/2011

**Per scheduled J11 implementation, contractor numbers 11301 (Virginia) and 11401 (West Virginia) were added to this LCD.** This revision becomes effective on 05/16/2011.

**01/24/2011 - In accordance with Section 911 of the Medicare Modernization Act of 2003, in compliance with the J11 AB MAC Statement of Work (SOW), C.5.1.8.2 – Consolidation of Local Coverage Determinations, this LCD has been selected for implementation within the Palmetto GBA J11 AB MAC territory. Effective date of this implementation is January 24, 2011.**

Printed on 12/5/2012. Page 6 of 7
Reason for Change Maintenance (annual review with new changes, formatting, etc.)

Related Documents
This LCD has no Related Documents.

LCD Attachments
There are no attachments for this LCD.

All Versions
Updated on 09/23/2012 with effective dates 09/27/2012 - N/A
Updated on 03/17/2011 with effective dates 05/16/2011 - 09/26/2012
Updated on 03/16/2011 with effective dates 05/16/2011 - N/A
Updated on 12/02/2010 with effective dates 01/24/2011 - N/A
Read the LCD Disclaimer opens in new window

Back to Top
CMS National Coverage Policy
Title XVIII of the Social Security Act, §1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Title XVIII of the Social Security Act, §1861(cc)(1) discusses CORF facility services.

Title XVIII of the Social Security Act, §1861(s)(2)(B) provides coverage of services incident to physicians services furnished to hospital patients.

Title XVIII of the Social Security Act, §1862(a)(1)(A) allows coverage and payment for only those services that are considered to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

42 CFR §485.70-CORF personnel qualifications- lists qualifications for respiratory therapists.

Federal Register: December 31, 2002 (Volume 67, Number 251) p 79999-80000 Final rule revisions to payment policies specific to G0237-G0239

CMS Manual System, Pub 100-02, Medicare Benefit Policy Manual, Chapter 6, §§20.4-20.4.1

Printed on 12/5/2012. Page 1 of 13
Indications and Limitations of Coverage and/or Medical Necessity

Respiratory therapy (respiratory care) is defined as those services prescribed by a physician or a non-physician practitioner for the assessment and diagnostic evaluation, treatment, management, and monitoring of patients with deficiencies and abnormalities of cardiopulmonary function.

Monitoring is defined as the periodic checking of the equipment in actual use to ascertain proper functioning; real time tracking the individual’s condition to assure that he/she is receiving effective respiratory therapy services; and periodic evaluation of the patient's progress in improvement of function.

Respiratory therapy (respiratory care) services may include but are not limited to the following:

- application techniques to support oxygenation and ventilation in an acute illness (e.g. establish/maintain artificial airway, ventilatory therapy, precise delivery of oxygen concentrations, aid in removal of secretions from pulmonary tree)

- therapeutic use/monitoring of medicinal gases, pharmacologically active mists and aerosols, and equipment (e.g., resuscitators, ventilators)

- bronchial hygiene therapy (e.g. deep breathing, coughing exercises, IPPB, postural drainage, chest percussion/vibration, and nasotracheal/endotracheal suctioning)

- diagnostic tests for evaluation by a physician (e.g. pulmonary function test, spirometry, and blood gas analyses)

- pulmonary rehabilitation techniques (e.g. exercise conditioning, breathing retraining, and patient education regarding management of patient's respiratory problems) and

- periodic assessment of the patient for the effectiveness of respiratory therapy services.

The above services may be performed by respiratory therapists, physical therapists, nurses, and other qualified personnel as described by relevant state practice acts. Documentation in the medical record must clearly support the need for respiratory therapy services to be separately reimbursed.

Respiratory therapy (respiratory care) services can be considered reasonable and necessary for the diagnosis and treatment of a specific illness or injury. The service provided must be consistent with the severity of the patient's documented illness and must be reasonable in terms of modality, amount, frequency, and duration of treatment. The treatment must be generally accepted by the professional community as safe and effective for the purpose used, and recognized standards of care should not be violated.
There must be a specific written order by the physician for all respiratory therapy (respiratory care) services.

Medicare coverage of respiratory therapy (respiratory care) provided as outpatient hospital or extended care services depends on the determination by the attending physician (as part of his/her plan of treatment) that for the safe and effective administration of such services the procedures or exercises in question need to be performed by a respiratory therapist. In addition, Medicare may cover postural drainage and pulmonary exercises furnished by a respiratory therapist as incident to a physician’s professional service. In order to be considered for reimbursement by Medicare, respiratory therapy services must be fully documented in the medical records. The documentation must clearly indicate that the services rendered were reasonable and medically necessary and required the skills of a licensed respiratory therapist.

Instructing a patient in the use of equipment, breathing exercises, etc. may be considered reasonable and necessary for the treatment of the patient's condition and can usually be given to a patient during the course of treatment by any of the health personnel involved, (e.g., physician, nurse, respiratory care practitioner or other qualified personnel). These educational instructions are bundled into the covered service and separate payment is not made. Separate billing for one-on-one education is rarely necessary and is usually only reasonable at the start of the treatment plan. Initially, for outpatient care where a series of visits providers "...an individualized physical conditioning and exercise program using proper breathing techniques..." separate billing for one-on-one intervention is both reasonable and necessary. Provision of more information than is ordinarily provided during the course of a treatment (e.g., extensive theoretical background in the pathology, etiology, and physiological effects of the disease) is not considered reasonable and necessary. Group sessions that only offer generalized (i.e., non-individualized) education and training are not covered.

Therapeutic procedures (G0237 through G0239) with an individualized physical conditioning and exercise program using proper breathing techniques can be considered for a patient with activity limitations. Breathing retraining, energy conservation, and relaxation techniques are often used. Ventilatory muscle training (VMT) may be considered reasonable and necessary in a very select population of pulmonary patients who demonstrate significantly decreased respiratory muscle strength and who remain symptomatic despite optimal therapy. Routine exercise, or any exercise, without a documented need for skilled care, is not covered.

Coding Information
Bill Type Codes:

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012x Hospital Inpatient (Medicare Part B only)
013x Hospital Outpatient
018x Hospital - Swing Beds
021x Skilled Nursing - Inpatient (Including Medicare Part A)
022x Skilled Nursing - Inpatient (Medicare Part B only)
023x Skilled Nursing - Outpatient
071x Clinic - Rural Health
074x Clinic - Outpatient Rehabilitation Facility (ORF)
075x Clinic - Comprehensive Outpatient Rehabilitation Facility (CORF)
077x Clinic - Federally Qualified Health Center (FQHC)
085x Critical Access Hospital

Revenue Codes:

Printed on 12/5/2012. Page 3 of 13
Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

0410  Respiratory Services - General Classification
0412  Respiratory Services - Inhalation Services
0420  Physical Therapy - General Classification
0421  Physical Therapy - Visit
0422  Physical Therapy - Hourly
0424  Physical Therapy - Evaluation or Re-evaluation
0430  Occupational Therapy - General Classification
0431  Occupational Therapy - Visit
0432  Occupational Therapy - Hourly
0434  Occupational Therapy - Evaluation or Reevaluation
0439  Occupational Therapy - Other Occupational Therapy
0469  Pulmonary Function - Other Pulmonary

CPT/HCPCS Codes
31500  Insert emergency airway
31502  Change of windpipe airway
31720  Clearance of airways
92950  Heart/lung resuscitation cpr
94002  Vent mgmt inpat init day
94003  Vent mgmt inpat subq day
94004  Vent mgmt nf per day
94010  Breathing capacity test
94011  Spirometry up to 2 yrs old
94012  Spirmtry w/brnchdil inf-2 yr
94013  Meas lung vol thru 2 yrs
94060  Evaluation of wheezing
94070  Evaluation of wheezing
94150  Vital capacity test
94200  Lung function test (MBC/MVV)
94250  Expired gas collection
94375  Respiratory flow volume loop
94400  CO2 breathing response curve
94450  Hypoxia response curve
94620  Pulmonary stress test/simple
94621  Pulm stress test/complex
94640  Airway inhalation treatment
94642  Aerosol inhalation treatment
94660  Pos airway pressure cpap
94662  Neg press ventilation cnp
94664  Evaluate pt use of inhaler
94667  Chest wall manipulation
94668  Chest wall manipulation
94726  Pulm funct tst plethysmogr
94727  Pulm function test by gas
94728  Pulm funct test oscillometry
94729  Co/membrane diffuse capacity
94750  Pulmonary compliance study
94772  Breath recording infant
G0237  Therapeutic procd strg endur
G0238  Oth resp proc, indiv
G0239  Oth resp proc, group
ICD-9 Codes that Support Medical Necessity

010.01 - 010.06 opens in new window
PRIMARY TUBERCULOUS COMPLEX BACTERIOLOGICAL OR HISTOLOGICAL EXAMINATION NOT DONE - PRIMARY TUBERCULOUS COMPLEX TUBERCLE BACILLI NOT FOUND BY BACTERIOLOGICAL OR HISTOLOGICAL EXAMINATION BUT TUBERCULOSIS CONFIRMED BY OTHER METHODS (INOCULATION OF ANIMALS)

010.11 - 010.16 opens in new window
TUBERCULOUS PLEURISY IN PRIMARY PROGRESSIVE TUBERCULOSIS BACTERIOLOGICAL OR HISTOLOGICAL EXAMINATION NOT DONE - TUBERCULOUS PLEURISY IN PRIMARY PROGRESSIVE TUBERCULOSIS TUBERCLE BACILLI NOT FOUND BY BACTERIOLOGICAL OR HISTOLOGICAL EXAMINATION BUT TUBERCULOSIS CONFIRMED BY OTHER METHODS (INOCULATION OF ANIMALS)

010.80 - 010.86 opens in new window
OTHER PRIMARY PROGRESSIVE TUBERCULOSIS CONFIRMATION UNSPECIFIED - OTHER PRIMARY PROGRESSIVE TUBERCULOSIS TUBERCLE BACILLI NOT FOUND BY BACTERIOLOGICAL OR HISTOLOGICAL EXAMINATION BUT TUBERCULOSIS CONFIRMED BY OTHER METHODS (INOCULATION OF ANIMALS)

011.00 - 011.96 opens in new window
TUBERCULOSIS OF LUNG INFILTRATIVE CONFIRMATION UNSPECIFIED - UNSPECIFIED PULMONARY TUBERCULOSIS TUBERCLE BACILLI NOT FOUND BY BACTERIOLOGICAL OR HISTOLOGICAL EXAMINATION BUT TUBERCULOSIS CONFIRMED BY OTHER METHODS (INOCULATION OF ANIMALS)

012.01 - 012.06 opens in new window
TUBERCULOUS PLEURISY BACTERIOLOGICAL OR HISTOLOGICAL EXAMINATION NOT DONE - TUBERCULOUS PLEURISY TUBERCLE BACILLI NOT FOUND BY BACTERIOLOGICAL OR HISTOLOGICAL EXAMINATION BUT TUBERCULOSIS CONFIRMED BY OTHER METHODS (INOCULATION OF ANIMALS)

012.21 - 012.26 opens in new window
ISOLATED TRACHEAL OR BRONCHIAL TUBERCULOSIS BACTERIOLOGICAL OR HISTOLOGICAL EXAMINATION NOT DONE - ISOLATED TRACHEAL OR BRONCHIAL TUBERCULOSIS TUBERCLE BACILLI NOT FOUND BY BACTERIOLOGICAL OR HISTOLOGICAL EXAMINATION BUT TUBERCULOSIS CONFIRMED BY OTHER METHODS (INOCULATION OF ANIMALS)

012.81 - 012.86 opens in new window
OTHER SPECIFIED RESPIRATORY TUBERCULOSIS BACTERIOLOGICAL OR HISTOLOGICAL EXAMINATION NOT DONE - OTHER SPECIFIED RESPIRATORY TUBERCULOSIS TUBERCLE BACILLI NOT FOUND BY BACTERIOLOGICAL OR HISTOLOGICAL EXAMINATION BUT TUBERCULOSIS CONFIRMED BY OTHER METHODS (INOCULATION OF ANIMALS)

020.2 - 020.5 opens in new window
SEPTICEMIC PLAGUE - PNEUMONIC PLAGUE UNSPECIFIED

022.1
PULMONARY ANTHRAX

031.0
PULMONARY DISEASES DUE TO OTHER MYCOBACTERIA

032.3
LARYNGEAL DIPHTHERIA

033.0 - 033.9 opens in new window
WHOOPING COUGH DUE TO BORDETELLA PERTUSSIS (B. PERTUSSIS) - WHOOPING COUGH UNSPECIFIED ORGANISM

039.1
PULMONARY ACTINOMYCOTIC INFECTION

042
HUMAN IMMUNODEFICIENCY VIRUS (HIV) DISEASE

052.1
VARICELLA (HEMORRHAGIC) PNEUMONITIS

055.1
POSTMEASLES PNEUMONIA

073.0
ORNITHOSIS WITH PNEUMONIA

081.2
SCRUB TYPHUS

083.0
Q FEVER

095.1
SYPHILIS OF LUNG

112.4
CANDIDIASIS OF LUNG

114.0
PRIMARY COCCIDIOIDOMYCOSIS (PULMONARY)

114.4 - 114.5 opens in new window
CHRONIC PULMONARY COCCIDIOIDOMYCOSIS - PULMONARY COCCIDIOIDOMYCOSIS UNSPECIFIED

115.05
HISTOPLASMA CAPSULATUM PNEUMONIA

115.15
HISTOPLASMA DUBOISII PNEUMONIA

115.95
HISTOPLASMOSIS PNEUMONIA UNSPECIFIED

117.3
ASPERGILLOSIS

117.5
CRYPTOCOCCOSIS

130.4
PNEUMONITIS DUE TO TOXOPLASMOSIS

Printed on 12/5/2012. Page 5 of 13
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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<tr>
<td>135</td>
<td>SARCOIDOSIS</td>
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<tr>
<td>136.3</td>
<td>PNEUMOCYSTOSIS</td>
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<td>MALIGNANT NEOPLASM OF TRACHEA - MALIGNANT NEOPLASM OF OTHER PARTS OF BRONCHUS OR LUNG</td>
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<td>MALIGNANT NEOPLASM OF PARIETAL PLEURA - MALIGNANT NEOPLASM OF PLEURA UNSPECIFIED</td>
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</tr>
<tr>
<td>163.9</td>
<td>KAPOSI'S SARCOMA LUNG</td>
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<td>165.8</td>
<td>MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES</td>
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<td>CYSTIC FIBROSIS WITH PULMONARY MANIFESTATIONS</td>
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<td>CYSTIC FIBROSIS WITH GASTROINTESTINAL MANIFESTATIONS</td>
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<td>CYSTIC FIBROSIS WITH OTHER MANIFESTATIONS</td>
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<td>Septic pulmonary embolism</td>
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<td>Primary pulmonary hypertension</td>
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494.0 - 494.1 opens in new window
BRONCHIECTASIS WITHOUT ACUTE EXACERBATION - BRONCHIECTASIS WITH ACUTE EXACERBATION

496
CHRONIC AIRWAY OBSTRUCTION NOT ELSEWHERE CLASSIFIED

500
COAL WORKERS' PNEUMOCONIOSIS

501
ASBESTOSIS

502
PNEUMOCONIOSIS DUE TO OTHER SILICA OR SILICATES

503
PNEUMOCONIOSIS DUE TO OTHER INORGANIC DUST

504
PNEUMONOPATHY DUE TO INHALATION OF OTHER DUST

505
PNEUMOCONIOSIS UNSPECIFIED

506.0 - 506.4 opens in new window
BRONCHITIS AND PNEUMONITIS DUE TO FUMES AND VAPORS - CHRONIC RESPIRATORY CONDITIONS DUE TO FUMES AND VAPORS

507.0 - 507.8 opens in new window
PNEUMONITIS DUE TO INHALATION OF FOOD OR VOMITUS - PNEUMONITIS DUE TO OTHER SOLIDS AND LIQUIDS

508.0
ACUTE PULMONARY MANIFESTATIONS DUE TO RADIATION

508.1
CHRONIC AND OTHER PULMONARY MANIFESTATIONS DUE TO RADIATION

508.2
RESPIRATORY CONDITIONS DUE TO SMOKE INHALATION

508.8
RESPIRATORY CONDITIONS DUE TO OTHER SPECIFIED EXTERNAL AGENTS

508.9
RESPIRATORY CONDITIONS DUE TO UNSPECIFIED EXTERNAL AGENT

510.0 - 510.9 opens in new window
EMPYEMA WITH FISTULA - EMPYEMA WITHOUT FISTULA

511.0
PLEURISY WITHOUT EFFUSION OR CURRENT TUBERCULOSIS

511.1
PLEURISY WITH EFFUSION WITH A BACTERIAL CAUSE OTHER THAN TUBERCULOSIS

511.81
MALIGNANT PLEURAL EFFUSION

511.89
OTHER SPECIFIED FORMS OF EFFUSION, EXCEPT TUBERCULOUS

512.0
SPONTANEOUS TENSION PNEUMOTHORAX

512.1
IATROGENIC PNEUMOTHORAX

512.2
POSTOPERATIVE AIR LEAK

512.81
PRIMARY SPONTANEOUS PNEUMOTHORAX

512.82
SECONDARY SPONTANEOUS PNEUMOTHORAX

512.83
CHRONIC PNEUMOTHORAX

512.84
OTHER AIR LEAK

512.89
OTHER PNEUMOTHORAX

513.0 - 513.1 opens in new window
ABSCESS OF LUNG - ABSCESS OF MEDIASTINUM

514
PULMONARY CONGESTION AND HYPOSTASIS

515
POSTINFLAMMATORY PULMONARY FIBROSIS

516.0
PULMONARY ALVEOLAR PROTEINOSIS

516.1
IDIOPATHIC PULMONARY HEMOSIDEROSIS

516.2
PULMONARY ALVEOLAR Microlithiasis

516.30
IDIOPATHIC INTERSTITIAL PNEUMONIA, NOT OTHERWISE SPECIFIED

516.31
IDIOPATHIC PULMONARY FIBROSIS

516.32
IDIOPATHIC NON-SPECIFIC INTERSTITIAL PNEUMONITIS

516.33
ACUTE INTERSTITIAL PNEUMONITIS

516.34
RESPIRATORY BRONCHIOLITIS INTERSTITIAL LUNG DISEASE

516.35
IDIOPATHIC LYMPHOID INTERSTITIAL PNEUMONIA

516.36
CRYPTOGENIC ORGANIZING PNEUMONIA

516.37
DEQUAMATIVE INTERSTITIAL PNEUMONIA

516.4
LYMPHANGIOLEIOMYOMATOSIS

516.5
ADULT PULMONARY LANGHERANS CELL HISTIOCYTOSIS

516.61
NEUROENDOCRINE CELL HYPERPLASIA OF INFANCY

516.62
PULMONARY INTERSTITIAL GLYCOGENOSIS

516.63
SURFACTANT MUTATIONS OF THE LUNG

516.64
ALVEOLAR CAPILLARY DYSPLASIA WITH VEIN MISALIGNMENT

516.69
OTHER INTERSTITIAL LUNG DISEASES OF CHILDHOOD

516.8
OTHER SPECIFIED ALVEOLAR AND PARIETOALVEOLAR PNEUMONOPATHIES
517.1 - 517.8 opens in new window
517.1 - RHEUMATIC PNEUMONIA - LUNG INVOLVEMENT IN OTHER DISEASES CLASSIFIED ELSEWHERE

518.0 - PULMONARY COLLAPSE
518.1 - INTERSTITIAL EMPHYSEMA
518.2 - COMPENSATORY EMPHYSEMA
518.3 - PULMONARY EOSINOPHILIA
518.4 - ACUTE EDEMA OF LUNG UNSPECIFIED
518.51 - ACUTE RESPIRATORY FAILURE FOLLOWING TRAUMA AND SURGERY
518.52 - OTHER PULMONARY INSUFFICIENCY, NOT ELSEWHERE CLASSIFIED, FOLLOWING TRAUMA AND SURGERY
518.53 - ACUTE AND CHRONIC RESPIRATORY FAILURE FOLLOWING TRAUMA AND SURGERY
518.6 - ALLERGIC BRONCHOPULMONARY ASPERGILLIOSIS
518.7 - TRANSFUSION RELATED ACUTE LUNG INJURY (TRALI)
518.81 - ACUTE RESPIRATORY FAILURE
518.82 - OTHER PULMONARY INSUFFICIENCY NOT ELSEWHERE CLASSIFIED
518.83 - CHRONIC RESPIRATORY FAILURE
518.84 - ACUTE AND CHRONIC RESPIRATORY FAILURE
518.89 - OTHER DISEASES OF LUNG NOT ELSEWHERE CLASSIFIED

519.00 - 519.8 opens in new window
519.00 - TRACHEOSTOMY COMPLICATION UNSPECIFIED - OTHER DISEASES OF RESPIRATORY SYSTEM NOT ELSEWHERE CLASSIFIED

573.5 - HEPATOPULMONARY SYNDROME
639.6 - EMBOLISM FOLLOWING ABORTION OR ECTOPIC AND MOLAR PREGNANCIES

668.00 - 668.04 opens in new window
668.00 - PULMONARY COMPLICATIONS OF ANESTHESIA OR OTHER SEDATION IN LABOR AND DELIVERY UNSPECIFIED AS TO EPISODE OF CARE - PULMONARY COMPLICATIONS OF ANESTHESIA OR OTHER SEDATION IN LABOR AND DELIVERY POSTPARTUM
710.1 - SYSTEMIC SCLEROSIS

770.10 - 770.18 opens in new window
770.10 - FETAL AND NEWBORN ASPIRATION, UNSPECIFIED - OTHER FETAL AND NEWBORN ASPIRATION WITH RESPIRATORY SYMPTOMS
770.87 - RESPIRATORY ARREST OF NEWBORN
770.88 - HYPOXEMIA OF NEWBORN

780.87 - SEPTICEMIA [SEPSIS] OF NEWBORN - OTHER INFECTIONS SPECIFIC TO THE PERINATAL PERIOD

780.97 - UNSPECIFIED SLEEP DISTURBANCE - OTHER SLEEP DISTURBANCES

786.00 - 786.09 opens in new window
786.00 - RESPIRATORY ABNORMALITY UNSPECIFIED - RESPIRATORY ABNORMALITY OTHER

786.1 - STRIDOR
786.2 - COUGH
786.30 - HEMOPTYSIS, UNSPECIFIED
786.31 - ACUTE IDIOPATHIC PULMONARY HEMORRHAGE IN INFANTS [AIPHI]
786.39 - OTHER HEMOPTYSIS
786.52 - PAINFUL RESPIRATION
786.6 - SWELLING MASS OR LUMP IN CHEST
786.7 - ABNORMAL CHEST SOUNDS
790.91 - ABNORMAL ARTERIAL BLOOD GASES
793.11 - SOLITARY PULMONARY NODULE
793.19 - OTHER NONSPECIFIC ABNORMAL FINDING OF LUNG FIELD
793.2 - NONSPECIFIC (ABNORMAL) FINDINGS ON RADIOLOGICAL AND OTHER EXAMINATION OF OTHER INTRATHORACIC ORGANS
794.2 - NONSPECIFIC ABNORMAL RESULTS OF FUNCTION STUDY OF PULMONARY SYSTEM
799.01 - ASPHYXIA
799.02 - HYPOXEMIA
799.1 - RESPIRATORY ARREST
799.82 - APPARENT LIFE THREATENING EVENT IN INFANT

Printed on 12/5/2012. Page 9 of 13
General Information

Documentations Requirements
A physician order for all respiratory therapy intervention/service must be recorded in the patient's medical record. The order must clearly indicate the evaluation or treatment to be performed, the specific modality and duration of all aspects of the treatment, including frequency of monitoring.

Documentation by the physician must indicate the cardiopulmonary diagnosis supporting the medical necessity of the service.

Documentation must be present in the respiratory services records to show:
• the plan of treatment and progress toward measurable goals

• that the care rendered was appropriately delivered by a qualified practitioner. As previously noted, the above services may be performed by respiratory therapists, physical therapists, nurses, and other qualified personnel.

Other qualified personnel may include occupational therapists. Therapeutic procedures whose principle aim is to treat a respiratory impairment should be identified using the G0237-G0239 series of codes. CPT codes 97000 to 97799 are not to be billed by professionals involved in treating respiratory conditions, unless these services are delivered by physical or occupational therapists and meet the other requirements for physical and occupational therapy services.

CORG social and/or psychological services do not include services for mental health diagnoses. Social and/or psychological services are covered only if the patient's physician or the CORF physician establishes that the services directly relate to the patient's rehabilitation plan of treatment and are needed to achieve the goals in the rehabilitation plan of treatment. Social and/or psychological services are those services that address the patient's response and adjustment to the rehabilitation treatment plan: rate of improvement and progress towards the rehabilitation goals, or other services as they directly relate to the respiratory therapy (respiratory care) plan of treatment being provided to the patient.

Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available to the A/B MAC upon request.

Appendices N/A

Utilization Guidelines N/A

Sources of Information and Basis for Decision
American Association of Respiratory Care (AARC) website www.aarc.org information about accredited respiratory care programs and online CRCE (continuing respiratory care education).


Mahler DA, Fierro-Carrion G, Baird JC. Evaluation of dyspnea in the elderly. Clinics in Geriatric Medicine. February 2003; 19(1):19-33. Describes that the prevalence of dyspnea in the elderly could be as high as 38% and raises the question of how much of this is related to obesity and deconditioning as opposed to actual pulmonary impairments.


Advisory Committee Meeting Notes 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, including include representatives from the provider community.

Contractor Advisory Committee meeting dates:

South Carolina -
North Carolina -
Virginia –
West Virginia –

Start Date of Comment Period

Printed on 12/5/2012. Page 11 of 13
Revision History Number Revision #5, 11/01/2012

Revision History Explanation Revision #5, 11/01/2012
Under **CMS National Coverage Policy** the following manual citations were added: CMS Manual System, Pub 100-02, Medicare Benefit Policy Manual, Chapter 12, §§10, 20, 20.1, 30, and 30.1. The following two change requests were removed as they have been manualized: CMS Manual System, Pub 100-03, Medicare National Coverage Determinations, Transmittal 78, dated December 5, 2007, Change Request 5834 and CMS Manual System, Pub 100-02, Medicare Benefit Policy, Transmittal 111, dated September 25, 2009, Change Request 6005. Under **Indications and Limitations of Coverage and/or Medical Necessity** next to last paragraph added the following verbiage: " These educational instructions are bundled into the covered service and separate payment is not made." And "Initially, for outpatient care where a series of visits providers ...an individualized physical conditioning and exercise program using proper breathing techniques..." separate billing for one-on-one intervention is both reasonable and necessary." Under **Documentation Requirements** deleted the reference to the Palmetto GBA Physical and Occupational Therapy LCDs. The word "Intermediary" was changed to "A/B MAC." Under **Sources of Information and Basis for Decision** deleted the following citation: South Carolina Society for Respiratory Care website www.scsrc.com the state branch of the AARC, gives history and mission. This revision becomes effective 11/01/2012.

Revision #4, 06/07/2012
This revision is to correct revision #3. CPT codes that were added were 94726, 94727, 94728 and 94729 **NOT** 97426, 97427, 97428 and 97429. Also CPT code 94720 is a deleted code. This revision was corrected on 01/20/2012.

Revision #3, 01/01/2012
Addition of 97426, 97427, 97428, and 97429 to the CPT/HCPCS code section. Deletion of 94240, 94260, 94350, 94360, 94370, 94725 previously listed in the CPT/HCPCS code section. Additions and deletions due to CPT/HCPCS annual update and code description changes – CR 7540. This revision becomes effective 01/01/2012.

Revision #2, 10/01/2011
Under **CMS National Coverage Policy** the following citation was updated to add §20.2 to the citation, CMS Manual System, Pub 100-02, Medicare Benefit Policy Manual, Chapter 12. Under **ICD-9 Codes That Support Medical Necessity** ICD-9 codes 488.11, 488.12 and 488.19 have been revised. The following ICD-9 have been added: 358.30, 358.31, 358.39, 415.13, 488.81, 488.82, 488.89, 508.2, 512.2, 516.4, 516.5, 573.5, 997.32, 998.00, 998.01, 998.02, 998.09, 999.32, 999.33, 999.34, 999.41, 999.42, 999.49, 999.51, 999.52, 999.59, V12.55 and V13.81. 512.8 expanded to 5th digit 512.81, 512.82, 518.83, 512.84 and 512.89. The following codes expanded to a 5th digit, 516.3 expanded to 516.30, 516.31, 516.32, 516.33, 516.34, 516.35, 516.36 and 516.37, 516.6 expanded to 516.61, 516.62, 516.63, 516.64 and 516.69, 518.5 expanded to 518.51, 518.52 and 518.53, 793.1 expanded to 793.11 and 793.19. This revision becomes effective on 10/01/2011.

Revision #1, 05/16/2011
**Per scheduled J11 implementation, contractor numbers 11301 (Virginia) and 11401 (West Virginia) were added to this LCD.** This revision becomes effective on 05/16/2011.

**01/24/2011** - In accordance with Section 911 of the Medicare Modernization Act of 2003, in compliance with the J11 AB MAC Statement of Work (SOW), C.5.1.8.2 – Consolidation of Local Coverage Determinations, this LCD has been selected for implementation within the Palmetto GBA J11 AB MAC territory. Effective date of this implementation is January 24, 2011.

11/25/2012 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document:
94729 descriptor was changed in Group 1

Reason for Change
Local Coverage Determination (LCD) for Cardiac Event Detection (L31595)

Contractor Information
Contractor Name  Palmetto GBA opens in new window
Contractor Number  11501
Contractor Type  MAC - Part A

LCD Information
Document Information

LCD ID Number  L31595

LCD Title  Cardiac Event Detection

Contractor's Determination Number  J11A-11-003-L

Primary Geographic Jurisdiction opens in new window
North Carolina

Oversight Region  Region IV

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CMS National Coverage Policy
Title XVIII of the Social Security Act, §1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

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

42 CFR §410.32 indicates tests must be ordered by the treating physician/nonphysician practitioner (NPP) and used in the management of the beneficiary.

CMS Internet-Only Manual, Pub 100-02, Medicare Benefits Manual, Ch 15, §§80 and 230

CMS Internet-Only Manual, Pub 100-03, Medicare National Coverage Determinations, Ch 1, Part 1, §20.15

Indications and Limitations of Coverage and/or Medical Necessity

Abstract:
Cardiac Event Detection (CED) involves the use of a long-term monitor by patients to document a suspected or paroxysmal dysrhythmia. Following the recording of events, the patient transmits data via telephone to a physician's office, hospital facility, Independent Diagnostic Testing Facility (IDTF), or other specified station that is equipped and staffed to assess electrocardiographic data and to initiate appropriate management action. The device must be patient or event activated.

The services included in this LCD require a 24-hour attended monitoring station to receive transmissions, and that the devices:

- are patient/event activated and intermittently record cardiac arrhythmic events;
- provide either symptom related memory loop or post-symptom recording; and
- are non-insertable (non-implanted).

A single service includes all recordings, transmissions and interpretations during a continuous 30-day period.

Ambulatory outpatient cardiac telemetry (outpatient cardiac monitoring) services are included among the cardiac event detection type of ambulatory EKG monitoring services.

**Indications:**

Cardiac event detection is covered for:

1. *Detection, characterization, and documentation of symptomatic transient arrhythmias,* when the frequency of the symptoms is limited or in asymptomatic patients who are at risk for clinically significant arrhythmias, and use of a 24-hour ambulatory EKG is unlikely to capture and document the arrhythmia;
2. Regulation of antiarrhythmic drug dosage, when needed to assess efficacy of treatment;
3. To monitor patients who have had surgical or ablative procedures for arrhythmias;

Although the service is a 30-day service, it is recognized that the event recorder may be discontinued once the symptom-producing arrhythmia has been documented and diagnosed or following multiple transmissions during symptoms, without arrhythmia. It is unlikely that the arrhythmias would always be diagnosed on the first day of recording, or that the service would always last only one day. The average duration of monitoring is anticipated to last 10-14 days, or more.

**Limitations:**

1. A CED service is medically unnecessary if it offers little or no potential for new clinical data beyond that which has been obtained from a previous test, (e.g., a standard electrocardiogram has already established a diagnosis), or if other tests are better suited to obtain the clinical data relevant to the patient's condition. The CED should be coordinated with results from standard EKGs, Holter monitor tests, and stress tests.
2. The receiving station must be staffed on a 24-hour basis with personnel trained to read EKGs (e.g., critical care nurses or paramedics), who should be able to direct the patient for the management of all emergencies. An answering service/answering machine would not fulfill this requirement.
3. Systems utilizing computers to dial the physician's office so the physician receives transmission by way of a relay are not covered since there is no 24-hour personnel attendance.
4. A test not ordered by a physician or qualified nonphysician practitioner treating the beneficiary will be denied as not medically necessary.
5. The purpose of CED is the long term monitoring of patients to document a suspected or paroxysmal dysrhythmia. Therefore, it is considered medically unnecessary to utilize a CED service when only a standard EKG or EKG rhythm strip is required (even if it is used to transmit that EKG or rhythm strip to another location.

6. It is expected that CEDs would not be used for the routine daily transmission of EKG rhythm strips, or monitoring, in the absence of identified symptoms necessitating diagnosis as stated in this LCD.

7. Event recorders are covered only as diagnostic tests or for evaluating a patient being actively managed on arrhythmic medication.

8. Cardiac event detection is not covered for patients in hospitals, emergency rooms, skilled nursing facilities or other specialized facilities and will be denied as not medically necessary.

9. Cardiac event detection is not covered for either outpatient or facility-based cardiac monitoring.

10. Cardiac event detection is a 30-day service for the purpose of documentation and diagnosis of paroxysmal or suspected arrhythmias. The performance of this test is predicated by the pre-test incidence of symptoms related to arrhythmias or the risk of a clinically significant arrhythmia in asymptomatic patients, and is considered not medically necessary for those patients who are not having significant recurrent arrhythmias which are anticipated to require treatment.

11. Testing for more than 30 consecutive days is only rarely medically necessary, and the need for the continued testing must be justified by the treating physician. Failure to document an arrhythmia during a 30-day test period is not sufficient justification to reimburse a second or subsequent test. It is unlikely to be medically necessary to repeat a second test within a year in the absence of new or recurrent undiagnosed symptoms.

12. Event recorders may be patient or auto activated, and may not use time-sampling technology. Accordingly, this test will be considered medically unnecessary for any patient who is unresponsive, comatose, severely confused or otherwise unable to recognize symptoms, or activate the recorder (patient activated devices) or unable to participate in the use of the device.

13. Event recorders are not covered for outpatient monitoring of recently discharged post-infarct patients, and will be denied as not medically necessary, except in circumstances where the patient is asymptomatic but is considered to be at high risk for clinically significant arrhythmias.

14. "Routine" continued monitoring in the absence of treatable symptoms is considered screening and is not medically necessary.

15. Because the cardiac event detection service requires the diagnosis and evaluation of intermittent arrhythmias, and patients must be continuously attached to symptom related memory loop recorders, each patient is required to have a recorder for his/her own exclusive use throughout the duration of the monitoring period. Recorders may not be "shared" amongst two or more patients, regardless of the environment or site of the service. Claims for CED will be denied as not medically necessary when patients do not have exclusive use of a recorder for the entire service period (30 days).

16. Cardiac event detection is a 30-day packaged service. Tests may not be billed within 30 days of each other, even if the earlier of the tests was discontinued when arrhythmias were documented and the patient is now reconnected for follow-up of therapy or intervention.

Coding Information

Bill Type Codes:
Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

013x Hospital Outpatient
085x Critical Access Hospital

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

0489 Cardiology - Other Cardiology
0730 EKG/ECG (Electrocardiogram) - General Classification
0739 EKG/ECG (Electrocardiogram) - Other EKG/ECG

CPT/HCPCS Codes

93228 EXTERNAL MOBILE CARDIOVASCULAR TELEMETRY WITH ELECTROCARDIOGRAPHIC RECORDING, CONCURRENT COMPUTERIZED REAL TIME DATA ANALYSIS AND GREATER THAN 24 HOURS OF ACCESSIBLE ECG DATA STORAGE (RETRIEVABLE WITH QUERY) WITH ECG TRIGGERED AND PATIENT SELECTED EVENTS TRANSMITTED TO A REMOTE ATTENDED SURVEILLANCE CENTER FOR UP TO 30 DAYS; REVIEW AND INTERPRETATION WITH REPORT BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL
93229 SELECTED EVENTS TRANSMITTED TO A REMOTE ATTENDED SURVEILLANCE CENTER FOR UP TO 30 DAYS; TECHNICAL SUPPORT FOR CONNECTION AND PATIENT INSTRUCTIONS FOR USE, ATTENDED SURVEILLANCE, ANALYSIS AND TRANSMISSION OF DAILY AND EMERGENT DATA REPORTS AS PRESCRIBED BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL EXTERNAL PATIENT AND, WHEN PERFORMED, AUTO ACTIVATED ELECTROCARDIOGRAPHIC RHYTHM DERIVED EVENT RECORDING WITH SYMPTOM-RELATED MEMORY LOOP WITH REMOTE DOWNLOAD CAPABILITY UP TO 30 DAYS, 24-HOUR ATTENDED MONITORING; INCLUDES TRANSMISSION, REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL EXTERNAL PATIENT AND, WHEN PERFORMED, AUTO ACTIVATED ELECTROCARDIOGRAPHIC RHYTHM DERIVED EVENT RECORDING WITH SYMPTOM-RELATED MEMORY LOOP WITH REMOTE DOWNLOAD CAPABILITY UP TO 30 DAYS, 24-HOUR ATTENDED MONITORING; RECORDING (INCLUDES CONNECTION, RECORDING, AND DISCONNECTION) EXTERNAL PATIENT AND, WHEN PERFORMED, AUTO ACTIVATED ELECTROCARDIOGRAPHIC RHYTHM DERIVED EVENT RECORDING WITH SYMPTOM-RELATED MEMORY LOOP WITH REMOTE DOWNLOAD CAPABILITY UP TO 30 DAYS, 24-HOUR ATTENDED MONITORING; TRANSMISSION AND ANALYSIS EXTERNAL PATIENT AND, WHEN PERFORMED, AUTO ACTIVATED ELECTROCARDIOGRAPHIC RHYTHM DERIVED EVENT RECORDING WITH SYMPTOM-RELATED MEMORY LOOP WITH REMOTE DOWNLOAD CAPABILITY UP TO 30 DAYS, 24-HOUR ATTENDED MONITORING; REVIEW AND INTERPRETATION BY A PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL
93799 UNLISTED CARDIOVASCULAR SERVICE OR PROCEDURE

ICD-9 Codes that Support Medical Necessity

It is the responsibility of the provider to code to the highest level specified in the ICD-9-CM (e.g., to the fourth or fifth digit). The correct use of an ICD-9-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

These ICD-9-CM codes can be used only with the conditions listed in the Indications and Limitations sections of this LCD.

426.0 ATRIOVENTRICULAR BLOCK COMPLETE
426.10 ATRIOVENTRICULAR BLOCK UNSPECIFIED
426.12 MOBITZ (TYPE) II ATRIOVENTRICULAR BLOCK

Printed on 12/5/2012. Page 4 of 7
426.13 OTHER SECOND DEGREE ATRIOVENTRICULAR BLOCK
426.6 OTHER HEART BLOCK
426.7 ANOMALOUS ATRIOVENTRICULAR EXCITATION
426.81 LOWN-GANONG-LEVINE SYNDROME
426.89 OTHER SPECIFIED CONDUCTION DISORDERS
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
435.9 UNSPECIFIED TRANSIENT CEREBRAL ISCHEMIA
780.2 SYNCOPE AND COLLAPSE
780.33 POST TRAUMATIC SEIZURES
780.4 DIZZINESS AND GIDDINESS
780.66 FEBRILE NONHEMOYTIC TRANSFUSION REACTION
785.0 TACHYCARDIA UNSPECIFIED
785.1 PALPITATIONS
786.09 RESPIRATORY ABNORMALITY OTHER
E942.0 CARDIAC RHYTHM REGULATORS CAUSING ADVERSE EFFECTS IN THERAPEUTIC USE
E942.1 CARDIOTONIC GLYCOSIDES AND DRUGS OF SIMILAR ACTION CAUSING ADVERSE EFFECTS IN THERAPEUTIC USE
E942.9 OTHER AND UNSPECIFIED AGENTS PRIMARILY AFFECTING THE CARDIOVASCULAR SYSTEM CAUSING ADVERSE EFFECTS IN THERAPEUTIC USE

Diagnoses that Support Medical Necessity
Not applicable
ICD-9 Codes that DO NOT Support Medical Necessity
Use of any ICD-9-CM code not listed in the "ICD-9-CM Codes That Support Medical Necessity" section of this LCD will be denied. In addition, the following ICD-9 CM codes are specifically listed as not supporting medical necessity for emphasis, and to avoid any provider errors.
410.00 - 410.92 opens in new window ACUTE MYOCARDIAL INFARCTION OF ANTEROLATERAL WALL EPISODE OF CARE
UNSPECIFIED - ACUTE MYOCARDIAL INFARCTION OF UNSPECIFIED SITE SUBSEQUENT EPISODE OF CARE

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity
Not applicable
Back to Top

General Information
Documentations Requirements

1. The patient’s medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

Printed on 12/5/2012. Page 5 of 7
2. Records must include EKG rhythm strips with interpretation for each transmission. The date and time of each transmission, when the symptoms occurred and what the symptoms were must be documented for each transmission. The medical record should also include when the reviewing physician and the ordering physician were notified of the transmission and its results.

3. The interpretation must be a *de novo* interpretation by the physician billing the interpretation, in addition to any “preliminary interpretation” by the company, hospital or other provider functioning as the receiving station, or billing the technical component of the test.

4. The CED provider's records must include the referring physician's request for the test and the indications for the test. This information should be incorporated into a formal report (interpretation) of the test.

5. Documentation of the necessity should include the referring physician's diagnostic impression, and an indication of relevant signs and symptoms.

6. The provider performing the technical component of the service must retain a written copy of the physician/NPP order for the test which should include the indication(s) for the test. This provider must also maintain copies of all transmissions, documentation of actions taken and physicians contacted or instructions given to the beneficiary.

7. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available to the A/B MAC upon request.

Appendices Not applicable

Utilization Guidelines

1. It is expected that it would not be necessary to perform a CED service (one 30-day service) more frequently than once in six months. Claims for services provided in excess of this parameter may be denied as not medically necessary.

2. It is not appropriate to utilize this service in a patient who is unable to activate the monitor or transmit the data when symptoms occur. These claims may be denied as not medically necessary.

3. Claims not meeting the criteria stated in these guidelines may be denied.

Sources of Information and Basis for Decision


Advisory Committee Meeting Notes 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, including include representatives from the provider community.

Contractor Advisory Committee meeting dates:

South Carolina -
North Carolina -
Virginia -
West Virginia -

Start Date of Comment Period

Printed on 12/5/2012. Page 6 of 7
End Date of Comment Period

Start Date of Notice Period 12/09/2010

Revision History Number Revision #2, 11/01/2012

Revision History Explanation Revision #2, 11/01/2012
Under **Indications and Limitations of Coverage and/or Medical Necessity-Indications** under #1 added or in asymptomatic patients who are at risk for clinically significant arrhythmias, at the end of the first sentence. Under **Limitations** #10 added to the second sentence, "or the risk of a clinically significant arrhythmia in asymptomatic patients." Under #13 added this statement to the end, "except in circumstances where the patient is asymptomatic but is considered to be at high risk for clinically significant arrhythmias." #7 under **Documentation Requirements** changed the word "Intermediary" to "A/B MAC." Under **Utilization Guidelines** deleted "In asymptomatic patient" from #1 and "an asymptomatic patient, or" from #2. Annual review completed. This revision becomes effective 11/01/2012.

Revision #1, 05/16/2011
Per scheduled J11 implementation, contractor numbers 11301 (Virginia) and 11401 (West Virginia) were added to this LCD. This revision becomes effective on 05/16/2011.

***01/24/2011*** - In accordance with Section 911 of the Medicare Modernization Act of 2003, in compliance with the J11 AB MAC Statement of Work (SOW), C.5.1.8.2 – Consolidation of Local Coverage Determinations, this LCD has been selected for implementation within the Palmetto GBA J11 AB MAC territory. Effective date of this implementation is January 24, 2011.

11/25/2012 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document:
- 93228 descriptor was changed in Group 1
- 93229 descriptor was changed in Group 1
- 93268 descriptor was changed in Group 1
- 93272 descriptor was changed in Group 1

Reason for Change

Related Documents
This LCD has no Related Documents.

LCD Attachments
There are no attachments for this LCD.

Back to Top
CMS National Coverage Policy

Title XVIII of the Social Security Act, §1862(a)(1)(A) allows coverage and payment for only those services that are considered to be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Title XVIII of the Social Security Act, §1862(a)(12) states no payment may be made for services in the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting teeth, except for inpatient services when "because of underlying medical condition or because of the severity of the dental procedure" the patient requires hospitalization.

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

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

42 CFR Part 411.15 states no payment may be made for services in the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting teeth, except for inpatient services when "because of underlying medical condition or because of the severity of the dental procedure" the patient requires hospitalization.
Indications and Limitations of Coverage and/or Medical Necessity

Dental services in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth, "except for inpatient hospital services in connection with such dental procedures when hospitalization is required because of the individual's underlying medical condition and clinical status."

Structures directly supporting the teeth means, the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum, and alveolar process.

In an outpatient setting when an excluded service is the primary procedure involved, it is not covered regardless of its complexity or difficulty. An alveoloplasty and a frenectomy are excluded from coverage when either of these procedures is performed in connection with an excluded service: e.g. the non-covered extraction or the preparation of the mouth for dentures.

**NON-COVERED SERVICES**

(The only exception are for inpatient services: "except for inpatient hospital services in connection with such dental procedures when hospitalization is required because of the individual's underlying medical condition and clinical status."

- the extraction of an impacted tooth
- an alveoloplasty, (the surgical improvement of the shape and condition of the alveolar process), when performed for the preparation of the mouth for dentures
- frenectomy when performed for the preparation of the mouth for dentures
- Extractions that are due to decay or periodontal disease
- Extractions done for the purpose of obtaining dentures
- Services related to chronic dental disease (i.e. gingivectomy)
- Removal of a benign growth or radicular cyst, in the mouth,(structures directly supporting the teeth means the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum, and alveolar process)
- Insertion of metallic implants used for enhancement of the structure of the jaws in order to support dentures or prosthesis

- Excision of torus mandibularis or excision of a maxillary torus palatinus is usually performed to accommodate a denture. The removal of the torus palatinus (a bony protuberance of the hard palate) and torus mandibularis could be a covered service. However, with rare exception, this surgery is performed in connection with an excluded service; i.e., the preparation of the mouth for dentures. Under such circumstances, reimbursement is not made for this purpose.

**COVERED SERVICES:**
- Surgery related to the jaw or any structure connected to the jaw including structures of the facial area below the eyes, for example (mandible, teeth, gums, tongue, palate, salivary glands, sinuses, etc.)

- Wiring of the teeth when performed in connection with the reduction of a jaw fracture

- Reduction of any fracture of the jaw or any facial bone, including dental splints or other appliances, if used for this purpose

- Reconstruction of a ridge if performed as a result of and at the same time as the surgical removal of a tumor (the total surgical procedure is covered)

- Removal of a torus palatinus (a bony protuberance of the hard palate) **may be covered**, if the procedure is not performed to prepare the mouth for dentures

- Extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease

- Insertion of metallic implants if the implants are used to assist in or enhance the retention of a dental prosthetic as a result of a covered service

The extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease is also covered. This is an exception to the requirement that to be covered, a non-covered procedure or service performed by a dentist must be an integral part of a covered procedure or service performed by the dentist. Whether such services as the administration of anesthesia, diagnostic x-rays, and other related procedures are covered depends upon whether the primary procedure being performed by the dentist is itself covered. Thus, an x-ray taken in connection with the reduction of a fracture of the jaw or facial bone is covered. However, a single x-ray or x-ray survey taken in connection with the care or treatment of teeth or the periodontium is not covered.

A dentist qualifies as a physician if, he/she is a doctor of dental surgery or dental medicine, and is legally authorized to practice dentistry in the state in which he/she performs such function, and who is acting within the scope of his/her license when he/she performs such functions. Such services include any otherwise covered service that may legally and alternatively be performed by doctors of medicine, osteopathy and dentistry; e.g., dental examinations to detect infections prior to certain surgical procedures, treatment of oral infections and interpretations of diagnostic x-ray examinations in connection with covered services. Payment for the services of dentists in an outpatient setting is limited to those procedures which are not primarily provided for the care, treatment, removal, or replacement of teeth or structures directly supporting the teeth. The coverage of any given dental service is not affected by the professional designation of the physician rendering the service; i.e., an excluded dental service remains excluded and a covered dental service is still covered whether furnished by a dentist or a doctor of medicine or osteopathy.

**Dental Examination Prior to Kidney Transplantation**

An oral or dental examination performed on an inpatient basis, as part of a comprehensive workup prior to renal transplant surgery is a covered service. This examination is for the identification, prior to a complex surgical procedure, of existing medical problems where the increased possibility of infection would not only reduce the chances for successful surgery but would also expose the patient to additional risks in undergoing such surgery.

**Coding Information**

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

- 012x Hospital Inpatient (Medicare Part B only)
- 013x Hospital Outpatient
- 018x Hospital - Swing Beds
- 021x Skilled Nursing - Inpatient (Including Medicare Part A)
- 022x Skilled Nursing - Inpatient (Medicare Part B only)
Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

0360 Operating Room Services - General Classification
0361 Operating Room Services - Minor Surgery
0369 Operating Room Services - Other OR Services

CPT/HCPCS Codes
41820 Excision gum each quadrant
41821 Excision of gum flap
41822 Excision of gum lesion
41823 Excision of gum lesion
41828 Excision of gum lesion
41830 Removal of gum tissue
41850 Treatment of gum lesion
41870 Gum graft
41872 Repair gum
41874 Repair tooth socket
41899 Dental surgery procedure

ICD-9 Codes that Support Medical Necessity

140.0 - 140.9 opens in new window MALIGNANT NEOPLASM OF UPPER LIP VERMILION BORDER - MALIGNANT NEOPLASM OF LIP UNSPECIFIED VERMILION BORDER
141.0 - 141.9 opens in new window MALIGNANT NEOPLASM OF BASE OF TONGUE - MALIGNANT NEOPLASM OF TONGUE UNSPECIFIED
142.0 - 142.8 opens in new window MALIGNANT NEOPLASM OF PAROTID GLAND - MALIGNANT NEOPLASM OF OTHER MAJOR SALIVARY GLANDS
143.0 - 143.9 opens in new window MALIGNANT NEOPLASM OF UPPER GUM - MALIGNANT NEOPLASM OF GUM UNSPECIFIED
144.0 - 144.9 opens in new window MALIGNANT NEOPLASM OF ANTERIOR PORTION OF FLOOR OF MOUTH - MALIGNANT NEOPLASM OF FLOOR OF MOUTH PART UNSPECIFIED
145.0 - 145.9 opens in new window MALIGNANT NEOPLASM OF CHEEK MUCOSA - MALIGNANT NEOPLASM OF MOUTH UNSPECIFIED
146.0 - 146.9 opens in new window MALIGNANT NEOPLASM OF TONSIL - MALIGNANT NEOPLASM OF OROPHARYNX UNSPECIFIED SITE
147.0 - 147.9 opens in new window MALIGNANT NEOPLASM OF SUPERIOR WALL OF NASOPHARYNX - MALIGNANT NEOPLASM OF NASOPHARYNX UNSPECIFIED SITE
148.0 - 148.9 opens in new window MALIGNANT NEOPLASM OF POSTCRICOID REGION OF HYPOPHARYNX - MALIGNANT NEOPLASM OF HYPOPHARYNX UNSPECIFIED SITE
149.0 - 149.1 opens in new window MALIGNANT NEOPLASM OF PHARYNX UNSPECIFIED - MALIGNANT NEOPLASM OF WALDEYER’S RING
149.8 MALIGNANT NEOPLASM OF OTHER SITES WITHIN THE LIP AND ORAL CAVITY
160.0 - 160.8 opens in new window MALIGNANT NEOPLASM OF NASAL CAVITIES - MALIGNANT NEOPLASM OF OTHER ACCESSORY SINUSES
161.0 - 161.8 opens in new window MALIGNANT NEOPLASM OF GLOTTIS - MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF LARYNX
195.0 MALIGNANT NEOPLASM OF HEAD FACE AND NECK
210.0 - 210.9 opens in new window BENIGN NEOPLASM OF LIP - BENIGN NEOPLASM OF PHARYNX UNSPECIFIED
212.0 - 212.1 opens in new window
BENIGN NEOPLASM OF NASAL CAVITIES MIDDLE EAR AND ACCESSORY SINUSES - BENIGN NEOPLASM OF LARYNX

213.0 - 213.1 opens in new window
BENIGN NEOPLASM OF BONES OF SKULL AND FACE - BENIGN NEOPLASM OF LOWER JAW BONE

230.0
CARCINOMA IN SITU OF LIP ORAL CAVITY AND PHARYNX

730.28
UNSPECIFIED OSTEOMYELITIS INVOLVING OTHER SPECIFIED SITES

802.20 - 802.29 opens in new window
CLOSED FRACTURE OF UNSPECIFIED SITE OF MANDIBLE - CLOSED FRACTURE OF MULTIPLE SITES OF MANDIBLE

802.30 - 802.39 opens in new window
OPEN FRACTURE OF UNSPECIFIED SITE OF MANDIBLE - OPEN FRACTURE OF MULTIPLE SITES OF MANDIBLE

802.4
CLOSED FRACTURE OF MALAR AND MAXILLARY BONES

802.5
OPEN FRACTURE OF MALAR AND MAXILLARY BONES

802.9
OPEN FRACTURE OF OTHER FACIAL BONES

Diagnoses that Support Medical Necessity
N/A

ICD-9 Codes that DO NOT Support Medical Necessity

520.0 - 520.9 opens in new window
ANODONTIA - UNSPECIFIED DISORDER OF TOOTH DEVELOPMENT AND ERUPTION

521.00 - 521.9 opens in new window
UNSPECIFIED DENTAL CARIES - UNSPECIFIED DISEASE OF HARD TISSUES OF TEETH

522.0 - 522.9 opens in new window
PULPITIS - OTHER AND UNSPECIFIED DISEASES OF PULP AND PERIAPICAL TISSUES

523.00 - 523.6 opens in new window
ACUTE GINGIVITIS, PLAQUE INDUCED - ACCRETIONS ON TEETH

523.8 - 523.9 opens in new window
OTHER SPECIFIED PERIODONTAL DISEASES - UNSPECIFIED GINGIVAL AND PERIODONTAL DISEASE

524.01
MAJOR ANOMALIES OF JAW SIZE MAXILLARY HYPERPLASIA

524.02
MAJOR ANOMALIES OF JAW SIZE MANDIBULAR HYPERPLASIA

524.03
MAJOR ANOMALIES OF JAW SIZE MAXILLARY HYPOPLASIA

524.04
MAJOR ANOMALIES OF JAW SIZE MANDIBULAR HYPOPLASIA

524.30
UNSPECIFIED ANOMALY OF TOOTH POSITION

524.31 - 524.39 opens in new window
CROWDING OF TEETH - OTHER ANOMALIES OF TOOTH POSITION

524.70 - 524.74 opens in new window
DENTAL ALVEOLAR ANOMALIES UNSPECIFIED ALVEOLAR ANOMALY - DENTAL ALVEOLAR ANOMALIES ALVEOLAR MANDIBULAR HYPOPLASIA

524.75
VERTICAL DISPLACEMENT OF ALVEOLUS AND TEETH

524.76
OCCLUSAL PLANE DEVIATION

524.79
DENTAL ALVEOLAR ANOMALIES OTHER SPECIFIED ALVEOLAR ANOMALY

525.0 - 525.3 opens in new window
EXFOLIATION OF TEETH DUE TO SYSTEMIC CAUSES - RETAINED DENTAL ROOT

525.60
UNSPECIFIED UNSATISFACTORY RESTORATION OF TOOTH

525.61
OPEN RESTORATION MARGINS

525.62
UNREPAIRABLE OVERHANGING OF DENTAL RESTORATIVE MATERIALS

525.63
FRACTURED DENTAL RESTORATIVE MATERIAL WITHOUT LOSS OF MATERIAL

525.64
FRACTURED DENTAL RESTORATIVE MATERIAL WITH LOSS OF MATERIAL

525.65
CONTOUR OF EXISTING RESTORATION OF TOOTH BIOLOGICALLY INCOMPATIBLE WITH ORAL HEALTH

525.67
POOR AESTHE TICS OF EXISTING RESTORATION

525.71
OSSEOINTEGRATION FAILURE OF DENTAL IMPLANT

525.72
POST-OSSEOINTEGRATION BIOLOGICAL FAILURE OF DENTAL IMPLANT

525.73
POST-OSSEOINTEGRATION MECHANICAL FAILURE OF DENTAL IMPLANT

525.79
OTHER ENDOSSEOUS DENTAL IMPLANT FAILURE

525.8 - 525.9 opens in new window
OTHER SPECIFIED DISORDERS OF THE TEETH AND SUPPORTING STRUCTURES - UNSPECIFIED DISORDER OF THE TEETH AND SUPPORTING STRUCTURES

526.61
PERFORATION OF ROOT CANAL SPACE

526.69
OTHER PERIRADICULAR PATHOLOGY ASSOCIATED WITH PREVIOUS ENDODONTIC TREATMENT

526.81
EXOSTOSIS OF JAW

Printed on 12/6/2012. Page 5 of 7
General Information

Documentations Requirements
1. Documentation supporting the medical necessity, such as ICD-9-CM codes, including the need for the surgery in an inpatient setting, must be submitted with each claim. Claims submitted without such evidence will be denied as not medically necessary.

2. Where the dental procedure is not the primary procedure performed, documentation of the primary procedure must be included in the patient’s medical records.

3. Documentation supporting the medical necessity should be legible, maintained in the patient’s medical record, and must be made available to the A/B MAC upon request.

Appendices N/A

Utilization Guidelines
If a non-covered service is performed as the primary procedure in conjunction with a covered procedure or service, regardless of the complexity, the total service is excluded from coverage.

Anesthesia services, provided by the surgeon performing the surgery, is considered bundled into the payment for the surgical procedure. Since the payment is bundled, the physician is precluded from billing the beneficiary for this service.

Where a patient is hospitalized solely for less than major noncovered dental treatment, both the professional services of the dentist and the inpatient hospital services are not covered. “except for inpatient hospital services in connection with such dental procedures when hospitalization is required because of the individual's underlying medical condition and clinical status.”

Items and services in connection with an excluded dental service (the care, treatment, filling, removal or replacement of teeth, or structures directly supporting the teeth) are not covered. (i.e. anesthesia services, lab, x-ray services).

Sources of Information and Basis for Decision

Amalgamation of national policy Advisory Committee Meeting Notes 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, including include representatives from the provider community.

Contractor Advisory Committee meeting dates:

South Carolina -
North Carolina -
Virginia –
West Virginia –

Start Date of Comment Period

End Date of Comment Period

Start Date of Notice Period 12/09/2010

Revision History Number Revision #2, 12/06/2012

Revision History Explanation Revision #2, 12/06/2012

Printed on 12/6/2012. Page 6 of 7

Revision #1, 05/16/2011

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Reason for Change Maintenance (annual review with new changes, formatting, etc.)

Related Documents
This LCD has no Related Documents.

LCD Attachments
There are no attachments for this LCD.

**All Versions**

Updated on 11/29/2012 with effective dates 12/06/2012 - N/A
Updated on 03/16/2011 with effective dates 05/16/2011 - 12/05/2012
Updated on 03/16/2011 with effective dates 05/16/2011 - N/A
Updated on 12/02/2010 with effective dates 01/24/2011 - N/A

Read the **LCD Disclaimer opens in new window**

Back to Top