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GREENVILLE HEALTH SYSTEM

Cardiac Services

Regulatory Compliance Manual

201 1

INTRODUCTION

Palmetto Health is committed to serving you and your patients. However, in doing so we also must adhere to federal guidelines that govern lab work for Medicare beneficiaries.

The purpose of this booklet is to provide a user friendly guide and reference to assist you to understand and comply with CMS guidelines for lab compliance.

The booklet includes excerpts from all of the **Medicare Part A** local and national coverage decisions **[NCDs** - National Coverage Decisions; **LCDs - Local** Coverage Decisions; **LMRPs - Local** Medical Review Policies**]** for lab tests. LCDs and LMRPs are very similar but are local policies that apply only to South Carolina.

These policies can assist you and your staff in determining the conditions under which Medicare does or does not cover these tests. By referring to these policies before the patient leaves your office, you will have the opportunity to answer the patient's questions about the need for the testing, especially when it appears likely that Medicare will not cover a test.

When a Medicare beneficiary arrives at any Palmetto Health Laboratory, each test ordered is electronically checked against the ICD-9 codes in the NCDs or LCDs/LMRPs. When medical necessity of a lab test is not supported by the reasons provided by the physician on the lab order/requisition, the patient will be asked to sign an Advanced Beneficiary Notice (ABN). Patients are often surprised and concerned when informed that the testing will probably not be covered. On occasion, patients refuse to sign the ABN, refuse to have the tests done, or request follow-up with the physician.

Guidelines for obtaining ABNs are provided in Appendix C. A reproducible copy of the ABN form (CMS-R-131-L) is provided with this booklet.

The lab also must follow other coding guidelines including the National Correct Coding Initiative edits (CCI). We may contact your office if a pattern of ordering tests governed by these edits is identified.

Note that information repeated in the local and national policies and other important information has been placed in the appendices for ease of use and as a quick reference. Please acquaint yourself with this information

Cardiac Cath

LCD Information

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L11319

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CARDIAC CATHETERIZATION

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99-0012-L

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Title XVIII of the Social Security Act, section 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.

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Indications and Limitations of Coverage and/or Medical Necessity back to top

Indications for Left Heart Cath:

1. Symptomatic patient with known or suspected coronary artery disease (CAD) *(suspected refers to the presence of clinical characteristics that suggest high risk)*

2. Asymptomatic or stable angina patient with suspected CAD suggested by ischemic findings on noninvasive testing or the presence of clinical characteristics

3. Patients with unstable angina

4. Patient categorized “High Risk” by non-invasive testing results, regardless of anginal severity (see Chart 1)

5. Symptomatic patients with nonspecific chest pain with high risk or ambiguous findings on noninvasive testing

6. Symptomatic patient who fails to stabilize with medical therapy

7. Asymptomatic post-bypass patient in whom documentation shows deterioration exists from previous noninvasive testing

8. Patient with acute myocardial infarction

9. Patient with malignant ventricular arrhythmias

10. Patient with depressed, resting LV dysfunction or large perfusion defect by non-invasive study

11. Patient categorized “Intermediate” or “High Risk”, with history of PTCA or CABG, unless prior cath data indicated no further revascularization would be technically possible

12. Patient, post-revascularization, with recurrent symptoms or recurrent ischemia on noninvasive testing

13. Symptomatic patient for a preoperative workup in major non-cardiac surgery, when there is evidence of an intermediate or high-risk based on noninvasive testing

14. Asymptomatic patient for a preoperative workup in major non-cardiac surgery, when there is evidence for a high risk adverse outcome based on noninvasive testing

15. Patient at high risk for CAD when other cardiac surgical procedures are planned

Indications for Right and Combined Heart Caths:

1. Patient with chest discomfort or ischemia by noninvasive testing prior to valve surgery

2. Patient without chest pain, but with documented multiple CAD risk factors and of substantial age, prior to valve surgery

3. Patient with angina, ischemia on noninvasive testing, or multiple CAD risk factors prior to surgical repair of congenital heart disease

4. Patient with normal systolic function but with unexplained episodes of acute pulmonary edema or hypoxia

5. Patient workup prior to and post heart transplant in
those patients with congestive heart failure (CHF)

6. Patient with systolic dysfunction of unexplained cause despite noninvasive testing

7. Patient with CHF due to systolic dysfunction with angina or with regional wall motion abnormalities when there is documented evidence of reversible myocardial ischemia for revascularization consideration

8. Symptomatic patient with pulmonary hypertension or right heart failure

9. Symptomatic patient with valvular stenosis or insufficiency

10. Symptomatic patient in whom intra-cardiac shunting is suspected

Indications for Aortic Root Aortography in conjunction with Heart Cath:

1. Known or suspected aortic valvular disease

2. Dysfunction of the prosthetic aortic valve

3. Aortic aneurysm or aortic dissection

4. History of aortocoronary bypass

5. Post inconclusive or normal cardiac catheterization in the symptomatic, hypertensive patient

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Diagnostic Tests and X-Rays

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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.

999x	Not Applicable

Revenue Codes: back to top

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.

99999	Not Applicable

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Right Heart Catheterization

93501	Right heart catheterization
93530	Rt heart cath, congenital
93541	Injection for lung angiogram
93542	Injection for heart x-rays
93545	Inject for coronary x-rays
93555	Imaging, cardiac cath
93556	Imaging, cardiac cath

Left Heart Catheterization	
93510	Left heart catheterization
93511	Left heart catheterization
93514	Left heart catheterization
93539	Injection, cardiac cath
93540	Injection, cardiac cath
93543	Injection for heart x-rays
93545	Inject for coronary x-rays
93555	Imaging, cardiac cath
93556	Imaging, cardiac cath
Combined Right and Left Heart Catheterization	
93524	Left heart catheterization
93526	Rt & Lt heart catheters
93527	Rt & Lt heart catheters
93528	Rt & Lt heart catheters
93529	Rt, lt heart catheterization
93531	R & l heart cath, congenital
93532	R & l heart cath, congenital
93533	R & l heart cath, congenital
93541	Injection for lung angiogram
93542	Injection for heart x-rays
Aortic Root Aortography in Conjunction with A Cardiac Catheterization	
93544	Injection for aortography
93555	Imaging, cardiac cath
93556	Imaging, cardiac cath

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Left Heart Cath:

394.0 - 394.9	MITRAL STENOSIS - OTHER AND UNSPECIFIED MITRAL VALVE DISEASES
395.0 - 395.9	RHEUMATIC AORTIC STENOSIS - OTHER AND UNSPECIFIED RHEUMATIC AORTIC DISEASES
396.0 - 396.9	MITRAL VALVE STENOSIS AND AORTIC VALVE STENOSIS - MITRAL AND AORTIC VALVE DISEASES UNSPECIFIED
397.0 -	DISEASES OF TRICUSPID VALVE - RHEUMATIC DISEASES OF

397.9	ENDOCARDIUM VALVE UNSPECIFIED
398.0 - 398.99	RHEUMATIC MYOCARDITIS - OTHER RHEUMATIC HEART DISEASES
402.00	MALIGNANT HYPERTENSIVE HEART DISEASE WITHOUT HEART FAILURE
402.01	MALIGNANT HYPERTENSIVE HEART DISEASE WITH HEART FAILURE
403.00	HYPERTENSIVE KIDNEY DISEASE, MALIGNANT, WITHOUT CHRONIC KIDNEY DISEASE
403.01	HYPERTENSIVE KIDNEY DISEASE, MALIGNANT, WITH CHRONIC KIDNEY DISEASE
405.01 - 405.09	MALIGNANT RENOVASCULAR HYPERTENSION - OTHER MALIGNANT SECONDARY HYPERTENSION
410.00 - 410.92	ACUTE MYOCARDIAL INFARCTION OF ANTEROLATERAL WALL EPISODE OF CARE UNSPECIFIED - ACUTE MYOCARDIAL INFARCTION OF UNSPECIFIED SITE SUBSEQUENT EPISODE OF CARE
411.0 - 411.89	POSTMYOCARDIAL INFARCTION SYNDROME - OTHER ACUTE AND SUBACUTE FORMS OF ISCHEMIC HEART DISEASE OTHER
412	OLD MYOCARDIAL INFARCTION
413.0 - 413.9	ANGINA DECUBITUS - OTHER AND UNSPECIFIED ANGINA PECTORIS
414.00 - 414.07	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED TYPE OF VESSEL NATIVE OR GRAFT - CORONARY ATHEROSCLEROSIS OF BYPASS GRAFT (ARTERY) (VEIN) OF TRANSPLANTED HEART
414.10 - 414.19	ANEURYSM OF HEART (WALL) - OTHER ANEURYSM OF HEART
414.9	CHRONIC ISCHEMIC HEART DISEASE UNSPECIFIED
415.0 - 415.19	ACUTE COR PULMONALE - OTHER PULMONARY EMBOLISM AND INFARCTION
416.0 - 416.9	PRIMARY PULMONARY HYPERTENSION - CHRONIC PULMONARY HEART DISEASE UNSPECIFIED
417.0 - 417.9	ARTERIOVENOUS FISTULA OF PULMONARY VESSELS - UNSPECIFIED DISEASE OF PULMONARY CIRCULATION
420.0 - 420.99	ACUTE PERICARDITIS IN DISEASES CLASSIFIED ELSEWHERE - OTHER ACUTE PERICARDITIS
424.0	MITRAL VALVE DISORDERS
424.1	AORTIC VALVE DISORDERS
424.2	TRICUSPID VALVE DISORDERS SPECIFIED AS NONRHEUMATIC

424.3	PULMONARY VALVE DISORDERS
424.90	ENDOCARDITIS VALVE UNSPECIFIED UNSPECIFIED CAUSE
424.91	ENDOCARDITIS IN DISEASES CLASSIFIED ELSEWHERE
424.99	OTHER ENDOCARDITIS VALVE UNSPECIFIED
425.0 - 425.9	ENDOMYOCARDIAL FIBROSIS - SECONDARY CARDIOMYOPATHY UNSPECIFIED
426.0	ATRIOVENTRICULAR BLOCK COMPLETE
426.10	ATRIOVENTRICULAR BLOCK UNSPECIFIED
426.11	FIRST DEGREE ATRIOVENTRICULAR BLOCK
426.12	MOBITZ (TYPE) II ATRIOVENTRICULAR BLOCK
426.13	OTHER SECOND DEGREE ATRIOVENTRICULAR BLOCK
426.2	LEFT BUNDLE BRANCH HEMIBLOCK
426.3	OTHER LEFT BUNDLE BRANCH BLOCK
426.4	RIGHT BUNDLE BRANCH BLOCK
426.50	BUNDLE BRANCH BLOCK UNSPECIFIED
426.51	RIGHT BUNDLE BRANCH BLOCK AND LEFT POSTERIOR FASCICULAR BLOCK
426.52	RIGHT BUNDLE BRANCH BLOCK AND LEFT ANTERIOR FASCICULAR BLOCK
426.53	OTHER BILATERAL BUNDLE BRANCH BLOCK
426.54	TRIFASCICULAR BLOCK
426.6	OTHER HEART BLOCK
426.7	ANOMALOUS ATRIOVENTRICULAR EXCITATION
426.81	LOWN-GANONG-LEVINE SYNDROME
426.82	LONG QT SYNDROME
426.89	OTHER SPECIFIED CONDUCTION DISORDERS
426.9	CONDUCTION DISORDER UNSPECIFIED
427.0 - 427.9	PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA - CARDIAC DYSRHYTHMIA UNSPECIFIED
428.0 - 428.9	CONGESTIVE HEART FAILURE UNSPECIFIED - HEART FAILURE UNSPECIFIED
429.0	MYOCARDITIS UNSPECIFIED
429.1	MYOCARDIAL DEGENERATION
429.2	CARDIOVASCULAR DISEASE UNSPECIFIED

429.3	CARDIOMEGALY
429.4	FUNCTIONAL DISTURBANCES FOLLOWING CARDIAC SURGERY
429.5	RUPTURE OF CHORDAE TENDINEAE
429.6	RUPTURE OF PAPILLARY MUSCLE
429.71	CERTAIN SEQUELAE OF MYOCARDIAL INFARCTION NOT ELSEWHERE CLASSIFIED ACQUIRED CARDIAC SEPTAL DEFECT
429.79	CERTAIN SEQUELAE OF MYOCARDIAL INFARCTION NOT ELSEWHERE CLASSIFIED OTHER
429.81 - 429.89	OTHER DISORDERS OF PAPILLARY MUSCLE - OTHER ILL-DEFINED HEART DISEASES
429.9	HEART DISEASE UNSPECIFIED
440.0 - 440.9	ATHEROSCLEROSIS OF AORTA - GENERALIZED AND UNSPECIFIED ATHEROSCLEROSIS
458.0	ORTHOSTATIC HYPOTENSION
492.0 - 492.8	EMPHYSEMATOUS BLEB - OTHER EMPHYSEMA
493.20	CHRONIC OBSTRUCTIVE ASTHMA UNSPECIFIED
493.21	CHRONIC OBSTRUCTIVE ASTHMA WITH STATUS ASTHMATICUS
496	CHRONIC AIRWAY OBSTRUCTION NOT ELSEWHERE CLASSIFIED
514	PULMONARY CONGESTION AND HYPOSTASIS
515	POSTINFLAMMATORY PULMONARY FIBROSIS
745.0 - 745.9	COMMON TRUNCUS - UNSPECIFIED DEFECT OF SEPTAL CLOSURE
746.00 - 746.9	CONGENITAL PULMONARY VALVE ANOMALY UNSPECIFIED - UNSPECIFIED CONGENITAL ANOMALY OF HEART
747.0	PATENT DUCTUS ARTERIOSUS
747.10 - 747.11	COARCTATION OF AORTA (PREDUCTAL) (POSTDUCTAL) - INTERRUPTION OF AORTIC ARCH
747.20 - 747.29	CONGENITAL ANOMALY OF AORTA UNSPECIFIED - OTHER CONGENITAL ANOMALIES OF AORTA
747.3	CONGENITAL ANOMALIES OF PULMONARY ARTERY
747.40 - 747.49	CONGENITAL ANOMALY OF GREAT VEINS UNSPECIFIED - OTHER ANOMALIES OF GREAT VEINS
780.8	GENERALIZED HYPERHIDROSIS
785.0 - 785.4	TACHYCARDIA UNSPECIFIED - GANGRENE

785.50 - 785.59	SHOCK UNSPECIFIED - OTHER SHOCK WITHOUT TRAUMA
785.6 - 785.9	ENLARGEMENT OF LYMPH NODES - OTHER SYMPTOMS INVOLVING CARDIOVASCULAR SYSTEM
786.02	ORTHOPNEA
786.05	SHORTNESS OF BREATH
786.09	RESPIRATORY ABNORMALITY OTHER
786.50	UNSPECIFIED CHEST PAIN
786.51	PRECORDIAL PAIN
786.52	PAINFUL RESPIRATION
786.59	OTHER CHEST PAIN
787.1	HEARTBURN
793.2	NONSPECIFIC ABNORMAL FINDINGS ON RADIOLOGICAL AND OTHER EXAMINATION OF OTHER INTRATHORACIC ORGANS
794.30 - 794.39	UNSPECIFIED ABNORMAL FUNCTION STUDY OF CARDIOVASCULAR SYSTEM - OTHER NONSPECIFIC ABNORMAL FUNCTION STUDY OF CARDIOVASCULAR SYSTEM
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Right Heart Caths and the Right Heart Component of Combined Caths:	
394.0 - 394.9	MITRAL STENOSIS - OTHER AND UNSPECIFIED MITRAL VALVE DISEASES
395.0 - 395.9	RHEUMATIC AORTIC STENOSIS - OTHER AND UNSPECIFIED RHEUMATIC AORTIC DISEASES
396.0 - 396.9	MITRAL VALVE STENOSIS AND AORTIC VALVE STENOSIS - MITRAL AND AORTIC VALVE DISEASES UNSPECIFIED
397.0 - 397.9	DISEASES OF TRICUSPID VALVE - RHEUMATIC DISEASES OF ENDOCARDIUM VALVE UNSPECIFIED
398.0 - 398.99	RHEUMATIC MYOCARDITIS - OTHER RHEUMATIC HEART DISEASES
415.0 - 415.19	ACUTE COR PULMONALE - OTHER PULMONARY EMBOLISM AND INFARCTION
416.0 - 416.9	PRIMARY PULMONARY HYPERTENSION - CHRONIC PULMONARY HEART DISEASE UNSPECIFIED
417.0 - 417.9	ARTERIOVENOUS FISTULA OF PULMONARY VESSELS - UNSPECIFIED DISEASE OF PULMONARY CIRCULATION
420.0 - 420.99	ACUTE PERICARDITIS IN DISEASES CLASSIFIED ELSEWHERE - OTHER ACUTE PERICARDITIS
421.0 -	ACUTE AND SUBACUTE BACTERIAL ENDOCARDITIS - ACUTE

421.9	ENDOCARDITIS UNSPECIFIED
422.0 - 422.99	ACUTE MYOCARDITIS IN DISEASES CLASSIFIED ELSEWHERE - OTHER ACUTE MYOCARDITIS
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424.99	OTHER ENDOCARDITIS VALVE UNSPECIFIED
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426.0	ATRIOVENTRICULAR BLOCK COMPLETE
426.10 - 426.12	ATRIOVENTRICULAR BLOCK UNSPECIFIED - MOBITZ (TYPE) II ATRIOVENTRICULAR BLOCK
426.82	LONG QT SYNDROME
427.31	ATRIAL FIBRILLATION
428.0 - 428.9	CONGESTIVE HEART FAILURE UNSPECIFIED - HEART FAILURE UNSPECIFIED
429.0 - 429.6	MYOCARDITIS UNSPECIFIED - RUPTURE OF PAPILLARY MUSCLE
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747.20 - 747.29	CONGENITAL ANOMALY OF AORTA UNSPECIFIED - OTHER CONGENITAL ANOMALIES OF AORTA
747.3	CONGENITAL ANOMALIES OF PULMONARY ARTERY
747.40 - 747.49	CONGENITAL ANOMALY OF GREAT VEINS UNSPECIFIED - OTHER ANOMALIES OF GREAT VEINS
748.0 - 748.9	CHOANAL ATRESIA - UNSPECIFIED CONGENITAL ANOMALY OF RESPIRATORY SYSTEM
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Aortic Root Aortography in Conjunction with a Heart Cath:

093.0	ANEURYSM OF AORTA SPECIFIED AS SYPHILITIC
093.1	SYPHILITIC AORTITIS
093.20 - 093.24	SYPHILITIC ENDOCARDITIS OF VALVE UNSPECIFIED - SYPHILITIC ENDOCARDITIS OF PULMONARY VALVE
395.0 - 395.2	RHEUMATIC AORTIC STENOSIS - RHEUMATIC AORTIC STENOSIS WITH INSUFFICIENCY
396.0 - 396.8	MITRAL VALVE STENOSIS AND AORTIC VALVE STENOSIS - MULTIPLE INVOLVEMENT OF MITRAL AND AORTIC VALVES
401.0	MALIGNANT ESSENTIAL HYPERTENSION
424.1	AORTIC VALVE DISORDERS
426.82	LONG QT SYNDROME
441.01	DISSECTION OF AORTA THORACIC
441.1	THORACIC ANEURYSM RUPTURED
441.2	THORACIC ANEURYSM WITHOUT RUPTURE
519.3	OTHER DISEASES OF MEDIASTINUM NOT ELSEWHERE CLASSIFIED
746.3	CONGENITAL STENOSIS OF AORTIC VALVE
746.4	CONGENITAL INSUFFICIENCY OF AORTIC VALVE
746.7	HYPOPLASTIC LEFT HEART SYNDROME
746.81	SUBAORTIC STENOSIS CONGENITAL
746.85	CORONARY ARTERY ANOMALY CONGENITAL
747.10 - 747.11	COARCTATION OF AORTA (PREDUCTAL) (POSTDUCTAL) - INTERRUPTION OF AORTIC ARCH
747.20 - 747.29	CONGENITAL ANOMALY OF AORTA UNSPECIFIED - OTHER CONGENITAL ANOMALIES OF AORTA
996.02	MECHANICAL COMPLICATION DUE TO HEART VALVE PROSTHESIS
996.71	OTHER COMPLICATIONS DUE TO HEART VALVE PROSTHESIS

V42.1	HEART REPLACED BY TRANSPLANT
V45.81	POSTSURGICAL AORTOCORONARY BYPASS STATUS

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XX000	Not Applicable

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

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Other Medicare Carriers local medical review policies

Scanlon PJ, Faxon DP, Audet AM, Carabello B, Dehmer GJ, Eagle KA, Legako RD, Leon DF, Murray JA, Nissen SE, Pepine CJ, Watson RM. ACC/AHA Guidelines for Coronary Angiography: Executive Summary and Recommendations: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee on Coronary Angiography). Circulation. 1999; 99:2345-2357.

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This policy does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from Cardiology.

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07/21/1999

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5
Policy Revision Date: 02/10/2006
Annual CPT, HCPCS, ICD-9-CM update 02/10/2006

Added 2006 ICD-9 code 426.82 as supporting medical necessity for:
Group 1-Right Heart Catheterization,
Group 2-Right Heart Caths and the Right Heart Component of Combined Caths
Group 3-Aortic Root Aortography in Conjunction with a Heart Cath

4
09/24/2004
Conversion to LCD

3
09/23/2003
Addition of new ICD-9-CM code 414.07

2
02/24/2003
Addition of 427.31 to 93527 (transseptal) for pulmonary vein ablation in treatment of chronic atrial fibrillation

1
01/04/2001

CAROTID, SUBCLAVIAN AND VERTEBRAL ANGIOGRAPHY & INTERVENTION

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L5821

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CAROTID, SUBCLAVIAN AND VERTEBRAL ANGIOGRAPHY & INTERVENTION

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

CMS Manual System, Pub 100-4, Medicare Claims Processing, Chapter 12, Section 40.6 which discusses multiple surgery.

CMS Manual System, Pub 100-3, Medicare National Coverage Determination, Chapter 1, Section 20.7 states percutaneous transluminal angioplasty in the treatment of obstructive lesions of the aortic arch vessels, including the carotid, subclavian, and vertebral arteries is excluded from coverage.

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Angiography of Vertebral, Carotid and Subclavian Systems

1. To determine the extent and degree of occlusive disease of the carotid or vertebral arteries in patients with symptoms of ischemic cerebral disease

· The previous noninvasive test must indicate significant stenotic (> 65%) or severely ulcerated disease in order to receive reimbursement for angiography of the carotids

· Surgical correction of the occlusive disease must be beneficial to the patient's clinical status

2. Tumors

3. Intractable seizures

4. Intracranial anomalies

5. Trauma

6. Hemorrhage

Percutaneous Interventions

Percutaneous angioplasty and/or stent implantation of the carotid and vertebral arteries is non-covered except for those performed in conjunction with a Medicare approved clinical trial.

Effective July 1, 2001, Medicare will cover PTA of the carotid artery concurrent with carotid stent placement when furnished in accordance with the Food and Drug Administration (FDA) approved protocols governing Category B Investigational Device Exemption (IDE) clinical trials. PTA of the carotid artery, when provided solely for the purpose of carotid artery dilation concurrent with carotid stent placement is considered to be a reasonable and necessary service only when provided in the context of such a clinical trial. Therefore, it is considered a covered service for the purposes of these trials. Performance of PTA in the carotid artery when used to treat obstructive lesions outside of approved protocols governing Category B IDE clinical trials remains a non-covered service.

Effective October 1, 2004, Medicare covers PTA of the carotid artery concurrent with the placement of an FDA-approved carotid stent for an FDA-approved indication when furnished in accordance with FDA- approved protocols governing post-approval studies (study has Post Market Approval Number). CMS determines that coverage of PTA of the carotid artery is reasonable and necessary under these circumstances only.

LIMITATIONS

Performance of PTA in the carotid artery when used to treat obstructive lesions outside of FDA-approved protocols governing Category B IDE trials and outside of FDA-required post approval studies remains a noncovered service.

Performance of PTA to treat obstructive lesions of the vertebral and cerebral arteries remains noncovered. The safety and efficacy of these procedures are not established.

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Diagnostic Tests and X-Rays

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999x	Not Applicable

Revenue Codes: back to top

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99999	Not Applicable

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***These Codes are not covered for carotid and vertebral vessels outside a clinical trial.**
***35475**
***35494**
***37215**
***37216**
***0075T**
***0076T**
***75960**

0075T	Perq stent/chest vert art
0076T	S&i stent/chest vert art
35475	Repair arterial blockage
35494	Atherectomy, percutaneous
36120	Establish access to artery
36200	Place catheter in aorta
36215	Place catheter in artery
36216	Place catheter in artery
36217	Place catheter in artery
36218	Place catheter in artery
37215	Transcath stent, cca w/eps
37216	Transcath stent, cca w/o eps
75650	Artery x-rays, head & neck
75660	Artery x-rays, head & neck
75662	Artery x-rays, head & neck

75665	Artery x-rays, head & neck
75671	Artery x-rays, head & neck
75676	Artery x-rays, neck
75680	Artery x-rays, neck
75685	Artery x-rays, spine
75960	Transcath iv stent rs&i

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191.0 - 191.9	MALIGNANT NEOPLASM OF CEREBRUM EXCEPT LOBES AND VENTRICLES - MALIGNANT NEOPLASM OF BRAIN UNSPECIFIED SITE
192.0 - 192.9	MALIGNANT NEOPLASM OF CRANIAL NERVES - MALIGNANT NEOPLASM OF NERVOUS SYSTEM PART UNSPECIFIED
193	MALIGNANT NEOPLASM OF THYROID GLAND
194.1 - 194.5	MALIGNANT NEOPLASM OF PARATHYROID GLAND - MALIGNANT NEOPLASM OF CAROTID BODY
195.0	MALIGNANT NEOPLASM OF HEAD FACE AND NECK
198.3	SECONDARY MALIGNANT NEOPLASM OF BRAIN AND SPINAL CORD
198.4	SECONDARY MALIGNANT NEOPLASM OF OTHER PARTS OF NERVOUS SYSTEM
200.00 - 200.88	RETICULOSARCOMA UNSPECIFIED SITE - OTHER NAMED VARIANTS OF LYMPHOSARCOMA AND RETICULOSARCOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
201.00 - 201.08	HODGKIN'S PARAGRANULOMA UNSPECIFIED SITE - HODGKIN'S PARAGRANULOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
201.10 - 201.18	HODGKIN'S GRANULOMA UNSPECIFIED SITE - HODGKIN'S GRANULOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
201.20 - 201.28	HODGKIN'S SARCOMA UNSPECIFIED SITE - HODGKIN'S SARCOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
201.40 - 201.48	HODGKIN'S DISEASE LYMPHOCYTIC-HISTIOCYTIC PREDOMINANCE UNSPECIFIED SITE - HODGKIN'S DISEASE LYMPHOCYTIC-HISTIOCYTIC PREDOMINANCE INVOLVING LYMPH NODES OF MULTIPLE SITES
201.50	HODGKIN'S DISEASE NODULAR SCLEROSIS UNSPECIFIED SITE -

- 201.58	HODGKIN'S DISEASE NODULAR SCLEROSIS INVOLVING LYMPH NODES OF MULTIPLE SITES
201.60 - 201.68	HODGKIN'S DISEASE MIXED CELLULARITY UNSPECIFIED SITE - HODGKIN'S DISEASE MIXED CELLULARITY INVOLVING LYMPH NODES OF MULTIPLE SITES
201.70 - 201.78	HODGKIN'S DISEASE LYMPHOCYTIC DEPLETION UNSPECIFIED SITE - HODGKIN'S DISEASE LYMPHOCYTIC DEPLETION INVOLVING LYMPH NODES OF MULTIPLE SITES
201.90 - 201.98	HODGKIN'S DISEASE UNSPECIFIED TYPE UNSPECIFIED SITE - HODGKIN'S DISEASE UNSPECIFIED TYPE INVOLVING LYMPH NODES OF MULTIPLE SITES
202.00 - 202.08	NODULAR LYMPHOMA UNSPECIFIED SITE - NODULAR LYMPHOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
202.10 - 202.18	MYCOSIS FUNGOIDES UNSPECIFIED SITE - MYCOSIS FUNGOIDES INVOLVING LYMPH NODES OF MULTIPLE SITES
202.20 - 202.28	SEZARY'S DISEASE UNSPECIFIED SITE - SEZARY'S DISEASE INVOLVING LYMPH NODES OF MULTIPLE SITES
202.30 - 202.38	MALIGNANT HISTIOCYTOSIS UNSPECIFIED SITE - MALIGNANT HISTIOCYTOSIS INVOLVING LYMPH NODES OF MULTIPLE SITES
202.40 - 202.48	LEUKEMIC RETICULOENDOTHELIOSIS UNSPECIFIED SITE - LEUKEMIC RETICULOENDOTHELIOSIS INVOLVING LYMPH NODES OF MULTIPLE SITES
202.50 - 202.58	LETTERER-SIWE DISEASE UNSPECIFIED SITE - LETTERER-SIWE DISEASE INVOLVING LYMPH NODES OF MULTIPLE SITES
202.60 - 202.68	MALIGNANT MAST CELL TUMORS UNSPECIFIED SITE - MALIGNANT MAST CELL TUMORS INVOLVING LYMPH NODES OF MULTIPLE SITES
202.80 - 202.88	OTHER MALIGNANT LYMPHOMAS UNSPECIFIED SITE - OTHER MALIGNANT LYMPHOMAS INVOLVING LYMPH NODES OF MULTIPLE SITES
202.90 - 202.98	OTHER AND UNSPECIFIED MALIGNANT NEOPLASMS OF LYMPHOID AND HISTIOCYTIC TISSUE UNSPECIFIED SITE - OTHER AND UNSPECIFIED MALIGNANT NEOPLASMS OF LYMPHOID AND HISTIOCYTIC TISSUE INVOLVING LYMPH NODES OF MULTIPLE SITES
225.0	BENIGN NEOPLASM OF BRAIN
225.1	BENIGN NEOPLASM OF CRANIAL NERVES

225.2	BENIGN NEOPLASM OF CEREBRAL MENINGES
237.3	NEOPLASM OF UNCERTAIN BEHAVIOR OF PARAGANGLIA
239.6	NEOPLASM OF UNSPECIFIED NATURE OF BRAIN
325	PHLEBITIS AND THROMBOPHLEBITIS OF INTRACRANIAL VENOUS SINUSES
342.00 - 342.82	FLACCID HEMIPLEGIA AND HEMIPARESIS AFFECTING UNSPECIFIED SIDE - OTHER SPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE
346.00	CLASSICAL MIGRAINE WITHOUT INTRACTABLE MIGRAINE
346.01	CLASSICAL MIGRAINE WITH INTRACTABLE MIGRAINE SO STATED
362.30 - 362.37	RETINAL VASCULAR OCCLUSION UNSPECIFIED - VENOUS ENGORGEMENT OF RETINA
368.12	TRANSIENT VISUAL LOSS
368.8	OTHER SPECIFIED VISUAL DISTURBANCES
430	SUBARACHNOID HEMORRHAGE
431	INTRACEREBRAL HEMORRHAGE
432.0 - 432.9	NONTRAUMATIC EXTRADURAL HEMORRHAGE - UNSPECIFIED INTRACRANIAL HEMORRHAGE
433.00 - 433.81	OCCLUSION AND STENOSIS OF BASILAR ARTERY WITHOUT CEREBRAL INFARCTION - OCCLUSION AND STENOSIS OF OTHER SPECIFIED PRECEREBRAL ARTERY WITH CEREBRAL INFARCTION
434.00 - 434.01	CEREBRAL THROMBOSIS WITHOUT CEREBRAL INFARCTION - CEREBRAL THROMBOSIS WITH CEREBRAL INFARCTION
434.10 - 434.11	CEREBRAL EMBOLISM WITHOUT CEREBRAL INFARCTION - CEREBRAL EMBOLISM WITH CEREBRAL INFARCTION
434.90 - 434.91	CEREBRAL ARTERY OCCLUSION UNSPECIFIED WITHOUT CEREBRAL INFARCTION - CEREBRAL ARTERY OCCLUSION UNSPECIFIED WITH CEREBRAL INFARCTION
435.0 - 435.9	BASILAR ARTERY SYNDROME - UNSPECIFIED TRANSIENT CEREBRAL ISCHEMIA
436	ACUTE BUT ILL-DEFINED CEREBROVASCULAR DISEASE
437.1	OTHER GENERALIZED ISCHEMIC CEREBROVASCULAR DISEASE
437.3	CEREBRAL ANEURYSM NONRUPTURED
437.4	CEREBRAL ARTERITIS
437.5	MOYAMOYA DISEASE

442.81	ANEURYSM OF ARTERY OF NECK
442.82	ANEURYSM OF SUBCLAVIAN ARTERY
443.21	DISSECTION OF CAROTID ARTERY
443.24	DISSECTION OF VERTEBRAL ARTERY
446.0	POLYARTERITIS NODOSA
446.7	TAKAYASU'S DISEASE
447.1	STRICTURE OF ARTERY
780.02	TRANSIENT ALTERATION OF AWARENESS
780.2	SYNCOPE AND COLLAPSE
780.39	OTHER CONVULSIONS
781.0 - 781.99	ABNORMAL INVOLUNTARY MOVEMENTS - OTHER SYMPTOMS INVOLVING NERVOUS AND MUSCULOSKELETAL SYSTEMS
782.0	DISTURBANCE OF SKIN SENSATION
784.0	HEADACHE
784.3	APHASIA
784.5	OTHER SPEECH DISTURBANCE
784.7	EPISTAXIS
787.2	DYSPHAGIA
793.0	NONSPECIFIC ABNORMAL FINDINGS ON RADIOLOGICAL AND OTHER EXAMINATION OF SKULL AND HEAD
852.00 - 852.09	SUBARACHNOID HEMORRHAGE FOLLOWING INJURY WITHOUT OPEN INTRACRANIAL WOUND WITH STATE OF CONSCIOUSNESS UNSPECIFIED - SUBARACHNOID HEMORRHAGE FOLLOWING INJURY WITHOUT OPEN INTRACRANIAL WOUND WITH CONCUSSION UNSPECIFIED
852.10 - 852.19	SUBARACHNOID HEMORRHAGE FOLLOWING INJURY WITH OPEN INTRACRANIAL WOUND WITH STATE OF CONSCIOUSNESS UNSPECIFIED - SUBARACHNOID HEMORRHAGE FOLLOWING INJURY WITH OPEN INTRACRANIAL WOUND WITH CONCUSSION UNSPECIFIED
852.20 - 852.29	SUBDURAL HEMORRHAGE FOLLOWING INJURY WITHOUT OPEN INTRACRANIAL WOUND WITH STATE OF CONSCIOUSNESS UNSPECIFIED - SUBDURAL HEMORRHAGE FOLLOWING INJURY WITHOUT OPEN INTRACRANIAL WOUND WITH CONCUSSION UNSPECIFIED
852.30 - 852.39	SUBDURAL HEMORRHAGE FOLLOWING INJURY WITH OPEN INTRACRANIAL WOUND WITH STATE OF CONSCIOUSNESS UNSPECIFIED - SUBDURAL HEMORRHAGE FOLLOWING INJURY

	WITH OPEN INTRACRANIAL WOUND WITH CONCUSSION UNSPECIFIED
852.40 - 852.49	EXTRADURAL HEMORRHAGE FOLLOWING INJURY WITHOUT OPEN INTRACRANIAL WOUND WITH STATE OF CONSCIOUSNESS UNSPECIFIED - EXTRADURAL HEMORRHAGE FOLLOWING INJURY WITHOUT OPEN INTRACRANIAL WOUND WITH CONCUSSION UNSPECIFIED
852.50 - 852.59	EXTRADURAL HEMORRHAGE FOLLOWING INJURY WITH OPEN INTRACRANIAL WOUND WITH STATE OF CONSCIOUSNESS UNSPECIFIED - EXTRADURAL HEMORRHAGE FOLLOWING INJURY WITH OPEN INTRACRANIAL WOUND WITH CONCUSSION UNSPECIFIED
853.00 - 853.19	OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE FOLLOWING INJURY WITHOUT OPEN INTRACRANIAL WOUND WITH STATE OF CONSCIOUSNESS UNSPECIFIED - OTHER AND UNSPECIFIED INTRACRANIAL HEMORRHAGE FOLLOWING INJURY WITH OPEN INTRACRANIAL WOUND WITH CONCUSSION UNSPECIFIED
854.00 - 854.19	INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE WITHOUT OPEN INTRACRANIAL WOUND WITH STATE OF CONSCIOUSNESS UNSPECIFIED - INTRACRANIAL INJURY OF OTHER AND UNSPECIFIED NATURE WITH OPEN INTRACRANIAL WOUND WITH CONCUSSION UNSPECIFIED
900.00 - 900.9	INJURY TO CAROTID ARTERY UNSPECIFIED - INJURY TO UNSPECIFIED BLOOD VESSEL OF HEAD AND NECK
996.1	MECHANICAL COMPLICATION OF OTHER VASCULAR DEVICE IMPLANT AND GRAFT

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Diagnoses that DO NOT Support Medical Necessity back to top

General Information

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

IDE number or PMA number must be in block 23 of the claims form. For all PMA studies requiring the use of CPT code 37799, please attach the hardcopy operative report to the claim to identify the procedure, vessels catheterized and FDA-approved stent used.

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N/A

Sources of Information and Basis for Decision back to top

Worthy SA, et al., The role of duplex sonography and angiography in the investigation of carotid artery disease. Neuroradiology 1997 Feb;39(2):122-6.

Guterman LR, et al., Cervical carotid revascularization. Neurosurg Clin N Am 2000 Jan;11(1):39-48,viii.

Mori T, et al., Cerebral angioplasty and stenting for intracranial vertebral atherosclerotic stenosis. Am J Neuroradiol 1999 May;20(5):787-789.

Phan TG, et al., Intra-arterial thrombolysis for vertebrobasilar circulation ischemia. Crit Care Clin 1999 Oct;15(4):719-742.

Morris PP, et al., Intracranial deployment of coronary stents for symptomatic atherosclerotic plague. Am J Neuroradiol 1999 Oct;20(9):1688-1694.

Nomura M, et al., Percutanoues transluminal angioplasty for intracranial vertebral and/or basilar artery stenosis. Clin Radiol 1999 Aug;54(8):521-527.

Staikov IN, et al., The site of atheromatosis in the subclavian and vertebral arteries and its implication for angioplasty. Neuroradiol 1999 Jul;41(7):537-542.

Canadian Medical Association Symposium. Controversies in cerebrovascular disease: Current indications for carotid endarterectomy. June 1998 publication.

Coggia M, et al., Embolic risk of the different stages of carotid bifurcation balloon angioplasty: An experimental study. J Vasc Surg 2000 Mar;31(3):550-557.

Canadian Medical Association Symposium. Controversies in cerebrovascular

disease: Appropriate imaging before carotid endarterectomy. June 1998 publication.

Other Carriers local medical review policies.

CMS Change Request 3489, effective 10/01/2004.

Advisory Committee Meeting Notes back to top

This policy does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from Cardiology and Vascular Surgery.

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04/19/2000

End Date of Comment Period back to top

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07/01/2000

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9

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9
Annual CPT, HCPCS, ICD-9-CM update review 02/10/2006

08
01/01/2005
Addition of new CPT codes for 2005

07
01/01/2005
2005 CPT/HCPCS description changes made by FU

06
10/01/2004
Change Request 3489 addition of PMA approvals for coverage of PTA with stent of carotid with a PMA number.

05

ECHO

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Echocardiography is a non-invasive technique in which pulsed high-frequency sound waves are used to visualize the contours, movements and dimensions of cardiac structures. Ultrahigh frequency sound waves are directed toward and reflected by cardiovascular structures. Reflected echoes are translated into electrical impulses for display on a monitor and for recording and storage on either videotape or digital recording.

Transthoracic Echocardiography (TTE) is a non-invasive test utilizing an ultrasonic transducer placed at an acoustic window (an area where bone and lung tissue are absent) on the surface of the patient's chest. The ultrasound generator is positioned in the esophagus for transesophageal echocardiography (TEE).

The most commonly utilized echocardiographic techniques are motion-mode (M-mode) and two-dimensional echocardiography. M-mode echocardiography employs a single pencil-like beam ultrasound view of cardiac structures. This method is especially useful for precisely recording the motion and dimensions of intracardiac structures, with respect to time. Two-dimensional echocardiography employs an ultrasound beam rapidly swept through an arc, producing a cross-sectional or fan-shaped view of cardiac structures. This technique is useful for recording lateral motion and providing the correct spatial relationship between cardiac structures. Doppler examination is a valuable adjunct to a complete echocardiographic examination. The basic principle utilizes the changes in frequency when a transmitted ultrasound wave is reflected from a moving surface, allowing measurement of velocity of movement (i.e., blood flow).

Echocardiography is generally indicated in the evaluation of impairment of cardiac structure/function. Accordingly, transthoracic and/or transesophageal echocardiography are reasonable and necessary to assess, diagnose, or treat the following conditions:

·Ventricular Function and Cardiomyopathies

·Hypertensive Heart Disease

·Acute Myocardial Infarction and Coronary Insufficiency

·Chronic Ischemic Heart Disease

·Exposure to Cardiotoxic Agents (Chemotherapeutic and External)

·Cardiac Transplant and Rejection Monitoring

·Native Valvular Heart Disease

·Prosthetic Heart Valves (Mechanical and Bio-Prostheses)

·Acute Endocarditis

·Pericardial Disease

·Structural Impairments of the Aorta

·Congenital Heart Disease

·Cardiac Thrombi and Embolic Sources

·Cardiac Tumors and Masses

·Critically Ill and Trauma Patients

·Interventional and Surgical Guidance

TEE can be of use during percutaneous and surgical cardiac interventions. In selected instances, TEE can provide guidance during the creation of shunts, placement of septation devices, performance of valvular plastic procedures and replacement when the surgical result cannot be adequately assessed by other means. Prior to elective percutaneous mitral valvuloplasty, TEE is used to assess left atrial thrombi.

·Arrhythmias/Cardioversion

Echocardiographic examination is covered for assessment of patients with certain cardiac arrhythmias (for instance, atrial fibrillation or flutter, re-entrant tachycardias, ventricular

tachycardia, or ventricular fibrillation) for underlying structural or functional cardiac abnormalities for which the knowledge obtained by echocardiography will influence treatment or provide prognostic information.

•For monitoring of cardiac output (Esophageal Doppler) for operative patients with a need for intra-operative fluid optimization

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Diagnostic Tests and X-Rays

Coding Information

Bill Type Codes: back to top

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.

12x	Hospital-inpatient or home health visits (Part B only)
13x	Hospital-outpatient (HHA-A also) (under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00)
18x	Hospital-swing beds
21x	SNF-inpatient, Part A
22x	SNF-inpatient or home health visits (Part B only)
23x	SNF-outpatient (HHA-A also)
71x	Clinic-rural health
73x	Clinic-independent provider based FQHC (eff 10/91)
85x	Special facility or ASC surgery-rural primary care hospital (eff 10/94)

Revenue Codes: back to top

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.

0480 - 0489	Cardiology-general classification - Cardiology-other

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93303	Echo transthoracic
93304	Echo transthoracic
93307	Echo exam of heart
93308	Echo exam of heart
93312	Echo transesophageal
93313	Echo transesophageal
93315	Echo transesophageal
93316	Echo transesophageal
93317	Echo transesophageal
93318	Echo transesophageal intraop
93320	Doppler echo exam, heart
93321	Doppler echo exam, heart
93325	Doppler color flow add-on
C8921	Comp transtho echo w/contr

C8922	Limit transtho echo w/contr
C8923	2D com transtho echo w/contr
C8924	2D lim transtho echo w/contr
C8925	2D TEE w/contrast, int/rept
C8926	Cong TEE w/contr, int/rept
C8927	TEE w/contrast; monitor
C8928	2D transtho w/contr; stress

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017.90 - 017.96	TUBERCULOSIS OF OTHER SPECIFIED ORGANS UNSPECIFIED EXAMINATION - TUBERCULOSIS OF OTHER SPECIFIED ORGANS TUBERCLE BACILLI NOT FOUND BY BACTERIOLOGICAL OR HISTOLOGICAL EXAMINATION BUT TUBERCULOSIS CONFIRMED BY OTHER METHODS (INOCULATION OF ANIMALS)
032.82	DIPHTHERITIC MYOCARDITIS
074.21 - 074.23	COXSACKIE PERICARDITIS - COXSACKIE MYOCARDITIS
086.0	CHAGAS' DISEASE WITH HEART INVOLVEMENT
088.81	LYME DISEASE
093.0 - 093.1	ANEURYSM OF AORTA SPECIFIED AS SYPHILITIC - SYPHILITIC AORTITIS
093.20	SYPHILITIC ENDOCARDITIS OF VALVE UNSPECIFIED
093.21 - 093.24	SYPHILITIC ENDOCARDITIS OF MITRAL VALVE - SYPHILITIC ENDOCARDITIS OF PULMONARY VALVE
093.81 - 093.89	SYPHILITIC PERICARDITIS - OTHER SPECIFIED CARDIOVASCULAR SYPHILIS

098.83	GONOCOCCAL PERICARDITIS
098.84	GONOCOCCAL ENDOCARDITIS
098.85	OTHER GONOCOCCAL HEART DISEASE
112.81	CANDIDAL ENDOCARDITIS
115.03 - 115.04	HISTOPLASMA CAPSULATUM PERICARDITIS - HISTOPLASMA CAPSULATUM ENDOCARDITIS
115.13 - 115.14	HISTOPLASMA DUBOISII PERICARDITIS - HISTOPLASMA DUBOISII ENDOCARDITIS
130.3	MYOCARDITIS DUE TO TOXOPLASMOSIS
135	SARCOIDOSIS
164.1	MALIGNANT NEOPLASM OF HEART
198.89	SECONDARY MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES
212.7	BENIGN NEOPLASM OF HEART
238.8	NEOPLASM OF UNCERTAIN BEHAVIOR OF OTHER SPECIFIED SITES
239.8	NEOPLASM OF UNSPECIFIED NATURE OF OTHER SPECIFIED SITES
275.0	DISORDERS OF IRON METABOLISM
276.50 - 276.52	VOLUME DEPLETION, UNSPECIFIED - HYPOVOLEMIA
276.6	FLUID OVERLOAD DISORDER
277.30 - 277.39	AMYLOIDOSIS, UNSPECIFIED - OTHER AMYLOIDOSIS
288.3	EOSINOPHILIA
391.0	ACUTE RHEUMATIC PERICARDITIS
391.1 - 391.2	ACUTE RHEUMATIC ENDOCARDITIS - ACUTE RHEUMATIC MYOCARDITIS

391.8	OTHER ACUTE RHEUMATIC HEART DISEASE
392.0	RHEUMATIC CHOREA WITH HEART INVOLVEMENT
393	CHRONIC RHEUMATIC PERICARDITIS
394.0 - 394.2	MITRAL STENOSIS - MITRAL STENOSIS WITH INSUFFICIENCY
395.0 - 395.2	RHEUMATIC AORTIC STENOSIS - RHEUMATIC AORTIC STENOSIS WITH INSUFFICIENCY
396.0 - 396.3	MITRAL VALVE STENOSIS AND AORTIC VALVE STENOSIS - MITRAL VALVE INSUFFICIENCY AND AORTIC VALVE INSUFFICIENCY
396.8	MULTIPLE INVOLVEMENT OF MITRAL AND AORTIC VALVES
397.0 - 397.1	DISEASES OF TRICUSPID VALVE - RHEUMATIC DISEASES OF PULMONARY VALVE
398.0	RHEUMATIC MYOCARDITIS
398.91	RHEUMATIC HEART FAILURE (CONGESTIVE)
401.0	MALIGNANT ESSENTIAL HYPERTENSION
402.00	MALIGNANT HYPERTENSIVE HEART DISEASE WITHOUT HEART FAILURE
402.01	MALIGNANT HYPERTENSIVE HEART DISEASE WITH HEART FAILURE
402.10	BENIGN HYPERTENSIVE HEART DISEASE WITHOUT HEART FAILURE
402.11	BENIGN HYPERTENSIVE HEART DISEASE WITH HEART FAILURE
402.90	UNSPECIFIED HYPERTENSIVE HEART DISEASE WITHOUT HEART FAILURE
402.91	UNSPECIFIED HYPERTENSIVE HEART DISEASE WITH HEART FAILURE
404.00 - 404.93	HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE, MALIGNANT, WITHOUT HEART FAILURE AND WITH CHRONIC KIDNEY DISEASE STAGE I THROUGH STAGE IV, OR UNSPECIFIED - HYPERTENSIVE HEART AND CHRONIC KIDNEY

	DISEASE, UNSPECIFIED, WITH HEART FAILURE AND CHRONIC KIDNEY DISEASE STAGE V OR END STAGE RENAL DISEASE
405.01	MALIGNANT RENOVASCULAR HYPERTENSION
410.00 - 410.92	ACUTE MYOCARDIAL INFARCTION OF ANTEROLATERAL WALL EPISODE OF CARE UNSPECIFIED - ACUTE MYOCARDIAL INFARCTION OF UNSPECIFIED SITE SUBSEQUENT EPISODE OF CARE
411.0 - 411.89	POSTMYOCARDIAL INFARCTION SYNDROME - OTHER ACUTE AND SUBACUTE FORMS OF ISCHEMIC HEART DISEASE OTHER
412	OLD MYOCARDIAL INFARCTION
413.0 - 413.9	ANGINA DECUBITUS - OTHER AND UNSPECIFIED ANGINA PECTORIS
414.00 - 414.07	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED TYPE OF VESSEL NATIVE OR GRAFT - CORONARY ATHEROSCLEROSIS OF BYPASS GRAFT (ARTERY) (VEIN) OF TRANSPLANTED HEART
414.10 - 414.12	ANEURYSM OF HEART (WALL) - DISSECTION OF CORONARY ARTERY
414.19	OTHER ANEURYSM OF HEART
414.8	OTHER SPECIFIED FORMS OF CHRONIC ISCHEMIC HEART DISEASE
415.0	ACUTE COR PULMONALE
415.11	IATROGENIC PULMONARY EMBOLISM AND INFARCTION
415.12	SEPTIC PULMONARY EMBOLISM
415.19	OTHER PULMONARY EMBOLISM AND INFARCTION
416.0	PRIMARY PULMONARY HYPERTENSION
416.8	OTHER CHRONIC PULMONARY HEART DISEASES
417.0 - 417.1	ARTERIOVENOUS FISTULA OF PULMONARY VESSELS - ANEURYSM OF PULMONARY ARTERY

420.0	ACUTE PERICARDITIS IN DISEASES CLASSIFIED ELSEWHERE
420.90 - 420.91	ACUTE PERICARDITIS UNSPECIFIED - ACUTE IDIOPATHIC PERICARDITIS
420.99	OTHER ACUTE PERICARDITIS
421.0	ACUTE AND SUBACUTE BACTERIAL ENDOCARDITIS
421.1	ACUTE AND SUBACUTE INFECTIVE ENDOCARDITIS IN DISEASES CLASSIFIED ELSEWHERE
421.9	ACUTE ENDOCARDITIS UNSPECIFIED
422.0	ACUTE MYOCARDITIS IN DISEASES CLASSIFIED ELSEWHERE
422.91 - 422.93	IDIOPATHIC MYOCARDITIS - TOXIC MYOCARDITIS
422.99	OTHER ACUTE MYOCARDITIS
423.0 - 423.2	HEMOPERICARDIUM - CONSTRICTIVE PERICARDITIS
423.3	CARDIAC TAMPONADE
423.8	OTHER SPECIFIED DISEASES OF PERICARDIUM
423.9	UNSPECIFIED DISEASE OF PERICARDIUM
424.0 - 424.3	MITRAL VALVE DISORDERS - PULMONARY VALVE DISORDERS
424.90 - 424.91	ENDOCARDITIS VALVE UNSPECIFIED UNSPECIFIED CAUSE - ENDOCARDITIS IN DISEASES CLASSIFIED ELSEWHERE
424.99	OTHER ENDOCARDITIS VALVE UNSPECIFIED
425.0 - 425.7	ENDOMYOCARDIAL FIBROSIS - NUTRITIONAL AND METABOLIC CARDIOMYOPATHY
425.8	CARDIOMYOPATHY IN OTHER DISEASES CLASSIFIED ELSEWHERE
425.9	SECONDARY CARDIOMYOPATHY UNSPECIFIED
426.10	ATRIOVENTRICULAR BLOCK UNSPECIFIED

426.11	FIRST DEGREE ATRIOVENTRICULAR BLOCK
427.0 - 427.1	PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA - PAROXYSMAL VENTRICULAR TACHYCARDIA
427.2	PAROXYSMAL TACHYCARDIA UNSPECIFIED
427.31 - 427.32	ATRIAL FIBRILLATION - ATRIAL FLUTTER
427.41 - 427.42	VENTRICULAR FIBRILLATION - 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
428.0 - 428.1	CONGESTIVE HEART FAILURE UNSPECIFIED - LEFT HEART FAILURE
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441.1 - 441.2	THORACIC ANEURYSM RUPTURED - THORACIC ANEURYSM WITHOUT RUPTURE
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746.87	MALPOSITION OF HEART AND CARDIAC APEX

746.89	OTHER SPECIFIED CONGENITAL ANOMALIES OF HEART
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747.83	PERSISTENT FETAL CIRCULATION
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901.0	INJURY TO THORACIC AORTA
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996.1	MECHANICAL COMPLICATION OF OTHER VASCULAR DEVICE IMPLANT AND GRAFT
996.61	INFECTION AND INFLAMMATORY REACTION DUE TO CARDIAC DEVICE IMPLANT AND GRAFT
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998.0	POSTOPERATIVE SHOCK NOT ELSEWHERE CLASSIFIED
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999.1	AIR EMBOLISM AS A COMPLICATION OF MEDICAL CARE NOT ELSEWHERE CLASSIFIED
999.31	INFECTION DUET CENTRAL VENOUS CATHETER
999.4	ANAPHYLACTIC SHOCK DUE TO SERUM NOT ELSEWHERE CLASSIFIED
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V72.81	PRE-OPERATIVE CARDIOVASCULAR EXAMINATION

EKG

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

CMS Manual System, Pub. 100-2, Medicare Benefit Policy, Chapter 6, Section 20.3.1 and 20.3.2

CMS Manual System, Pub. 100-3, Medicare National Coverage Determinations Manual, Chapter 1, Part 1, Section 20.15.

CMS Manual System, Pub.100-8, Medicare Program Integrity, Transmittal 63, dated January 23, 2004, Change Request 3010.

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The coverage criteria and definition of electrocardiographic services are found in the CMS Manual System, Pub. 100-3, Medicare National Coverage Determinations Manual (Internet-Only Manual).

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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.

12x	Hospital-inpatient or home health visits (Part B only)
13x	Hospital-outpatient (HHA-A also) (under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00)
14x	Hospital-other (Part B)
18x	Hospital-swing beds
21x	SNF-inpatient (including Part A)
22x	SNF-inpatient or home health visits (Part B only)
23x	SNF-outpatient (HHA-A also)
71x	Clinic-rural health
72x	Clinic-hospital based or independent renal dialysis facility
73x	Clinic-independent provider based FQHC (eff 10/91)
75x	Clinic-CORF
85x	Special facility or ASC surgery-rural primary care hospital (eff 10/94)

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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.

073X	EKG/ECG-general classification

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93005	Electrocardiogram, tracing
93012	Transmission of ecg
93041	Rhythm ECG, tracing
93225	ECG monitor/record, 24 hrs
93226	ECG monitor/report, 24 hrs

93231	Ecg monitor/record, 24 hrs
93232	ECG monitor/report, 24 hrs
93236	ECG monitor/report, 24 hrs
93270	ECG recording
93271	Ecg/monitoring and analysis

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079.0 - 079.99	ADENOVIRUS INFECTION IN CONDITIONS CLASSIFIED ELSEWHERE AND OF UNSPECIFIED SITE - UNSPECIFIED VIRAL INFECTION
093.0	ANEURYSM OF AORTA SPECIFIED AS SYPHILITIC
093.20 - 093.9	SYPHILITIC ENDOCARDITIS OF VALVE UNSPECIFIED - CARDIOVASCULAR SYPHILIS UNSPECIFIED
164.0 - 164.1	MALIGNANT NEOPLASM OF THYMUS - MALIGNANT NEOPLASM OF HEART
212.7	BENIGN NEOPLASM OF HEART
240.0 - 246.9	GOITER SPECIFIED AS SIMPLE - UNSPECIFIED DISORDER OF THYROID
250.10 - 250.13	DIABETES WITH KETOACIDOSIS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH KETOACIDOSIS, TYPE I [JUVENILE TYPE], UNCONTROLLED
250.20 - 250.23	DIABETES WITH HYPEROSMOLARITY, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH HYPEROSMOLARITY, TYPE I [JUVENILE TYPE], UNCONTROLLED
250.30 - 250.33	DIABETES WITH OTHER COMA, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH OTHER COMA, TYPE I [JUVENILE TYPE], UNCONTROLLED
250.70 - 250.73	DIABETES WITH PERIPHERAL CIRCULATORY DISORDERS, TYPE II OR UNSPECIFIED TYPE, NOT STATED AS UNCONTROLLED - DIABETES WITH PERIPHERAL CIRCULATORY DISORDERS, TYPE I [JUVENILE TYPE], UNCONTROLLED
272.0	PURE HYPERCHOLESTEROLEMIA
272.2	MIXED HYPERLIPIDEMIA
274.0 - 274.9	GOUTY ARTHROPATHY - GOUT UNSPECIFIED
276.0 - 276.9	HYPEROSMOLALITY AND/OR HYPERNATREMIA - ELECTROLYTE AND FLUID DISORDERS NOT ELSEWHERE CLASSIFIED

277.00 - 277.01	CYSTIC FIBROSIS WITHOUT MECONIUM ILEUS - CYSTIC FIBROSIS WITH MECONIUM ILEUS
277.3	AMYLOIDOSIS
277.81 - 277.89	PRIMARY CARNITINE DEFICIENCY - OTHER SPECIFIED DISORDERS OF METABOLISM
306.2	CARDIOVASCULAR MALFUNCTION ARISING FROM MENTAL FACTORS
337.0	IDIOPATHIC PERIPHERAL AUTONOMIC NEUROPATHY
337.9	UNSPECIFIED DISORDER OF AUTONOMIC NERVOUS SYSTEM
390 - 459.9	RHEUMATIC FEVER WITHOUT HEART INVOLVEMENT - UNSPECIFIED CIRCULATORY SYSTEM DISORDER
668.10 - 668.14	CARDIAC COMPLICATIONS OF ANESTHESIA OR OTHER SEDATION IN LABOR AND DELIVERY UNSPECIFIED AS TO EPISODE OF CARE - CARDIAC COMPLICATIONS OF ANESTHESIA OR OTHER SEDATION IN LABOR AND DELIVERY POSTPARTUM
674.50	PERIPART CARDIOMYOPATHY UNSPECIFIED
674.51	PERIPARTUM CARDIOMYOPATHY WITH DELIVERY WITH OR WITHOUT ANTEPARTUM CONDITION
674.52	PERIPARTUM CARDIOMYOPATHY WITH DELIVERY WITH POSTPARTUM COMPLICATION
674.53	PERIPARTUM CARDIOMYOPATHY WITH ANTEPARTUM CONDITION OR COMPLICATION
674.54	PERIPARTUM CARDIOMYOPATHY WITH POSTPARTUM CONDITION OR COMPLICATION
710.0 - 710.9	SYSTEMIC LUPUS ERYTHEMATOSUS - UNSPECIFIED DIFFUSE CONNECTIVE TISSUE DISEASE
714.0 - 714.9	RHEUMATOID ARTHRITIS - UNSPECIFIED INFLAMMATORY POLYARTHROPATHY
729.5	PAIN IN LIMB
745.0 - 745.9	COMMON TRUNCUS - UNSPECIFIED DEFECT OF SEPTAL CLOSURE
746.00 - 747.9	CONGENITAL PULMONARY VALVE ANOMALY UNSPECIFIED - UNSPECIFIED CONGENITAL ANOMALY OF CIRCULATORY SYSTEM
780.2	SYNCOPE AND COLLAPSE
780.31 - 780.39	FEBRILE CONVULSIONS - OTHER CONVULSIONS
780.4	DIZZINESS AND GIDDINESS
780.79	OTHER MALAISE AND FATIGUE

780.8	GENERALIZED HYPERHIDROSIS
781.3	LACK OF COORDINATION
782.61 - 782.62	PALLOR - FLUSHING
785.0	TACHYCARDIA UNSPECIFIED
785.1	PALPITATIONS
785.2	UNDIAGNOSED CARDIAC MURMURS
785.3	OTHER ABNORMAL HEART SOUNDS
785.50 - 785.59	SHOCK UNSPECIFIED - OTHER SHOCK WITHOUT TRAUMA
785.9	OTHER SYMPTOMS INVOLVING CARDIOVASCULAR SYSTEM
786.00	RESPIRATORY ABNORMALITY UNSPECIFIED
786.01	HYPERVENTILATION
786.02	ORTHOPNEA
786.03	APNEA
786.04	CHEYNE-STOKES RESPIRATION
786.05	SHORTNESS OF BREATH
786.06	TACHYPNEA
786.09	RESPIRATORY ABNORMALITY OTHER
786.50 - 786.59	UNSPECIFIED CHEST PAIN - OTHER CHEST PAIN
786.6	SWELLING MASS OR LUMP IN CHEST
787.01 - 787.03	NAUSEA WITH VOMITING - VOMITING ALONE
789.01	ABDOMINAL PAIN RIGHT UPPER QUADRANT
789.02	ABDOMINAL PAIN LEFT UPPER QUADRANT
789.06	ABDOMINAL PAIN EPIGASTRIC
794.30 - 794.39	UNSPECIFIED ABNORMAL FUNCTION STUDY OF CARDIOVASCULAR SYSTEM - OTHER NONSPECIFIC ABNORMAL FUNCTION STUDY OF CARDIOVASCULAR SYSTEM
794.5	NONSPECIFIC ABNORMAL RESULTS OF FUNCTION STUDY OF THYROID
799.01	ASPHYXIA
799.02	HYPOXEMIA
799.1	RESPIRATORY ARREST

860.0 - 860.5	TRAUMATIC PNEUMOTHORAX WITHOUT OPEN WOUND INTO THORAX - TRAUMATIC PNEUMOHEMOTHORAX WITH OPEN WOUND INTO THORAX
861.00 - 861.32	UNSPECIFIED INJURY OF HEART WITHOUT OPEN WOUND INTO THORAX - LACERATION OF LUNG WITH OPEN WOUND INTO THORAX
959.11	OTHER INJURY OF CHEST WALL
959.19	OTHER AND UNSPECIFIED INJURY OF OTHER SITES OF TRUNK
972.0 - 972.9	POISONING BY CARDIAC RHYTHM REGULATORS - POISONING BY OTHER AND UNSPECIFIED AGENTS PRIMARILY AFFECTING THE CARDIOVASCULAR SYSTEM
980.0 - 989.9	TOXIC EFFECT OF ETHYL ALCOHOL - TOXIC EFFECT OF UNSPECIFIED SUBSTANCE CHIEFLY NONMEDICINAL AS TO SOURCE
995.0 - 995.89	OTHER ANAPHYLACTIC SHOCK NOT ELSEWHERE CLASSIFIED - OTHER SPECIFIED ADVERSE EFFECTS NOT ELSEWHERE CLASSIFIED
996.00 - 996.09	MECHANICAL COMPLICATIONS OF UNSPECIFIED CARDIAC DEVICE IMPLANT AND GRAFT - OTHER MECHANICAL COMPLICATION OF CARDIAC DEVICE IMPLANT AND GRAFT
996.80 - 996.89	COMPLICATIONS OF UNSPECIFIED TRANSPLANTED ORGAN - COMPLICATIONS OF OTHER SPECIFIED TRANSPLANTED ORGAN
997.1	CARDIAC COMPLICATIONS NOT ELSEWHERE CLASSIFIED
997.2	PERIPHERAL VASCULAR COMPLICATIONS NOT ELSEWHERE CLASSIFIED
997.3	RESPIRATORY COMPLICATIONS NOT ELSEWHERE CLASSIFIED
V43.21	HEART REPLACED BY HEART ASSIST DEVICE
V43.22	HEART REPLACED BY FULLY IMPLANTABLE ARTIFICIAL HEART
V45.00 - V45.09	UNSPECIFIED CARDIAC DEVICE IN SITU - OTHER SPECIFIED CARDIAC DEVICE IN SITU
V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
V71.7	OBSERVATION FOR SUSPECTED CARDIOVASCULAR DISEASE
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N/A

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1. If the provider of the service is other than the ordering/referring physician, that provider must maintain hard copy documentation of the results and interpretation, along with copies of the ordering/referring physician's order for the studies. The physician must state the clinical indication/medical necessity for the study in order for the test to be medicallyconsidered reasonable and necessary.

2. If the ordering/referring physician does an EKG for the monitoring of a high-risk medication the medical record documentation maintained, must indicate the drug being monitored.

3. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available to the Intermediary upon request.

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N/A

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N/A

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Jacobs, D., Demott, W., Finley, P., Horvat, R., Kasten, B. and Tilzer, L. (1994). Laboratory Text Handbook (3rd ed.) Hudson: Lexi-Comp, Inc.

Pagana, K., and Pagana, J. (1995). Mosby's Diagnostic and Laboratory Test Reference. (2nd ed.). St. Louis: Mosby

Advisory Committee Meeting Notes back to top

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the Intermediary, this policy was developed in cooperation with advisory groups, which include representatives from the affected provider community. Advisory Committee Meeting date: N/A.

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Revision #11, 11/22/2004

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Revision #7, 10/02/2002

Revision #6, 08/22/2002

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Qualified Individuals

The accuracy of noninvasive vascular diagnostic studies depends on the knowledge, skill, and experience of the technologist and interpreter. Consequently, the providers of interpretations must be capable of demonstrating documented training and experience and maintain documentation for post-payment audit.

All noninvasive vascular diagnostic studies must **be either** (1) performed by, or under the direct supervision of, persons that have demonstrated minimum entry level competency by being credentialed in vascular technology, **or (2) performed in facilities with laboratories accredited in vascular technology.** Examples of appropriate personnel certification include the Registered Vascular Technologist (RVT) credential and the Registered Cardiovascular Sonographer (RCVT) credential in Vascular Technology, **and appropriate laboratory accreditation includes the Intersocietal Commission for the Accreditation of Vascular Laboratories (ICAVL) or American College of Radiology (ACR).** Direct supervision requires the credentialed individuals physical presence in the facility **during the examination.**

Indications by Scan and Anatomical Site

Cerebrovascular Arterial Studies (CPT Codes 93875-93888)

A. Indications for Cerebrovascular Evaluations:

1. Cervical bruits

2. Amaurosis fugax

3. Focal cerebral or ocular transient ischemic attacks (i.e., localizing symptoms,

weakness of one side of the face, slurred speech, weakness of a limb). **Visual** transient ischemic attacks are defined as **retinal or hemispheric** visual field deficits and not temporary blurred vision.

4. Drop attacks or syncope are rare indications primarily seen with vertebrobasilar or bilateral carotid artery disease. Incoordination or limb dysfunction should be grouped with unilateral weakness of the face or extremities.

B. Examples Of Signs and Symptoms That Do Not Demonstrate Medical Necessity

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

2. Headaches are not an indication for extracranial studies.

C. Acceptable Procedures for Reimbursement:

1. Duplex scan (93880 or 93882)

2. Doppler ultrasound with spectrum analysis (93875)

3. Oculopneumoplethysmography (OPPG) (93875)

4. Periorbital Doppler (93875) when OPPG is contraindicated

5. Transcranial Doppler (TCD) (see below) (93886 or 93888).

Multiple cerebrovascular procedures can be allowed during the same encounter given the provider can demonstrate medical necessity on post-payment audit. That is, physiologic studies and a duplex scan are allowed on the same date of service given the provider is able to document medical necessity (e.g., greater than or equal to 50% stenosis on duplex scan or significant symptoms as demonstrated by the indications for the study) on post-payment audit.

D. Methods Not Acceptable For Reimbursement:

1. Pulse delay oculoplethysmography

2. Carotid phonoangiography and other forms of bruit analysis are covered services but are included in the reimbursement for the office visit

3. Periorbital photoplethysmography

E. Recommendations For Follow-up Studies:

1. Stenosis of 20-50% ***(diameter reduction)***, an annual study

2. Stenosis of 50-79%, every six months

3. Stenosis of 80-99%, surgery is usually recommended

4. After carotid endarterectomy, repeat examinations are allowed at six weeks, six months, and one year. ***During the first year, follow-up studies should be unilateral unless signs and symptoms provide indications for a bilateral procedure.***

Transcranial Doppler (TCD) (93886 or 93888)

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

A. Indications for Cerebrovascular Evaluations:

1. Detection and evaluation of the hemodynamic effects of severe stenosis or occlusion of the extracranial (greater than or equal to 60% diameter reduction) and major basal intracranial arteries (greater than or equal to 50% diameter reduction)

2. Detection and serial evaluation of cerebral vasospasm complicating subarachnoid hemorrhage

3. Evaluation of invasive therapeutic interventions for cerebral arteriovenous malformation

4. Evaluation of intracranial hemodynamic abnormalities in patients with suspected brain death

5. Intraoperative and perioperative monitoring of intracranial flow velocity and hemodynamic patterns during carotid endarterectomy. This is primarily a Medicare Part A procedure but the professional component could be reimbursed given it is provided during the operative procedure by a physician that is not a member of the operating team.

6. Evaluation of cerebral embolization

B. Examples of indications that do not demonstrate necessity:

1. Evaluation of brain tumors

2. Assessment of familial and degenerative diseases of the cerebrum, brainstem, cerebellum, basal ganglia and motor neurons

3. Evaluation of infectious and inflammatory condition

4. Psychiatric disorders

5. Epilepsy

C. The following indications are not covered:

1. Assessing patients with migraine

2. Monitoring during carotid endarterectomy, cardiopulmonary bypass and other cerebrovascular and cardiovascular interventions, and surgical procedures ***(except during carotid endarterectomy, as noted above)***

3. Evaluation of patients with dilated vasculopathies such as fusiform aneurysms

4. Assessing autoregulation, physiologic, and pharmacological responses of cerebral arteries

Peripheral Arterial Examinations - (CPT Codes 93920 through 93931)

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

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

A. Indications for Peripheral Arterial Evaluations

1. Claudication of less than one block or of such severity that it interferes significantly with the patient's occupation or lifestyle

2. Rest pain (typically including the forefoot), usually associated with absent pulses, which becomes increasingly severe with elevation and diminishes with placement of the leg in a dependent position

3. Tissue loss defined as gangrene or pregangreneous changes of the

extremity, or ischemic ulceration of the extremity occurring in the absence of pulses

4. Aneurysmal disease

5. Evidence of thromboembolic events

6. Blunt or penetrating trauma (including complications of diagnostic and/or therapeutic procedures)

7. For evaluation of dialysis access, see policy regarding CPT 93990

B. Examples of signs and symptoms that do not indicate medical necessity:

1. Continuous burning of the feet is considered to be a neurologic symptom

2. “Leg pain, nonspecific” and “Pain in limb” as single diagnoses are too general to warrant further investigation unless they can be related to other signs and symptoms.

3. Edema rarely occurs with arterial occlusive disease unless it is in the immediate postoperative period, in association with another inflammatory process or in association with rest pain.

4. Absence of relatively minor pulses (i.e., dorsalis pedis or posterior tibial) in the absence of symptoms. The absence of pulses is not an indication to proceed beyond the physical examination unless it is related to other signs and/or symptoms.

C. Acceptable Procedures for Reimbursement

1. Duplex scan (93925, 93926, 93930, or 93931

2. Single level physiologic studies (e.g., Doppler waveform analysis, volume plethysmography, transcutaneous oxygen tension measurement) (93922)

3. Segmental physiologic studies or with provocative functional maneuvers (93923)

4. Physiologic studies at rest and following treadmill stress testing (93924)

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

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

Duplex scanning and physiologic studies may be reimbursed during the same encounter if the physiologic studies are abnormal and/or to evaluate vascular trauma, thromboembolic events or aneurysmal

disease, given the provider can document medical necessity.

D. Methods Not Acceptable for Reimbursement

1. Mechanical Oscillometry

2. Inductance Plethysmography

3. Photoelectric Plethysmography

4. ABI (considered part of the physical examination).

Peripheral Venous Examinations - (CPT Codes 93965 through 93971)

Indications for Peripheral Venous Examinations

Indications for venous examinations are separated into two major categories: deep vein thrombosis and chronic venous insufficiency. Studies are medically necessary only if the patient is a candidate for anticoagulation, ***thrombolysis*** or invasive therapeutic procedures.

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

A. Indications
Deep Vein Thrombosis (DVT):

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

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

2. Clinical signs and/or symptoms of PE including hemoptysis, chest pain, and/or dyspnea

3. Unexplained lower extremity edema status-post major surgical procedures

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

Chronic Venous Insufficiency:

Chronic venous insufficiency may be divided into three categories: primary varicose veins, ***secondary varicose veins*** and post-thrombotic (post-

phlebitic) syndrome. It is not medically necessary to study primary varicose veins. Objective tests of venous function may be indicated in patients ***with ulceration*** suspected to be secondary to venous insufficiency in order to confirm the diagnosis by documenting venous valvular incompetence prior to treatment.

B. Acceptable Procedures for Reimbursement:

1. Duplex scan (93970 or 93971)

2. Doppler waveform analysis including responses to compressions and other maneuvers (93965)

3. Impedance Plethysmography (93965)

4. Air Plethysmography (93965)

5. Strain Gauge Plethysmography (93965)

C. Methods Not Acceptable for Reimbursement:

1. Mechanical Oscillometry

2. Inductance Plethysmography

3. Capacitance Plethysmography

4. Photoelectric Plethysmography

Performance of both duplex scanning (93970 or 93971) and physiological tests (93965) of extremity veins during the same encounter is not medically necessary.

Follow-up Studies and Limited Studies

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

Post-intervention Follow-up Studies:

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

1. In the immediate post-operative period, patients may be studied if re-established pulses are lost, become equivocal, or if the patient develops related signs and/or symptoms of ischemia with impending repeat intervention.

2. With regard to autogenous lower extremity vein bypass surgeries, a study can be performed at three month intervals during the first year, at six month

intervals during the second year, and annually thereafter. Follow-up studies are not medically necessary post-angioplasty in the absence of signs and/or symptoms of ischemia. Synthetic grafts may be studied if the patient develops signs and/or symptoms of occlusive disease.

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

Hemodialysis Access Examination - (CPT Code 93990)

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

When a dialysis patient exhibits signs and symptoms of compromise to the vascular access site, Doppler flow studies may provide diagnostic information that will determine the appropriate medical intervention. Medicare considers a Doppler flow study medically necessary when the beneficiary's dialysis access site manifests signs or symptoms associated with vascular compromise, and when the results of this test are necessary to determine the clinical course of treatment.

Appropriate indications for Duplex scan of hemodialysis access sites include:

1. ICD-9-CM codes:

a) 996.73: Complication (Complication NOS, occlusion NOS, embolism, fibrosis, hemorrhage, pain, stenosis, thrombosis) due to renal dialysis device, implant, and graft

b) V56.31: Encounter for adequacy testing for hemodialysis

2. Clear documentation in the dialysis record of signs of chronic (i.e., three successive dialysis sessions) of abnormal function including:

a. Difficult cannulation by multiple personnel

b. Thrombus aspiration by multiple personnel

c. Elevated dynamic venous pressure greater than 200 mmHg when measured during dialysis with the blood pump set on a 200 cc/min pump,

d. Elevated recirculation time of 12% or greater

e. Low urea reduction rate of less than 60%

f. Shunt collapse suggesting poor arterial inflow

g. An access with a palpable “water hammer” pulse on examination, which implies venous outflow obstruction.

h. Routine evaluation on a daily or weekly basis without evidence of the above is considered screening and is not a covered service.

Ultrasound Guided Repair of Pseudoaneurysm - CPT Code 76936

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

Acceptable indications include a pulsatile mass indicating a pseudoaneurysm and the patient must be at least ***three (3) days*** status-post invasive vascular procedure. When performed in conjunction with the invasive procedure, 76936 is considered part of the invasive procedure and is not separately reportable.

Limitations

Thermography, mechanical oscillometry, inductance plethysmography, capacitance plethysmography, and photoelectric plethysmography are not covered services. Light reflection rheography is not a covered service, based on lack of documentation of medical necessity in the current literature.

It is the responsibility of the provider to ensure the medical necessity of procedures and to maintain a record for post-payment audit. Noninvasive vascular studies are medically necessary only if the outcome will potentially impact the clinical course of the patient. That is, if it is obvious from the findings of the history and physical examination that the patient is going to proceed to angiography, then noninvasive vascular studies are not medically necessary.

A duplex scan includes a real-time scan (see CPT-4; Diagnostic Ultrasound). Consequently billing for both a duplex scan and echography of the same body part represents unbundling and is not allowed.

Coverage Topic back to top

Diagnostic Tests and X-Rays

Coding Information

Bill Type Codes: back to top

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.

999x	Not Applicable

Revenue Codes: back to top

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.

99999	Not Applicable

CPT / HCPCS Codes back to top

76936	ULTRASOUND GUIDED COMPRESSION REPAIR OF ARTERIAL PSEUDOANEURYSM OR ARTERIOVENOUS FISTULAE (INCLUDES DIAGNOSTIC ULTRASOUND EVALUATION, COMPRESSION OF LESION AND IMAGING)
93875	NON-INVASIVE PHYSIOLOGIC STUDIES OF EXTRACRANIAL ARTERIES, COMPLETE BILATERAL STUDY (EG, PERIORBITAL FLOW DIRECTION WITH ARTERIAL COMPRESSION, OCULAR PNEUMOPLETHYSMOGRAPHY, DOPPLER ULTRASOUND SPECTRAL ANALYSIS)
93880	DUPLEX SCAN OF EXTRACRANIAL ARTERIES; COMPLETE BILATERAL STUDY
93882	DUPLEX SCAN OF EXTRACRANIAL ARTERIES; UNILATERAL OR LIMITED STUDY
93886	TRANSCRANIAL DOPPLER STUDY OF THE INTRACRANIAL ARTERIES;

	COMPLETE STUDY
93922	NON-INVASIVE PHYSIOLOGIC STUDIES OF UPPER OR LOWER EXTREMITY ARTERIES, SINGLE LEVEL, BILATERAL (EG, ANKLE/BRACHIAL INDICES, DOPPLER WAVEFORM ANALYSIS, VOLUME PLETHYSMOGRAPHY, TRANSCUTANEOUS OXYGEN TENSION MEASUREMENT)
93923	NON-INVASIVE PHYSIOLOGIC STUDIES OF UPPER OR LOWER EXTREMITY ARTERIES, MULTIPLE LEVELS OR WITH PROVOCATIVE FUNCTIONAL MANEUVERS, COMPLETE BILATERAL STUDY (EG, SEGMENTAL BLOOD PRESSURE MEASUREMENTS, SEGMENTAL DOPPLER WAVEFORM ANALYSIS, SEGMENTAL VOLUME PLETHYSMOGRAPHY, SEGMENTAL TRANSCUTANEOUS OXYGEN TENSION MEASUREMENTS, MEASUREMENTS WITH POSTURAL PROVOCATIVE TESTS, MEASUREMENTS WITH REACTIVE HYPEREMIA)
93924	NON-INVASIVE PHYSIOLOGIC STUDIES OF LOWER EXTREMITY ARTERIES, AT REST AND FOLLOWING TREADMILL STRESS TESTING, COMPLETE BILATERAL STUDY
93925	DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS; COMPLETE BILATERAL STUDY
93926	DUPLEX SCAN OF LOWER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS; UNILATERAL OR LIMITED STUDY
93930	DUPLEX SCAN OF UPPER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS; COMPLETE BILATERAL STUDY
93931	DUPLEX SCAN OF UPPER EXTREMITY ARTERIES OR ARTERIAL BYPASS GRAFTS; UNILATERAL OR LIMITED STUDY
93965	NON-INVASIVE PHYSIOLOGIC STUDIES OF EXTREMITY VEINS, COMPLETE BILATERAL STUDY (EG, DOPPLER WAVEFORM ANALYSIS WITH RESPONSES TO COMPRESSION AND OTHER MANEUVERS, PHLEBORHEOGRAPHY, IMPEDANCE PLETHYSMOGRAPHY)
93970	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND OTHER MANEUVERS; COMPLETE BILATERAL STUDY
93971	DUPLEX SCAN OF EXTREMITY VEINS INCLUDING RESPONSES TO COMPRESSION AND OTHER MANEUVERS; UNILATERAL OR LIMITED STUDY
93975	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL, PELVIC, SCROTAL CONTENTS AND/OR RETROPERITONEAL ORGANS; COMPLETE STUDY
93976	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF ABDOMINAL, PELVIC, SCROTAL CONTENTS AND/OR RETROPERITONEAL ORGANS; LIMITED STUDY
93978	DUPLEX SCAN OF AORTA, INFERIOR VENA CAVA, ILIAC VASCULATURE, OR BYPASS GRAFTS; COMPLETE STUDY

93979	DUPLEX SCAN OF AORTA, INFERIOR VENA CAVA, ILIAC VASCULATURE, OR BYPASS GRAFTS; UNILATERAL OR LIMITED STUDY
93980	DUPLEX SCAN OF ARTERIAL INFLOW AND VENOUS OUTFLOW OF PENILE VESSELS; COMPLETE STUDY
93990	DUPLEX SCAN OF HEMODIALYSIS ACCESS (INCLUDING ARTERIAL INFLOW, BODY OF ACCESS AND VENOUS OUTFLOW)

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CPT Codes 93875-93888:

342.00 - 342.92	FLACCID HEMIPLEGIA AND HEMIPARESIS AFFECTING UNSPECIFIED SIDE - UNSPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE
344.00 - 344.1	QUADRIPLEGIA UNSPECIFIED - PARAPLEGIA
344.2	DIPLEGIA OF UPPER LIMBS
344.30 - 344.32	MONOPLEGIA OF LOWER LIMB AFFECTING UNSPECIFIED SIDE - MONOPLEGIA OF LOWER LIMB AFFECTING NONDOMINANT SIDE
344.40 - 344.42	MONOPLEGIA OF UPPER LIMB AFFECTING UNSPECIFIED SIDE - MONOPLEGIA OF UPPER LIMB AFFECTING NONDOMINANT SDE
344.5	UNSPECIFIED MONOPLEGIA
344.9	PARALYSIS UNSPECIFIED
362.30 - 362.37	RETINAL VASCULAR OCCLUSION UNSPECIFIED - VENOUS ENGORGEMENT OF RETINA
362.84	RETINAL ISCHEMIA
368.10 - 368.11	SUBJECTIVE VISUAL DISTURBANCE UNSPECIFIED - SUDDEN VISUAL LOSS
368.12	TRANSIENT VISUAL LOSS
368.40 - 368.47	VISUAL FIELD DEFECT UNSPECIFIED - HETERONYMOUS BILATERAL FIELD DEFECTS
433.00 - 433.91	OCCLUSION AND STENOSIS OF BASILAR ARTERY WITHOUT CEREBRAL INFARCTION - OCCLUSION AND STENOSIS OF UNSPECIFIED PRECEREBRAL ARTERY WITH CEREBRAL INFARCTION
434.00 - 434.91	CEREBRAL THROMBOSIS WITHOUT CEREBRAL INFARCTION - CEREBRAL ARTERY OCCLUSION UNSPECIFIED WITH CEREBRAL INFARCTION
435.0 - 435.9	BASILAR ARTERY SYNDROME - UNSPECIFIED TRANSIENT CEREBRAL ISCHEMIA

436	ACUTE BUT ILL-DEFINED CEREBROVASCULAR DISEASE
437.0	CEREBRAL ATHEROSCLEROSIS
437.3	CEREBRAL ANEURYSM NONRUPTURED
437.4	CEREBRAL ARTERITIS
437.7	TRANSIENT GLOBAL AMNESIA
442.81	ANEURYSM OF ARTERY OF NECK
442.82	ANEURYSM OF SUBCLAVIAN ARTERY
446.0	POLYARTERITIS NODOSA
780.2	SYNCOPE AND COLLAPSE
780.4	DIZZINESS AND GIDDINESS
781.2	ABNORMALITY OF GAIT
781.3	LACK OF COORDINATION
781.4	TRANSIENT PARALYSIS OF LIMB
782.0	DISTURBANCE OF SKIN SENSATION
784.3	APHASIA
784.40 - 784.49	VOICE DISTURBANCE UNSPECIFIED - OTHER VOICE DISTURBANCE
784.5	OTHER SPEECH DISTURBANCE
785.9	OTHER SYMPTOMS INVOLVING CARDIOVASCULAR SYSTEM
900.00 - 900.81	INJURY TO CAROTID ARTERY UNSPECIFIED - INJURY TO EXTERNAL JUGULAR VEIN
901.1	INJURY TO INNOMINATE AND SUBCLAVIAN ARTERIES
996.1	MECHANICAL COMPLICATION OF OTHER VASCULAR DEVICE IMPLANT AND GRAFT
996.70	OTHER COMPLICATIONS DUE TO UNSPECIFIED DEVICE IMPLANT AND GRAFT
997.00 - 997.02	NERVOUS SYSTEM COMPLICATION UNSPECIFIED - IATROGENIC CEREBROVASCULAR INFARCTION OR HEMORRHAGE
998.0	POSTOPERATIVE SHOCK NOT ELSEWHERE CLASSIFIED
CPT Codes 93922-93931:	
440.0	ATHEROSCLEROSIS OF AORTA
440.21	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES WITH INTERMITTENT CLAUDICATION
440.22	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES WITH REST PAIN

440.23	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES WITH ULCERATION
440.24	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES WITH GANGRENE
440.30	ATHEROSCLEROSIS OF UNSPECIFIED BYPASS GRAFT OF THE EXTREMITIES
440.31	ATHEROSCLEROSIS OF AUTOLOGOUS VEIN BYPASS GRAFT OF THE EXTREMITIES
440.32	ATHEROSCLEROSIS OF NONAUTOLOGOUS BIOLOGICAL BYPASS GRAFT OF THE EXTREMITIES
441.00 - 441.9	DISSECTION OF AORTA ANEURYSM UNSPECIFIED SITE - AORTIC ANEURYSM OF UNSPECIFIED SITE WITHOUT RUPTURE
442.0	ANEURYSM OF ARTERY OF UPPER EXTREMITY
442.3	ANEURYSM OF ARTERY OF LOWER EXTREMITY
443.0 - 443.1	RAYNAUD'S SYNDROME - THROMBOANGIITIS OBLITERANS (BUERGER'S DISEASE)
443.22	DISSECTION OF ILIAC ARTERY
444.0 - 444.9	EMBOLISM AND THROMBOSIS OF ABDOMINAL AORTA - EMBOLISM AND THROMBOSIS OF UNSPECIFIED ARTERY
445.01 - 445.02	ATHEROEMBOLISM OF UPPER EXTREMITY - ATHEROEMBOLISM OF LOWER EXTREMITY
447.0 - 447.1	ARTERIOVENOUS FISTULA ACQUIRED - STRICTURE OF ARTERY
447.2	RUPTURE OF ARTERY
526.89	OTHER SPECIFIED DISEASES OF THE JAWS
707.10 - 707.19	UNSPECIFIED ULCER OF LOWER LIMB - ULCER OF OTHER PART OF LOWER LIMB
707.8	CHRONIC ULCER OF OTHER SPECIFIED SITES
785.4	GANGRENE
903.00 - 903.9	INJURY TO AXILLARY VESSEL(S) UNSPECIFIED - INJURY TO UNSPECIFIED BLOOD VESSEL OF UPPER EXTREMITY
904.0 - 904.3	INJURY TO COMMON FEMORAL ARTERY - INJURY TO SAPHENOUS VEINS
904.40 - 904.42	INJURY TO POPLITEAL VESSEL(S) UNSPECIFIED - INJURY TO POPLITEAL VEIN
904.50 - 904.9	INJURY TO TIBIAL VESSEL(S) UNSPECIFIED - INJURY TO BLOOD VESSELS OF UNSPECIFIED SITE
990	EFFECTS OF RADIATION UNSPECIFIED

996.00 - 996.2	MECHANICAL COMPLICATIONS OF UNSPECIFIED CARDIAC DEVICE IMPLANT AND GRAFT - MECHANICAL COMPLICATION OF NERVOUS SYSTEM DEVICE IMPLANT AND GRAFT
996.30 - 996.49	MECHANICAL COMPLICATION OF UNSPECIFIED GENITOURINARY DEVICE IMPLANT AND GRAFT - OTHER MECHANICAL COMPLICATION OF OTHER INTERNAL ORTHOPEDIC DEVICE, IMPLANT, AND GRAFT
996.51 - 996.59	MECHANICAL COMPLICATION OF PROSTHETIC CORNEAL GRAFT - MECHANICAL COMPLICATION OF OTHER IMPLANT AND INTERNAL DEVICE NOT ELSEWHERE CLASSIFIED
996.70 - 996.79	OTHER COMPLICATIONS DUE TO UNSPECIFIED DEVICE IMPLANT AND GRAFT - OTHER COMPLICATIONS DUE TO OTHER INTERNAL PROSTHETIC DEVICE IMPLANT AND GRAFT
997.2	PERIPHERAL VASCULAR COMPLICATIONS NOT ELSEWHERE CLASSIFIED
998.11 - 998.2	HEMORRHAGE COMPLICATING A PROCEDURE - ACCIDENTAL PUNCTURE OR LACERATION DURING A PROCEDURE NOT ELSEWHERE CLASSIFIED
CPT Codes 93965-93971:	
415.11	IATROGENIC PULMONARY EMBOLISM AND INFARCTION
451.0 - 451.9	PHLEBITIS AND THROMBOPHLEBITIS OF SUPERFICIAL VESSELS OF LOWER EXTREMITIES - PHLEBITIS AND THROMBOPHLEBITIS OF UNSPECIFIED SITE
454.0	VARICOSE VEINS OF LOWER EXTREMITIES WITH ULCER
454.1	VARICOSE VEINS OF LOWER EXTREMITIES WITH INFLAMMATION
454.2	VARICOSE VEINS OF LOWER EXTREMITIES WITH ULCER AND INFLAMMATION
459.10 - 459.19	POSTPHLEBETIC SYNDROME WITHOUT COMPLICATIONS - POSTPHLEBETIC SYNDROME WITH OTHER COMPLICATION
459.2 - 459.39	COMPRESSION OF VEIN - CHRONIC VENOUS HYPERTENSION WITH OTHER COMPLICATION
585.1	CHRONIC KIDNEY DISEASE, STAGE I
585.2	CHRONIC KIDNEY DISEASE, STAGE II (MILD)
585.3	CHRONIC KIDNEY DISEASE, STAGE III (MODERATE)
585.4	CHRONIC KIDNEY DISEASE, STAGE IV (SEVERE)
585.5	CHRONIC KIDNEY DISEASE, STAGE V
585.6	END STAGE RENAL DISEASE
585.9	CHRONIC KIDNEY DISEASE, UNSPECIFIED
671.00 - 671.04	VARICOSE VEINS OF LEGS COMPLICATING PREGNANCY AND THE PUERPERIUM UNSPECIFIED AS TO EPISODE OF CARE -

	POSTPARTUM VARICOSE VEINS OF LEGS
671.20 - 671.24	SUPERFICIAL THROMBOPHLEBITIS COMPLICATING PREGNANCY AND THE PUERPERIUM UNSPECIFIED AS TO EPISODE OF CARE - POSTPARTUM SUPERFICIAL THROMBOPHLEBITIS
671.30 - 671.33	DEEP PHLEBOTHROMBOSIS ANTEPARTUM UNSPECIFIED AS TO EPISODE OF CARE - DEEP PHLEBOTHROMBOSIS ANTEPARTUM
671.40 - 671.44	DEEP PHLEBOTHROMBOSIS POSTPARTUM UNSPECIFIED AS TO EPISODE OF CARE - DEEP PHLEBOTHROMBOSIS POSTPARTUM
695.9	UNSPECIFIED ERYTHEMATOUS CONDITION
707.10 - 707.19	UNSPECIFIED ULCER OF LOWER LIMB - ULCER OF OTHER PART OF LOWER LIMB
729.5	PAIN IN LIMB
729.81	SWELLING OF LIMB
747.60 - 747.69	ANOMALY OF THE PERIPHERAL VASCULAR SYSTEM UNSPECIFIED SITE - ANOMALIES OF OTHER SPECIFIED SITES OF PERIPHERAL VASCULAR SYSTEM
782.2	LOCALIZED SUPERFICIAL SWELLING MASS OR LUMP
782.3	EDEMA
785.4	GANGRENE
786.00 - 786.02	RESPIRATORY ABNORMALITY UNSPECIFIED - ORTHOPNEA
786.03 - 786.09	APNEA - RESPIRATORY ABNORMALITY OTHER
786.52 - 786.59	PAINFUL RESPIRATION - OTHER CHEST PAIN
794.2	NONSPECIFIC ABNORMAL RESULTS OF FUNCTION STUDY OF PULMONARY SYSTEM
903.00 - 903.9	INJURY TO AXILLARY VESSEL(S) UNSPECIFIED - INJURY TO UNSPECIFIED BLOOD VESSEL OF UPPER EXTREMITY
904.0 - 904.9	INJURY TO COMMON FEMORAL ARTERY - INJURY TO BLOOD VESSELS OF UNSPECIFIED SITE
996.1	MECHANICAL COMPLICATION OF OTHER VASCULAR DEVICE IMPLANT AND GRAFT
996.70 - 996.79	OTHER COMPLICATIONS DUE TO UNSPECIFIED DEVICE IMPLANT AND GRAFT - OTHER COMPLICATIONS DUE TO OTHER INTERNAL PROSTHETIC DEVICE IMPLANT AND GRAFT
997.2	PERIPHERAL VASCULAR COMPLICATIONS NOT ELSEWHERE CLASSIFIED
998.2	ACCIDENTAL PUNCTURE OR LACERATION DURING A PROCEDURE

	NOT ELSEWHERE CLASSIFIED
999.2	OTHER VASCULAR COMPLICATIONS OF MEDICAL CARE NOT ELSEWHERE CLASSIFIED
V12.51	PERSONAL HISTORY OF VENOUS THROMBOSIS AND EMBOLISM
V12.52	PERSONAL HISTORY OF THROMBOPHLEBITIS
V72.81	PRE-OPERATIVE CARDIOVASCULAR EXAMINATION
CPT code 93990	
996.73	OTHER COMPLICATIONS DUE TO RENAL DIALYSIS DEVICE IMPLANT AND GRAFT
V56.31	ENCOUNTER FOR ADEQUACY TESTING FOR HEMODIALYSIS
For Vein Mapping Prior to Coronary Bypass - Code 93971	
V72.81	PRE-OPERATIVE CARDIOVASCULAR EXAMINATION
For Vein Mapping Prior to Dialysis Graft Placement - 93971	
585.1	CHRONIC KIDNEY DISEASE, STAGE I
585.2	CHRONIC KIDNEY DISEASE, STAGE II (MILD)
585.3	CHRONIC KIDNEY DISEASE, STAGE III (MODERATE)
585.4	CHRONIC KIDNEY DISEASE, STAGE IV (SEVERE)
585.5	CHRONIC KIDNEY DISEASE, STAGE V
585.6	END STAGE RENAL DISEASE
585.9	CHRONIC KIDNEY DISEASE, UNSPECIFIED

Diagnoses that Support Medical Necessity back to top
N/A

ICD-9 Codes that DO NOT Support Medical Necessity back to top
N/A

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

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N/A

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

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

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N/A

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Non-invasive Vascular Diagnostic Studies, in Physicians' Current Procedural Terminology 1995, American Medical Association, pps. 543-544, 1995

Manual System, Pub 100-3, Medicare National Coverage, Chapter 1, Section 20.4

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Assessment: Transcranial Doppler. Report of the American Academy of Neurology, Therapeutics and Technology Assessment Subcommittee. Neurology 1990; 40:680.1.

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Testing; Part II, Vascular Laboratory Operations, Peripheral Venous Testing, 1995.

Program Memorandum Transmittal AB-01-129, Change Request 1855.

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This policy does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from .

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11
Annual CPT, HCPCS, ICD-9-CM update review 02/15/2006

10
05/18/2005
Revised wording to Carriers Manual reference

09
01/01/2005
Addition of ICD-9-CM code 443.22 per provider request for reconsideration.

08
01/01/2005
Reviewed with 2005 code additions.

07
11/28/2003
Revised wording for Carriers Manual references

Outpatient Physical Therapy

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L10214

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Outpatient Physical Therapy

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99A-0021-L

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

Title XVIII of the Social Security Act, section 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 42, Code of Federal Regulations, Sections 424.24 and 410.61

CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 1, Sections 110.1-110.5

CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 8, Sections 30.4.1.1 and 30.4.1.2

CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 12, Sections 10, 20, 30, 40, 40.1 and 40.2

CMS Manual System, Pub 100-2, Medicare Benefit Policy, Chapter 15, Sections 220-230.1 and 230.4-230.5

CMS Manual System, Pub 100-3, Medicare National Coverage Determinations, Chapter 1, Part 1, Sections 10.2, 30.1, and 30.1.1

CMS Manual System, Pub 100-3, Medicare National Coverage Determinations, Chapter 1, Part 2, Sections 150.4, 150.5, 150.8, 160.2, 160.3, 160.7, 160.12, and 160.15

CMS Manual System, Pub 100-3, Medicare National Coverage Determinations, Chapter 1, Part 3, Section 170.1

CMS Manual System, Pub 100-3, Medicare National Coverage Determinations, Chapter 1, Part 4, Sections 240.3 and 270.4

CMS Manual System, Pub 100-4, Medicare Claims Processing Manual, Chapter 5, Section 100.5

CMS Manual System, Pub 100-8, Medicare Program Integrity Manual, Chapter 3, Section 3.4.1.1 (B)

CMS Manual System, Pub 100-4, Medicare Claims Processing, Transmittal 124, dated March 19, 2004, Change Request 3149

CMS Manual System, Pub 100-8, Medicare Program Integrity Manual, Transmittal 63, dated January 23, 2004, Change Request 3010

CMS Manual System, Pub 100-2, Medicare Benefit Policy, Transmittal 34, dated May 6, 2005, Change Request 3648

CMS Manual System, Pub. 100-04, Medicare Claims Processing, Transmittal 515, dated April 1, 2005, Change Request 3647

Program Memorandum:
· AB-02-078; Change Request 2083; dated May 29, 2002

CMS Manual System, Pub. 100-04, Medicare Claims Processing, Transmittal 676, dated September 16, 2005, Change Request 4057

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Indications and Limitations of Coverage and/or Medical Necessity back to top

Physical therapy services are part of a constellation of rehabilitative services designed to improve or restore physical functioning as well as to prevent injury, impairments, functional limitations and disability following disease, injury or loss of a body part. Impairments, functional limitations and disabilities are addressed by the design and implementation of a therapeutic intervention tailored to the specific needs of the individual patient. The specific interventions most commonly utilized are exercise, manual therapy, heat, cold, electricity, ultraviolet light, ultrasound, hydrotherapy, and massage to improve circulation, strengthen muscles, maintain or restore motion, and train or retrain an individual to perform the activities of daily living.

All physical therapy services must be performed by or under the supervision of a qualified physical therapist.

Although there is an overlap in services provided by physical and occupational therapists, this policy addresses only physical therapy.

For the purposes of this Local Coverage Determination (LCD) Policy, the following descriptions/definitions of terms are used:

Direct Supervision: This requires that the physician or non-physician practitioner (NPP) or therapist be immediately available during the course of therapy.

General Supervision: This requires the initial direction and periodic inspection/review of the actual activity or service.

Qualified Physical Therapist: An individual who is licensed as a physical

therapist and meets the practice requirements in the state where they are practicing.

For outpatient settings, references to “physicians” throughout this policy include non-physician practitioners, such as nurse practitioner’s, clinical nurse specialists and physician assistants. Such non-physician practitioners may certify, order and establish the plan of care for services by physical therapists as authorized by state law.

A qualified physical therapist, for program coverage purposes, is defined as an individual who is licensed as a physical therapist and meets the practice requirements in the state where they are practicing. Physiatrists, physicians or NPPs, and qualified physical therapists have the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate a patient’s level of function, and determine whether a physical therapy program could reasonably be expected to improve, restore or compensate for lost function. Where appropriate, the physical therapist can recommend to the physician or NPP a plan of treatment. While the skills of a qualified physical therapist are required to evaluate the patient’s level of function and develop a plan of treatment, implementation of the plan may also be carried out by a qualified physical therapy assistant functioning under the general supervision of the qualified physical therapist. General supervision requires the initial direction and periodic inspection of the actual activity.

General Physical Therapy Guidelines:

1. Physical therapy services are covered services provided the services are of a level of complexity and sophistication, or the patient's condition is such that the services can be safely and effectively performed only by a licensed physical therapist or under his/her supervision. Services normally considered a routine part of nursing care are not covered as physical therapy (i.e., turning patients to prevent pressure injuries, walking a patient in the hallway postoperatively or ambulation without gait training).

2. Covered physical therapy must be furnished while the individual is or was under the care of a physician. Services must relate directly and specifically to a written plan of treatment regimen established by the physician or non-physician practitioner after any necessary consultation with the qualified physical therapist, or by the physical therapist providing the services and must be reasonable and necessary to the treatment of the individual's illness or injury.

3. In order for the plan of treatment to be covered, it must address a condition for which physical therapy is an accepted method of treatment as defined by standards of medical practice. Also, the plan of treatment must be for a condition that is expected to improve significantly within a reasonable and generally predictable period of time or establishes a safe and effective maintenance program. If at any point in the treatment of an illness it is determined that the expectations will not materialize, the services are no longer considered reasonable and necessary and are excluded from coverage.

4. Physical therapy is only covered when it is rendered under a written plan of

treatment established by the physician, non-physician practitioner or the qualified physical therapist, to address specific therapeutic goals for which modalities and procedures are planned out specifically in terms of type, frequency and duration. The physician or non-physician practitioner should periodically review the plan of treatment.

5. The physician or non-physician practitioner and/or therapist must document the patient's functional limitations in terms that are objective and measurable.

6. Rehabilitation Services for Vision Impairment: The coverage criteria and definition of rehabilitation services for beneficiaries with vision impairment are found in Program Memorandum, Transmittal AB-02-078, dated May 29, 2002, Change Request 2083.

SPECIFIC PROCEDURE AND MODALITY GUIDELINES

Wound Care selective (CPT codes 97597 and 97598)

a) Debridement:

Debridement is indicated whenever necrotic tissue is present on a documented open wound. Debridement may also be indicated in cases of abnormal wound repair.

b) Conservative Sharp Debridement:

Conservative sharp debridement is a minor procedure that requires no anesthesia and is performed on an outpatient basis. Scalpel, scissors, and forceps may be used and only clearly identified devitalized tissue is removed. Generally, there is no specific bleeding associated with this procedure.

Wound Care non-selective (CPT code 97602, 97605 and 97606)

a) Enzymatic Debridement:

Debridement with topical enzymes is used when necrotic substances to be removed from a wound are protein, fibrin and collagen. The manufacturers product insert contains indications, contra-indications, precautions, dosage, and administration. It would be the clinician's responsibility to comply with the product insert/guidelines.

b) Autolytic Debridement:

This type of debridement is indicated where manageable amounts of necrotic tissue are present, and there is no infection. Autolytic debridement occurs when the enzymes that are naturally found in wound fluids are sequestered under synthetic dressings. They are contraindicated for wounds that contain infection.

c) Mechanical Debridement:

Wet-to-moist dressings may be used with wounds that have a high percentage of necrotic tissue. Wet-to-moist dressings should be used cautiously as

maceration of surrounding tissue may hinder healing.
Hydrotherapy and wound irrigation are also forms of mechanical debridement used to remove necrotic tissue. They also should be used cautiously, as maceration of surrounding tissue may hinder healing.

d) Negative Pressure Wound Therapy:

Negative pressure wound therapy is a non-invasive treatment by which controlled localized negative pressure is delivered to a wide variety of acute, sub-acute, and chronic wounds. They should be used cautiously as maceration of surrounding tissue may hinder healing.

Note: Please refer to the Hyperbaric Oxygen Therapy (HBO therapy) LCD # 98A-0016-L and to the Metabolically Active Dermal Skin Substitute Dressings LCD # 03A-0010-L.

Fabrication / Application of Casts, Splints and Strapping (CPT codes 29065-29590)

Fabrication and application of casts, splints, and strapping (e.g., the use of elastic wraps, heavy cloth, adhesive tape) will be considered reasonable and necessary if used to support weak or ineffective joints/muscles, reduce/correct joint limitations/deformities and/or protect body parts from injury, thus enhancing the performance of tasks or movements. The casts, splints and strapping are often used in conjunction with therapeutic exercise, functional training, and other interventions and should be selected in the context of patient needs and social/culture environments.

Body and Upper Extremity Casts:

Application of long arm cast (CPT code 29065)

Indicated for the shoulder and/or elbow in the treatment of fractures, dislocations, sprains/strains, tendinitis, post-op reconstruction, contractures and/or other deformities involving soft tissue.

Application of short arm cast (CPT code 29075)

Indicated for the forearm, wrist and/or hand in the treatment of fractures, dislocations, sprains/strains, tendinitis, post-op reconstruction, contractures or other deformities involving soft tissue.

Apply hand / wrist cast (CPT code 29085)

Indicated for the forearm, wrist and/or hand in the treatment of fractures, dislocations, sprains/strains, tendinitis, post-op reconstruction, contractures or other deformities involving soft tissue.

SPLINTS:

Apply long arm splint (CPT code 29105)

Indicated for the shoulder and/or elbow in the treatment of fractures, dislocations, sprains/strains, tendinitis, post-op reconstruction, contractures or other deformities involving soft tissue.

Apply forearm splint (CPT codes 29125 and 29126)

Indicated for the forearm, wrist and/or hand in the treatment of fractures, dislocations, sprains/strains, tendinitis, post-op reconstruction, contractures or other deformities involving soft tissue.

Application of finger splint (CPT codes 29130 and 29131)

Indicated for the finger in the treatment of fractures, dislocations, sprains/strains, tendinitis, post-op reconstruction, contractures or other deformities involving soft tissue.

Strapping-Any Age

Strapping of chest (CPT code 29200)

Indicated for the lumbar spine or abdominal musculature in the treatment of contusions, dislocations, fractures, sprains/strains, post-op conditions, contractures or other deformities involving soft tissue.

Strapping of low back (CPT code 29220)

Indicated for the lumbar spine or abdominal musculature in the treatment of contusions, dislocations, fracture, sprains/strains, post-op conditions, contractures or other deformities involving soft tissue.

Strapping of shoulder (CPT code 29240)

Indicated for any portion of the shoulder girdle complex in the treatment of contusions, dislocations, fractures, sprains/strains, post-op conditions, contractures or other deformities involving soft tissue.

Strapping of elbow or wrist (CPT code 29260)

Indicated for the elbow and wrist when there is involvement of the humerus, forearm, wrist or hand in the treatment of contusions, dislocations, fractures, sprains/strains, post-op conditions, contractures or other deformities involving soft tissue.

Strapping of hand or finger (CPT code 29280)

Indicated when there is involvement of the hand or digits in the treatment of contusions, dislocations, fractures, sprain/strains, post-op conditions, contractures or other deformities involving soft tissues.

Lower Extremity Casts:

Application of long leg cast (CPT codes 29345 and 29365)

Indicated when there is involvement of the femur, patella, tibia, fibula, ankle or foot in the treatment of contusions, dislocations, fractures, sprains/strains, post-op conditions, contractures or other deformities involving soft tissue.

Apply short leg cast (CPT code 29405)

Indicated when there is involvement of the tibia, fibula, ankle or foot in the treatment of contusions, dislocations, fractures, sprains/strains, post-op conditions, contractures or other deformities involving soft tissue.

Apply rigid leg cast (CPT code 29445)

Indicated for recent amputees or patients with lower extremity ulcers.

Splints

Application of long leg splint (CPT code 29505)

Indicated when there is involvement of the femur, patella, tibia, fibula, ankle or foot in the treatment of contusions, dislocations, fractures, sprains/strains, post-op conditions, contractures or other deformities involving soft tissue.

Application lower leg splint (CPT code 29515)

Indicated when there is involvement of the tibia, fibula, ankle or foot in the treatment of contusions, dislocations, fractures, sprains/strains, post-op conditions, contractures or other deformities involving soft tissue.

Strapping-Any Age

Strapping of hip (CPT code 29520)

Indicated when there is involvement of the lower back, abdomen or hip in the treatment of contusions, dislocations, fractures, sprains/strains, post-op conditions, contractures or other deformities involving soft tissue.

Strapping of knee (CPT code 29530)

Indicated when there is involvement of the thigh, knee, or lower leg in the treatment of contusions, dislocations, fractures, sprains/strains, post-op conditions, contractures or other deformities involving soft tissue.

Strapping of ankle (CPT code 29540)

Indicated when there is involvement of the lower leg, ankle and/or foot in the treatment of contusions, dislocations, fractures, sprains/strains, post-op conditions, contractures or other deformities involving soft tissue.

Strapping of toes (CPT code 29550)

Indicated when there is involvement of any of the toes in the treatment of contusions, dislocations, fractures, sprains/strains, post-op conditions, contractures or other deformities involving soft tissue.

Application of paste boot (CPT code 29580)

A dressing for ulcers resulting from venous insufficiency, consisting of a paste made from gelatin zinc oxide and glycerin, which is applied to the leg then covered with a spiral bandage, this in turn being given a coat of the paste. The process is repeated until satisfactory rigidity is attained.

Application of foot splint (CPT code 29590)

Specific for the correction of talipes equinovarus (i.e., club foot).

Biofeedback training any method (CPT code 90901)

The coverage criteria and definition of biofeedback therapy is found in the CMS Manual System, Pub 100-3, Medicare National Coverage Determinations Internet Only Manual).

Biofeedback peri/uro/rectal (CPT 90911)

The coverage criteria and definition of biofeedback therapy is found in the CMS Manual System, Pub 100-3, Medicare National Coverage Determinations Internet Only Manual).

Limb muscle testing, manual (CPT code 95831)

Hand muscle testing, manual (CPT code 95832)

Body muscle testing, manual (CPT codes 95833 and 95834).

The measurement of muscle performance using manual muscle testing only.

Range of Motion Measurements (CPT codes 95851 and 95852)

Determination of range of motion using a tape measure, flexible ruler, electronic device or goniometer.

PT Evaluation (CPT code 97001) and PT Re-evaluation (CPT code 97002):

Evaluation is a comprehensive service that requires professional skills to make clinical judgments about conditions for which services are indicated based on objective measurements and subjective evaluations of patient performance and functional abilities. Evaluation is warranted e.g., for a new diagnosis or when a condition is treated in a new setting. These evaluative judgments are essential to development of the plan of care, including goals and the selection of interventions. The time spent in evaluation does not count as treatment time.

1. The initial examination has three components:

a. The patient history,
b. Relevant systems reviews, and
c. Tests and measures.

2. Factors that influence the complexity of the examination and evaluation process include the clinical findings, extent of loss of function, social considerations, and the patient's overall physical function and health status. Thus, the evaluation reflects the chronicity or severity of the current problem, the possibility of multi-site or multi-system involvement, the presence of preexisting systemic conditions or diseases, and the stability of the condition. Physical therapists also consider the level of the current impairments and the probability of prolonged impairment, functional limitation, disability, the living environment, and the social supports.

3. Initial evaluations or reevaluations may be determined reasonable and necessary even when the evaluation determines that skilled rehabilitation is not required if the patient's condition showed a need for an evaluation, or even if the goals established by the plan of treatment are not realized.

4. Reevaluation is periodically indicated during an episode of care when the professional assessment indicates a significant improvement or decline in the patient’s condition or functional status. Some regulations and state practice acts require reevaluation at specific intervals. A reevaluation is focused on evaluation of progress toward current goals and making a professional judgment about continued care, modifying goals, and/or treatment or terminating services.

5. The treatment notes for each service should reflect:

a. An ongoing reassessment of the patients response to treatment,
b. Progress toward predicted goals,
c. Clinical rationale for continued skilled treatment, and
d. Recommended changes to the plan of treatment.

6. A reevaluation may be appropriate at a planned discharge.

7. Routine screening and assessments during admission to care and routine assessments are not covered.

Maintenance Program

1. A maintenance program which entails the design of a maintenance regimen required to delay or minimize muscular and functional deterioration in patients suffering from a chronic disease may be considered reasonable and necessary.

2. The repetitive services required to maintain function generally do not involve complex and sophisticated physical therapy procedures and do not require the judgment and skill of a qualified physical therapist for safety and effectiveness. However, in certain instances, the specialized knowledge and judgment may be required to establish a maintenance program. In such situations, the following services constitute physical therapy:

a. The initial evaluation of the patient's needs

b. The design by a qualified physical therapist of a maintenance program appropriate to the capacity and tolerance of the patient and the treatment objectives of the physician or non-physician practitioner

c. The instruction of the patient or supportive personnel, e.g., aides, nursing personnel or family members, if furnished on an outpatient basis, in carrying out the program

d. Reevaluations required to assess the patient's condition and adjust the program may be considered reasonable and necessary.

3. It is not reasonable and necessary for physical therapists to perform or supervise maintenance programs that do not require the professional skills of physical therapists. These situations include:

a. Services related to activities for the general good and welfare of patients (i.e., general exercises to promote overall fitness and flexibility)

b. Repetitive exercises to maintain gait or maintain strength and endurance, and assisted walking

c. Range of motion and passive exercises that are not related to restoration of a specific loss of function but are useful in maintaining range of motion in paralyzed extremities

d. Maintenance therapies after the patient has achieved therapeutic goals or for patients who show no further meaningful progress.

Hot or Cold Packs therapy (CPT code 97010):

1. Hot or cold packs are used primarily in conjunction with therapeutic procedures to provide analgesia, relieve muscle spasm and reduce inflammation and edema. Typically, cold packs are used for acute, painful conditions, and hot packs are used for subacute or chronic painful conditions.

2. The payment for hot or cold packs is bundled into the payment for other covered services and is not reimbursable.

Mechanical Traction therapy (CPT code 97012):

1. Traction is generally limited to the cervical or lumbar spine with the hope of relieving pain in or originating from those areas.

2. Specific indications for the use of mechanical traction include:

a. Cervical and/or lumbar radiculopathy

b. Back disorders such as disc herniation, lumbago, and sciatica.

Vasopneumatic Device Therapy (CPT code 97016):

1. The use of vasopneumatic devices may be considered reasonable and necessary for the application of pressure to an extremity for the purpose of reducing edema.

2. Specific indications for the use of vasopneumatic devices include:

a. Reduction of edema after acute injury

b. Lymphedema of an extremity

c. Education and training on the use of vasopneumatic devices for home use.

Note: Further treatment on the use of vasopneumatic devices by physical therapists, after the education and training visits, is usually not reasonable and necessary. Generally, education and training can be completed in three visits.

Paraffin Bath Therapy (CPT code 97018):

1. Paraffin bath, also known as hot wax treatment, is primarily used for pain relief in chronic joint problems of the wrists, hands, and feet.

2. Heat treatments of this type do not ordinarily require the skills of a qualified physical therapist. However, in a particular case, the skills, knowledge and judgment of a qualified physical therapist might be required in such treatments or baths, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds or other complications. Also, if such treatments are given prior to but as an integral part of a skilled physical therapy procedure, they would be considered part of the physical therapy service.

Whirlpool Therapy (CPT code 97022)/Hydrotherapy (CPT code 97036):

1. Heat treatments of this type and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. However, in a particular case, the skills, knowledge and judgment of a qualified physical therapist might be required in such treatments or baths, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds or other complications. Also, if such treatments are given prior to but as an integral part of a skilled physical therapy procedure, they would be considered part of the physical therapy service.

2. Whirlpool bath and Hubbard Tanks are the most common forms of hydrotherapy. The use of whirlpool is considered reasonable and necessary when used as part of a plan directed at facilitating the healing of an open wound (e.g., burns).

3. Specific indications for the use of whirlpools include the following:

a. The patient having a documented open wound which is draining, has a foul odor, or evidence of necrotic tissue

b. The patient having a documented need for wound debridement/bandage removal

c. Exfoliative skin impairments.

Diathermy Treatment (CPT code 97024):

Diathermy coverage criteria and definition are found in the CMS Manual System, Pub 100-3, Medicare National Coverage Determinations (Internet Only Manual).

Infrared Therapy (CPT code 97026):

Heat treatments of this type and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. However, in a particular case, the skills, knowledge and judgment of a qualified physical therapist might be required in such treatments or baths, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds or other complications. Also, if such treatments are given prior to but as an integral part of a skilled physical therapy procedure, they would be considered part of the physical therapy service.

Infrared application applied in the absence of associated procedures or modalities or used alone to reduce discomfort is considered **not** reasonable and necessary and, therefore, is not covered.

Ultraviolet Therapy (CPT code 97028):

The application of ultraviolet therapy is considered reasonable and necessary for the patient requiring the application of a drying heat. The specific indications for this therapy are as follows:

a. A patient having an open wound; minimal erythema; dosage must be documented

b. Severe psoriasis limiting range of motion

Electrical Stimulation Therapy (CPT codes 64550 and 97032, HCPCS codes G0281 and G0283)

The coverage criteria and definition of electrical stimulation and electromagnetic therapy are found in the CMS Manual System, Pub 100-3, Medicare National Coverage Determinations (Internet Only Manual).

Electrical Current Therapy (CPT code 97033)

1. Iontophoresis is a process in which electrically charged molecules or atoms (i. e., ions) are driven into tissue with an electrical field. Voltage provides the driving force. Parameters such as drug polarity and electrophoretic mobility must be known in order to be able to assess whether iontophoresis can deliver therapeutic concentrations of a medication at sites below the skin.

2. The application of iontophoresis is considered reasonable and necessary for the topical delivery of medications into a specific area of the body.

3. Specific indications for the use of iontophoresis application include:

a. The patient having tendonitis or calcific tendonitis

b. The patient having bursitis

c. The patient having adhesive capsulitis

d. The patient having hyperhidrosis.

Contrast Bath Therapy (CPT code 97034)

1. Contrast baths are a special form of therapeutic heat and cold that can be applied to distal extremities. The effectiveness of contrast baths is thought to be due to reflex hyperemia produced by the alternating exposure to heat and cold.

2. The use of contrast baths is considered reasonable and necessary to desensitize patients to pain by reflex hyperemia produced by the alternating exposure to heat and cold.

3. Specific indications for the use of contrast baths include:

a. The patient having rheumatoid arthritis or other inflammatory arthritis

b. The patient having reflex sympathetic dystrophy

c. The patient having a sprain or strain resulting from an acute injury.

4. Heat treatments of this type and whirlpool baths do not ordinarily require the skills of a qualified physical therapist. However, in a particular case, the skills, knowledge and judgment of a qualified physical therapist might be required in such treatments or baths, e.g., where the patient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds or other complications. Also, if such treatments are given prior to but as an integral part of a skilled physical therapy procedure, they would be considered part of the physical therapy service.

Ultrasound Therapy (CPT code 97035)

1. Therapeutic ultrasound is a deep heating modality that produces a sound wave of 0.8 to 3.0 MHz. In the human body, ultrasound has several pronounced effects on biologic tissues. It is attenuated by certain tissues and reflected by bone. Thus, tissues lying immediately next to bone can receive an even greater dosage of ultrasound, as much as 30% more. Because of the increased extensibility ultrasound produces in tissues of high collagen content, combined with the close proximity of joint capsules, tendons, and ligaments to cortical bone where they receive a more intense irradiation, it is an ideal

modality for increasing mobility in those tissues with restricted range of motion.

2. The application of ultrasound is considered reasonable and necessary for patients requiring deep heat to a specific area for reduction of pain, spasm, and joint stiffness, and the increase of muscle, tendon and ligament flexibility.

3. Specific indications for the use of ultrasound application include:

a. The patient having tightened structures limiting joint motion that require an increase in extensibility

b. The patient having symptomatic soft tissue calcification

c. The patient having neuromas.

Note: Ultrasound application is **not** considered to be reasonable and necessary for the treatment of asthma, bronchitis or any other pulmonary condition.

GENERAL GUIDELINES FOR THERAPEUTIC PROCEDURES:

1. Therapeutic procedures are procedures that attempt to reduce impairments and improve function through the application of clinical skills and/or services.

2. Use of these procedures requires that these services be rendered under the supervision of a physical therapist.

3. Therapeutic exercises and neuromuscular reeducation are examples of therapeutic interventions. The expected goals documented in the written plan of treatment, effected by the use of each of these procedures, will help define whether these procedures are reasonable and necessary. Therefore, since any one or a combination of more than one of these procedures may be used in a written plan of treatment, documentation must support the use of each procedure as it relates to a specific therapeutic goal.

4. Services provided concurrently by a physical therapist and occupational therapist may be covered, if separate and distinct goals are documented in the written plan of treatment.

5. Requires (one on one) direct patient contact.

Therapeutic Exercises (CPT code 97110)

1. Therapeutic Exercise is performed with a patient either actively, active-assisted, or passively participating (e.g., treadmill, isokinetic exercise, lumbar stabilization, stretching, strengthening, CPM-continuous passive motion).

2. Therapeutic Exercise is considered reasonable and necessary if at least one of the following conditions is present and documented:

a. The patient having weakness, contracture, stiffness secondary to spasm, spasticity, decreased range of motion, gait problem, balance and/or coordination deficits, abnormal posture, muscle imbalance

b. The patient needing to improve mobility, flexibility, strengthening, coordination, control of extremities, dexterity, range of motion, or endurance as part of activities of daily living training, or reeducation.

3. Documentation for therapeutic exercise typically includes objective loss of joint motion, strength, mobility (e.g., degrees of motion, strength grades, levels of assistance).

Neuromuscular Reeducation (CPT code 97112)

1. This therapeutic procedure is provided to improve balance, coordination, kinesthetic sense, posture, and proprioception (e.g., proprioceptive neuromuscular facilitation, Feldenkrais, Bobath, BAP's boards, and desensitization techniques).

2. Neuromuscular reeducation may be considered reasonable and necessary for impairments, which affect the body's neuromuscular system (e.g., poor static or dynamic sitting/standing balance, loss of gross and fine motor coordination, tilt table or standing table, hypo/hypertonicity).

Aquatic Therapy Exercises (CPT code 97113)

1. This procedure uses the therapeutic properties of water (e.g., buoyancy, resistance). The procedure may be reasonable and necessary for a loss or restriction of joint motion, strength, or mobility (e. g., degrees or motion, strength grades, levels of assistance).

2. Aquatic Therapy with therapeutic exercise may be considered reasonable and necessary in the treatment of the following conditions:

a. The patient having pain, joint stiffness or muscle spasms resulting from rheumatoid arthritis

b. The patient having had a cast removed or recent surgery and requiring mobilization of limbs

c. The patient having paraparesis or hemiparesis

d. The patient having had a recent amputation

e. The patient recovering from a paralytic condition

f. The patient requiring limb mobilization after a head trauma

g. The patient having the inability to tolerate exercise for rehabilitation under gravity based weight bearing.

Note: Aquatic Therapy (CPT code 97113) should not be billed in situations where no exercise is being performed in the water environment (e.g., debridement of ulcers).

Gait Training Therapy (CPT code 97116)

1. This procedure may be reasonable and necessary for training patients whose walking abilities have been impaired by neurological, muscular, or skeletal abnormalities or trauma.

2. Specific indications for gait training include:

a. The patient having suffered a cerebral vascular accident resulting in impairment in the ability to ambulate, now stabilized and ready to begin rehabilitation

b. The patient having recently suffered a musculoskeletal trauma requiring ambulation reeducation

c. The patient having a chronic, progressively debilitating condition for which safe ambulation has recently become a concern

d. The patient having had an injury or condition that requires instruction in the use of a walker, crutches, or cane

e. The patient having been fitted with a brace/lower limb prosthesis/orthosis and requires instruction in ambulation

f. The patient having a condition that requires retraining in stairs/steps or chair transfer in addition to general ambulation.

3. Gait training is **not** considered reasonable and necessary when the patient's walking ability is not expected to improve.

4. Repetitive walk-strengthening exercise for feeble or unstable patients or to increase endurance does not require professional skills and will be denied as not reasonable and necessary.

Massage Therapy (CPT code 97124)

1. Massage is the application of systemic manipulation to the soft tissues of the body for therapeutic purposes. Although various assistive devices and electrical equipment are available for the purpose of delivering massage, use of the hands is considered the most effective method of application, because palpation can be used as an assessment as well as a treatment tool.

2. Massage therapy, including effleurage, pétrissage, and/or tapotement (stroking, compression, percussion) may be considered reasonable and necessary if at least one of the following conditions is present and documented:

a. The patient having paralyzed musculature contributing to impaired circulation

b. The patient having sensitivity of tissues to pressure

c. The patient having tight muscles resulting in shortening and/or spasticity of

affective muscles

d. The patient having abnormal adherence of tissue to surrounding tissue

e. The patient requiring relaxation in preparation for neuromuscular reeducation or therapeutic exercise

f. The patient having contractures and decreased range of motion.

3. In most cases, postural drainage and pulmonary exercises can be carried out safely and effectively by nursing personnel. To be considered for payment, the physical therapist must identify the intervention that is best suited for the patient, taking into consideration the patient's condition and any contraindications that may be present. As there can be an overlap of skills between disciplines, i.e., respiratory therapy, skilled nursing and physical therapy, the documentation must clearly support the need for the intervention to be provided by the physical therapist.

NOTE: Please refer to the Respiratory Therapy (Respiratory Care) LCD #04A-0003-L.

Manual Therapy (CPT code 97140)

1. **Joint Mobilization (Peripheral or Spinal)**

This procedure may be considered reasonable and necessary if restricted joint motion is present and documented. It may be reasonable and necessary as an adjunct to therapeutic exercises when loss of articular motion and flexibility impedes the therapeutic procedure.

2. **Myofascial release/Soft Tissue Mobilization**

This procedure involves the application of skilled manual therapy techniques (active or passive) to soft tissues in order to effect changes in the soft tissues, articular structures, neural or vascular systems. Examples are facilitation of fluid exchange, restoration of movement in acutely edematous muscles, or stretching of shortened muscular or connective tissue.

Myofascial release/soft tissue mobilization can be considered reasonable and necessary if at least one of the following conditions is present and documented:

a. The patient having restricted joint or soft tissue motion in an extremity, neck or trunk **or**

b. Treatment being a necessary adjunct to other physical therapy interventions such as 97110, 97112 or 97530.

3. **Manipulation**

This procedure may be considered reasonable and necessary for treatment of painful spasm or restricted motion of soft tissues. It may also be used an adjunct to other therapeutic procedures such as 97110, 97112 or 97530.

4. **Decongestive Physiotherapy**

The goal of this type of therapy is to reduce lymphedema of extremity by routing the fluid to functional pathways, preventing backflow as the new routes become established, and to use the most appropriate methods to maintain the reduction of the extremity after therapy is complete. This therapy involves intensive treatment to reduce the size of the extremity by a combination of manual decongestive therapy and serial compression bandaging, followed by an exercise program.

1. It is expected that during these sessions, education is being provided to the patient and or caregiver on the correct application of the compression bandage.

2. It is also expected that after the completion of the therapy, the patient and or caregiver can perform these activities without supervision.

Group Therapeutic Procedures (CPT code 97150)

A group for the purpose of performing group therapy will be defined as:

a. 2-4 patients per therapist receiving active therapy but not one on one treatment and

b. The patients may be performing the same exercise or a different exercise but the physical therapist is instructing all the patients in the group.

Note: Regardless of the procedure or modality being performed, if the patient is not receiving direct one on one contact but is being supervised by the therapist, the group therapy code should be used.

Orthotic Training (CPT code 97760)

1. This procedure may be considered reasonable and necessary, if there is an indication for education for the application of orthotics, and the functional use of the orthotic is present and documented.

2. Generally, orthotic training can be completed in three visits.

3. The medical record should document the distinct treatments rendered when orthotic training for a lower extremity is done during the same visit as gait training (CPT code 97116).

4. The patient is capable of being trained to use the particular device prescribed in an appropriate manner. In some cases, the patient may not be able to perform this function, but a responsible individual can be trained to apply the device.

Prosthetic Training (CPT code 97761)

1. This procedure may be considered reasonable and necessary, if there is an indication for education in the application of the prosthetic, and the functional

use of the prosthetic is present and documented.

2. The medical record should document the distinct goals and service rendered when prosthetic training for a lower extremity is done during the same visit as gait training (CPT code 97116).

3. Periodic revisits beyond the third month would require documentation to support medical necessity.

Therapeutic Activities (CPT code 97530)

1. Therapeutic activities are considered reasonable and necessary for patients needing a broad range of rehabilitative techniques that involves movement. Movement activities can be for a specific body part or could involve the entire body. This procedure involves the use of functional activities (e.g., bending, lifting, carrying, reaching, catching and overhead activities) to improve functional performance in a progressive manner. The activities are usually directed at a loss or restriction of mobility, strength, balance, or coordination. They require the skills of physical therapists and are designed to address a specific functional need of the patient. These dynamic activities must be part of an active written plan of treatment and be directed at a specific outcome.

2. In order for therapeutic activities to be covered, the following requirements must be met:

a. The patient having a condition for which therapeutic activities can reasonably be expected to restore or improve functioning

b. The patient's condition being such that he/she is unable to perform therapeutic activities except under the direct supervision of a physician or non-physician practitioner or physical therapist

c. There being a clear correlation between the type of exercise performed and the patient's underlying medical condition for which the therapeutic activities were prescribed.

Self-Care Management Training (CPT code 97535)

The coverage criteria and definition of self-care management training is found in the CMS Manual System, Pub 100-3, Medicare National Coverage Determinations (Internet Only Manual).

Community/Work Reintegration (CPT code 97537, 97545, and 97546)

Services that are related **solely** to specific employment opportunities work skills, or work settings are not reasonable and necessary for the diagnosis and treatment of an illness or injury and are excluded from coverage by section 1862(a)(1) of the Social Security Act.

Wheelchair Management Training (CPT code 97542)

1. This service trains the patient in functional activities that promote optimal

safety, mobility and transfers. Patients who are wheelchair bound may occasionally need skilled input on positioning to avoid pressure points, contractures, and other medical complications.

2. This procedure is reasonable and necessary only when it requires the skills of a physical therapist and is designed to address specific needs of the patient, and must be part of an active written plan of treatment directed at a specific goal.

3. The patient and/or caregiver must have the capacity to learn from instructions.

4. Typically, three to four sessions should be sufficient to teach the patient and/or caregiver these skills.

5. When billing 97542 for wheelchair propulsion training, documentation must relate the training to expected functional goals that are attainable by the patient.

Prosthetic Checkout (CPT Code 97762)

1. These assessments are reasonable and necessary when there is a modification or reissue of a recently issued device or a reassessment of a newly issued device.

2. These assessments may be reasonable and necessary when patients experience a loss of function directly related to the device (e.g., pain, skin breakdown, and falls).

Physical Performance Test or Measurement (CPT code 97750)

This testing may be reasonable and necessary for patients with neurological or musculoskeletal conditions when such tests are needed to formulate or evaluate a specific written plan of treatment, or to determine a patient's capacity.

Assistive Technology Assessment (CPT code 97755)

This assessment requires professional skill to gather data by observation and patient inquiry and may include limited objective testing and measurement to make clinical judgments regarding the patient's condition(s). Assessment determines, e.g., changes in the patient's status since the last visit and whether the planned procedure or service should be modified. Based on these assessment data, the professional may make judgment about progress toward goals and/or determine that a more complete evaluation or reevaluation is indicated.

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Physical, Occupational, and Speech Therapy

Coding Information

Bill Type Codes: back to top

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.

12x	Hospital-inpatient or home health visits (Part B only)
13x	Hospital-outpatient (HHA-A also) (under OPPS 13X must be used for ASC claims submitted for OPPS payment -- eff. 7/00)
14x	Hospital-other (Part B)
18x	Hospital-swing beds
21x	SNF-inpatient (including Part A)
22x	SNF-inpatient or home health visits (Part B only)
23x	SNF-outpatient (HHA-A also)
34x	HHA-other (Part B)
71x	Clinic-rural health
73x	Clinic-independent provider based FQHC (eff 10/91)
74x	Clinic-ORF only (eff 4/97); ORF and CMHC (10/91 - 3/97)
75x	Clinic-CORF
85x	Special facility or ASC surgery-rural primary care hospital (eff 10/94)

Revenue Codes: back to top

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.

042X	Physical therapy-general classification

CPT / HCPCS Codes back to top

29065	Application of long arm cast
29075	Application of forearm cast
29085	Apply hand/wrist cast
29105	Apply long arm splint
29125	Apply forearm splint
29126	Apply forearm splint
29130	Application of finger splint
29131	Application of finger splint
29200	Strapping of chest
29220	Strapping of low back
29240	Strapping of shoulder
29260	Strapping of elbow or wrist
29280	Strapping of hand or finger
29345	Application of long leg cast
29365	Application of long leg cast
29405	Apply short leg cast
29445	Apply rigid leg cast
29505	Application, long leg splint
29515	Application lower leg splint
29520	Strapping of hip
29530	Strapping of knee
29540	Strapping of ankle and/or ft
29550	Strapping of toes
29580	Application of paste boot
29590	Application of foot splint
64550	Apply neurostimulator
90901	Biofeedback train, any meth
90911	Biofeedback peri/uro/rectal
95831	Limb muscle testing, manual
95832	Hand muscle testing, manual
95833	Body muscle testing, manual

95834	Body muscle testing, manual
95851	Range of motion measurements
95852	Range of motion measurements
97001	Pt evaluation
97002	Pt re-evaluation
97010	Hot or cold packs therapy
97012	Mechanical traction therapy
97016	Vasopneumatic device therapy
97018	Paraffin bath therapy
97022	Whirlpool therapy
97024	Diathermy eg, microwave
97026	Infrared therapy
97028	Ultraviolet therapy
97032	Electrical stimulation
97033	Electric current therapy
97034	Contrast bath therapy
97035	Ultrasound therapy
97036	Hydrotherapy
97110	Therapeutic exercises
97112	Neuromuscular reeducation
97113	Aquatic therapy/exercises
97116	Gait training therapy
97124	Massage therapy
97140	Manual therapy
97150	Group therapeutic procedures
97530	Therapeutic activities
97535	Self care mngment training
97537	Community/work reintegration
97542	Wheelchair mngment training
97545	Work hardening
97546	Work hardening add-on
97597	Active wound care/20 cm or <

97598	Active wound care > 20 cm
97602	Wound(s) care non-selective
97605	Neg press wound tx, < 50 cm
97606	Neg press wound tx, > 50 cm
97750	Physical performance test
97755	Assistive technology assess
97760	Orthotic mgmt and training
97761	Prosthetic training
97762	C/o for orthotic/prosth use
97799	Physical medicine procedure
G0281	Elec stim unattend for press
G0283	Elec stim other than wound
G0329	Electromagntic tx for ulcers

ICD-9 Codes that Support Medical Necessity back to top

138	LATE EFFECTS OF ACUTE POLIOMYELITIS
333.83	SPASMODIC TORTICOLLIS
333.84	ORGANIC WRITERS' CRAMP
333.91	STIFF-MAN SYNDROME
337.21 - 337.29	REFLEX SYMPATHETIC DYSTROPHY OF THE UPPER LIMB - REFLEX SYMPATHETIC DYSTROPHY OF OTHER SPECIFIED SITE
342.01 - 342.02	FLACCID HEMIPLEGIA AND HEMIPARESIS AFFECTING DOMINANT SIDE - FLACCID HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE
342.11 - 342.12	SPASTIC HEMIPLEGIA AND HEMIPARESIS AFFECTING DOMINANT SIDE - SPASTIC HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE
342.81 - 342.82	OTHER SPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING DOMINANT SIDE - OTHER SPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE
342.91 - 342.92	UNSPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING DOMINANT SIDE - UNSPECIFIED HEMIPLEGIA AND HEMIPARESIS AFFECTING NONDOMINANT SIDE
344.01 - 344.09	QUADRIPLEGIA C1-C4 COMPLETE - OTHER QUADRIPLEGIA

344.1	PARAPLEGIA
344.2	DIPLEGIA OF UPPER LIMBS
344.31 - 344.32	MONOPLEGIA OF LOWER LIMB AFFECTING DOMINANT SIDE - MONOPLEGIA OF LOWER LIMB AFFECTING NONDOMINANT SIDE
344.41 - 344.42	MONOPLEGIA OF UPPER LIMB AFFECTING DOMINANT SIDE - MONOPLEGIA OF UPPER LIMB AFFECTING NONDOMINANT SDE
344.60 - 344.61	CAUDA EQUINA SYNDROME WITHOUT NEUROGENIC BLADDER - CAUDA EQUINA SYNDROME WITH NEUROGENIC BLADDER
344.81 - 344.89	LOCKED-IN STATE - OTHER SPECIFIED PARALYTIC SYNDROME
353.0 - 353.8	BRACHIAL PLEXUS LESIONS - OTHER NERVE ROOT AND PLEXUS DISORDERS
354.0 - 354.8	CARPAL TUNNEL SYNDROME - OTHER MONONEURITIS OF UPPER LIMB
355.0 - 355.79	LESION OF SCIATIC NERVE - OTHER MONONEURITIS OF LOWER LIMB
356.0 - 356.8	HEREDITARY PERIPHERAL NEUROPATHY - OTHER SPECIFIED IDIOPATHIC PERIPHERAL NEUROPATHY
368.41	SCOTOMA INVOLVING CENTRAL AREA
368.45	GENERALIZED VISUAL FIELD CONTRACTION OR CONSTRICTION
368.46	HOMONYMOUS BILATERAL FIELD DEFECTS
368.47	HETERONYMOUS BILATERAL FIELD DEFECTS
369.01	BETTER EYE: TOTAL VISION IMPAIRMENT; LESSER EYE: TOTAL VISION IMPAIRMENT
369.03	BETTER EYE: NEAR-TOTAL VISION IMPAIRMENT; LESSER EYE: TOTAL VISION IMPAIRMENT
369.04	BETTER EYE: NEAR-TOTAL VISION IMPAIRMENT; LESSER EYE: NEAR-TOTAL VISION IMPAIRMENT
369.06	BETTER EYE: PROFOUND VISION IMPAIRMENT; LESSER EYE: TOTAL VISION IMPAIRMENT
369.07	BETTER EYE: PROFOUND VISION IMPAIRMENT; LESSER EYE: NEAR-TOTAL VISION IMPAIRMENT
369.08	BETTER EYE: PROFOUND VISION IMPAIRMENT; LESSER EYE: PROFOUND VISION IMPAIRMENT
369.12	BETTER EYE: SEVERE VISION IMPAIRMENT; LESSER EYE: TOTAL VISION IMPAIRMENT
369.13	BETTER EYE: SEVERE VISION IMPAIRMENT; LESSER EYE: NEAR-TOTAL VISION IMPAIRMENT

369.14	BETTER EYE: SEVERE VISION IMPAIRMENT; LESSER EYE: PROFOUND VISION IMPAIRMENT
369.16	BETTER EYE: MODERATE VISION IMPAIRMENT; LESSER EYE: TOTAL VISION IMPAIRMENT
369.17	BETTER EYE: MODERATE VISION IMPAIRMENT; LESSER EYE: NEAR-TOTAL VISION IMPAIRMENT
369.18	BETTER EYE: MODERATE VISION IMPAIRMENT; LESSER EYE: PROFOUND VISION IMPAIRMENT
369.22	BETTER EYE: SEVERE VISION IMPAIRMENT; LESSER EYE: SEVERE VISION IMPAIRMENT
369.24	BETTER EYE: MODERATE VISION IMPAIRMENT; LESSER EYE: SEVERE VISION IMPAIRMENT
369.25	BETTER EYE: MODERATE VISION IMPAIRMENT; LESSER EYE: MODERATE VISION IMPAIRMENT
438.21 - 438.22	HEMIPLEGIA AFFECTING DOMINANT SIDE - HEMIPLEGIA AFFECTING NONDOMINANT SIDE
438.31 - 438.32	MONOPLEGIA OF UPPER LIMB AFFECTING DOMINANT SIDE - MONOPLEGIA OF UPPER LIMB AFFECTING NONDOMINANT SIDE
438.41 - 438.42	MONOPLEGIA OF LOWER LIMB AFFECTING DOMINANT SIDE - MONOPLEGIA OF LOWER LIMB AFFECTING NONDOMINANT SIDE
438.51 - 438.52	OTHER PARALYTIC SYNDROME AFFECTING DOMINANT SIDE - OTHER PARALYTIC SYNDROME AFFECTING NONDOMINANT SIDE
438.81 - 438.84	APRAXIA CEREBROVASCULAR DISEASE - ATAXIA
440.23	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES WITH ULCERATION
454.0 - 454.2	VARICOSE VEINS OF LOWER EXTREMITIES WITH ULCER - VARICOSE VEINS OF LOWER EXTREMITIES WITH ULCER AND INFLAMMATION
457.0	POSTMASTECTOMY LYMPHEDEMA SYNDROME
457.1	OTHER LYMPHEDEMA
459.31	CHRONIC VENOUS HYPERTENSION WITH ULCER
459.33	CHRONIC VENOUS HYPERTENSION WITH ULCER AND INFLAMMATION
514	PULMONARY CONGESTION AND HYPOSTASIS
524.60 - 524.69	TEMPOROMANDIBULAR JOINT DISORDERS UNSPECIFIED - TEMPOROMANDIBULAR JOINT DISORDERS OTHER SPECIFIED TEMPOROMANDIBULAR JOINT DISORDERS
607.89	OTHER SPECIFIED DISORDERS OF PENIS

611.71	MASTODYNIA
625.6	STRESS INCONTINENCE FEMALE
665.61	DAMAGE TO PELVIC JOINTS AND LIGAMENTS WITH DELIVERY
665.64	DAMAGE TO PELVIC JOINTS AND LIGAMENTS POSTPARTUM
681.00 - 681.11	UNSPECIFIED CELLULITIS AND ABSCESS OF FINGER - ONYCHIA AND PARONYCHIA OF TOE
682.0 - 682.7	CELLULITIS AND ABSCESS OF FACE - CELLULITIS AND ABSCESS OF FOOT EXCEPT TOES
683	ACUTE LYMPHADENITIS
696.1	OTHER PSORIASIS AND SIMILAR DISORDERS
707.00 - 707.8	DECUBITUS ULCER, UNSPECIFIED SITE - CHRONIC ULCER OF OTHER SPECIFIED SITES
709.2	SCAR CONDITIONS AND FIBROSIS OF SKIN
715.00 - 715.89	OSTEOARTHROSIS GENERALIZED INVOLVING UNSPECIFIED SITE - OSTEOARTHROSIS INVOLVING OR WITH MULTIPLE SITES BUT NOT SPECIFIED AS GENERALIZED
718.01 - 718.05	ARTICULAR CARTILAGE DISORDER INVOLVING SHOULDER REGION - ARTICULAR CARTILAGE DISORDER INVOLVING PELVIC REGION AND THIGH
718.41 - 718.49	CONTRACTURE OF JOINT OF SHOULDER REGION - CONTRACTURE OF JOINT OF MULTIPLE SITES
718.51 - 718.59	ANKYLOSIS OF JOINT OF SHOULDER REGION - ANKYLOSIS OF JOINT OF MULTIPLE SITES
718.81 - 718.89	OTHER JOINT DERANGEMENT NOT ELSEWHERE CLASSIFIED INVOLVING SHOULDER REGION - OTHER JOINT DERANGEMENT NOT ELSEWHERE CLASSIFIED INVOLVING MULTIPLE SITES
719.41 - 719.49	PAIN IN JOINT INVOLVING SHOULDER REGION - PAIN IN JOINT INVOLVING MULTIPLE SITES
719.51 - 719.59	STIFFNESS OF JOINT NOT ELSEWHERE CLASSIFIED INVOLVING SHOULDER REGION - STIFFNESS OF JOINT NOT ELSEWHERE CLASSIFIED INVOLVING MULTIPLE SITES
719.61 - 719.69	OTHER SYMPTOMS REFERABLE TO JOINT OF SHOULDER REGION - OTHER SYMPTOMS REFERABLE TO JOINT OF MULTIPLE SITES
719.7	DIFFICULTY IN WALKING
719.81 - 719.89	OTHER SPECIFIED DISORDERS OF JOINT OF SHOULDER REGION - OTHER SPECIFIED DISORDERS OF JOINT OF MULTIPLE SITES
720.2	SACROILIITIS NOT ELSEWHERE CLASSIFIED
722.0	DISPLACEMENT OF CERVICAL INTERVERTEBRAL DISC WITHOUT

	MYELOPATHY
722.10	DISPLACEMENT OF LUMBAR INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.11	DISPLACEMENT OF THORACIC INTERVERTEBRAL DISC WITHOUT MYELOPATHY
722.81 - 722.83	POSTLAMINECTOMY SYNDROME OF CERVICAL REGION - POSTLAMINECTOMY SYNDROME OF LUMBAR REGION
723.1	CERVICALGIA
723.3	CERVICOBRACHIAL SYNDROME (DIFFUSE)
723.4	BRACHIAL NEURITIS OR RADICULITIS NOS
723.5	TORTICOLLIS UNSPECIFIED
724.1	PAIN IN THORACIC SPINE
724.2	LUMBAGO
724.3	SCIATICA
724.4	THORACIC OR LUMBOSACRAL NEURITIS OR RADICULITIS UNSPECIFIED
724.5	BACKACHE UNSPECIFIED
724.6	DISORDERS OF SACRUM
724.8	OTHER SYMPTOMS REFERABLE TO BACK
726.0	ADHESIVE CAPSULITIS OF SHOULDER
726.11 - 726.19	CALCIFYING TENDINITIS OF SHOULDER - OTHER SPECIFIED DISORDERS OF BURSAE AND TENDONS IN SHOULDER REGION
726.2	OTHER AFFECTIONS OF SHOULDER REGION NOT ELSEWHERE CLASSIFIED
726.31	MEDIAL EPICONDYLITIS
726.32	LATERAL EPICONDYLITIS
727.03	TRIGGER FINGER (ACQUIRED)
727.81	CONTRACTURE OF TENDON (SHEATH)
728.2	MUSCULAR WASTING AND DISUSE ATROPHY NOT ELSEWHERE CLASSIFIED
728.3	OTHER SPECIFIC MUSCLE DISORDERS
728.4	LAXITY OF LIGAMENT
728.5	HYPERMOBILITY SYNDROME
728.6	CONTRACTURE OF PALMAR FASCIA
728.71 -	PLANTAR FASCIAL FIBROMATOSIS - OTHER FIBROMATOSES OF

728.79	MUSCLE LIGAMENT AND FASCIA
728.81 - 728.85	INTERSTITIAL MYOSITIS - SPASM OF MUSCLE
728.87	MUSCLE WEAKNESS (GENERALIZED)
728.89	OTHER DISORDERS OF MUSCLE LIGAMENT AND FASCIA
729.5	PAIN IN LIMB
733.10 - 733.19	PATHOLOGICAL FRACTURE UNSPECIFIED SITE - PATHOLOGICAL FRACTURE OF OTHER SPECIFIED SITE
736.05	WRIST DROP (ACQUIRED)
736.79	OTHER ACQUIRED DEFORMITIES OF ANKLE AND FOOT
736.81	UNEQUAL LEG LENGTH (ACQUIRED)
754.1	CONGENITAL MUSCULOSKELETAL DEFORMITIES OF STERNOCLEIDOMASTOID MUSCLE
755.30 - 755.39	UNSPECIFIED REDUCTION DEFORMITY OF LOWER LIMB CONGENITAL - LONGITUDINAL DEFICIENCY PHALANGES COMPLETE OR PARTIAL
755.60 - 755.64	UNSPECIFIED CONGENITAL ANOMALY OF LOWER LIMB - CONGENITAL DEFORMITY OF KNEE (JOINT)
781.0	ABNORMAL INVOLUNTARY MOVEMENTS
781.2	ABNORMALITY OF GAIT
781.3	LACK OF COORDINATION
781.4	TRANSIENT PARALYSIS OF LIMB
781.8	NEUROLOGICAL NEGLECT SYNDROME
781.92 - 781.99	ABNORMAL POSTURE - OTHER SYMPTOMS INVOLVING NERVOUS AND MUSCULOSKELETAL SYSTEMS
782.0	DISTURBANCE OF SKIN SENSATION
782.3	EDEMA
782.8	CHANGES IN SKIN TEXTURE
783.3	FEEDING DIFFICULTIES AND MISMANAGEMENT
785.4	GANGRENE
787.6	INCONTINENCE OF FECES
788.31 - 788.34	URGE INCONTINENCE - INCONTINENCE WITHOUT SENSORY AWARENESS
805.01 - 805.08	CLOSED FRACTURE OF FIRST CERVICAL VERTEBRA - CLOSED FRACTURE OF MULTIPLE CERVICAL VERTEBRAE

805.2	CLOSED FRACTURE OF DORSAL (THORACIC) VERTEBRA WITHOUT SPINAL CORD INJURY
805.4	CLOSED FRACTURE OF LUMBAR VERTEBRA WITHOUT SPINAL CORD INJURY
805.6	CLOSED FRACTURE OF SACRUM AND COCCYX WITHOUT SPINAL CORD INJURY
807.01 - 807.08	CLOSED FRACTURE OF ONE RIB - CLOSED FRACTURE OF EIGHT OR MORE RIBS
807.2	CLOSED FRACTURE OF STERNUM
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808.2	CLOSED FRACTURE OF PUBIS
808.41 - 808.49	CLOSED FRACTURE OF ILIUM - CLOSED FRACTURE OF OTHER SPECIFIED PART OF PELVIS
809.0 - 809.1	FRACTURE OF BONES OF TRUNK CLOSED - FRACTURE OF BONES OF TRUNK OPEN
810.01 - 810.03	CLOSED FRACTURE OF STERNAL END OF CLAVICLE - CLOSED FRACTURE OF ACROMIAL END OF CLAVICLE
811.01 - 811.09	CLOSED FRACTURE OF ACROMIAL PROCESS OF SCAPULA - CLOSED FRACTURE OF OTHER PART OF SCAPULA
812.01 - 812.59	FRACTURE OF SURGICAL NECK OF HUMERUS CLOSED - OTHER FRACTURE OF LOWER END OF HUMERUS OPEN
813.01 - 813.93	FRACTURE OF OLECRANON PROCESS OF ULNA CLOSED - FRACTURE OF UNSPECIFIED PART OF RADIUS WITH ULNA OPEN
814.00 - 814.19	CLOSED FRACTURE OF CARPAL BONE UNSPECIFIED - OPEN FRACTURE OF OTHER BONE OF WRIST
815.00 - 815.19	CLOSED FRACTURE OF METACARPAL BONE(S) SITE UNSPECIFIED - OPEN FRACTURE OF MULTIPLE SITES OF METACARPUS
816.00 - 816.13	CLOSED FRACTURE OF PHALANX OR PHALANGES OF HAND UNSPECIFIED - OPEN FRACTURE OF MULTIPLE SITES OF PHALANX OR PHALANGES OF HAND
817.0 - 817.1	MULTIPLE CLOSED FRACTURES OF HAND BONES - MULTIPLE OPEN FRACTURES OF HAND BONES
818.0 - 818.1	ILL-DEFINED CLOSED FRACTURES OF UPPER LIMB - ILL-DEFINED OPEN FRACTURES OF UPPER LIMB
820.00 - 820.9	FRACTURE OF UNSPECIFIED INTRACAPSULAR SECTION OF NECK OF FEMUR CLOSED - FRACTURE OF UNSPECIFIED PART OF NECK OF FEMUR OPEN
821.00 - 821.39	FRACTURE OF UNSPECIFIED PART OF FEMUR CLOSED - OTHER FRACTURE OF LOWER END OF FEMUR OPEN

822.0 - 822.1	CLOSED FRACTURE OF PATELLA - OPEN FRACTURE OF PATELLA
823.00 - 823.92	CLOSED FRACTURE OF UPPER END OF TIBIA - OPEN FRACTURE OF UNSPECIFIED PART OF FIBULA WITH TIBIA
824.0 - 824.9	FRACTURE OF MEDIAL MALLEOLUS CLOSED - UNSPECIFIED FRACTURE OF ANKLE OPEN
825.0 - 825.39	FRACTURE OF CALCANEUS CLOSED - OTHER FRACTURES OF TARSAL AND METATARSAL BONES OPEN
826.0 - 826.1	CLOSED FRACTURE OF ONE OR MORE PHALANGES OF FOOT - OPEN FRACTURE OF ONE OR MORE PHALANGES OF FOOT
827.0 - 827.1	OTHER MULTIPLE AND ILL-DEFINED FRACTURES OF LOWER LIMB CLOSED - OTHER MULTIPLE AND ILL-DEFINED FRACTURES OF LOWER LIMB OPEN
831.01 - 831.09	CLOSED ANTERIOR DISLOCATION OF HUMERUS - CLOSED DISLOCATION OF OTHER SITE OF SHOULDER
832.01 - 832.09	CLOSED ANTERIOR DISLOCATION OF ELBOW - CLOSED DISLOCATION OF OTHER SITE OF ELBOW
833.01 - 833.09	CLOSED DISLOCATION OF RADIOULNAR (JOINT) DISTAL - CLOSED DISLOCATION OF OTHER PART OF WRIST
834.01 - 834.02	CLOSED DISLOCATION OF METACARPOPHALANGEAL (JOINT) - CLOSED DISLOCATION OF INTERPHALANGEAL (JOINT) HAND
835.01 - 835.03	CLOSED POSTERIOR DISLOCATION OF HIP - OTHER CLOSED ANTERIOR DISLOCATION OF HIP
836.0 - 836.3	TEAR OF MEDIAL CARTILAGE OR MENISCUS OF KNEE CURRENT - DISLOCATION OF PATELLA CLOSED
836.51 - 836.59	ANTERIOR DISLOCATION OF TIBIA PROXIMAL END CLOSED - OTHER DISLOCATION OF KNEE CLOSED
837.0	CLOSED DISLOCATION OF ANKLE
838.01 - 838.09	CLOSED DISLOCATION OF TARSAL (BONE) JOINT UNSPECIFIED - CLOSED DISLOCATION OF OTHER PART OF FOOT
839.61	CLOSED DISLOCATION STERNUM
840.0 - 840.8	ACROMIOCLAVICULAR (JOINT) (LIGAMENT) SPRAIN - SPRAIN OF OTHER SPECIFIED SITES OF SHOULDER AND UPPER ARM
841.0 - 841.9	RADIAL COLLATERAL LIGAMENT SPRAIN - SPRAIN OF UNSPECIFIED SITE OF ELBOW AND FOREARM
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847.0 - 847.4	NECK SPRAIN - SPRAIN OF COCCYX
848.41 - 848.42	STERNOCLAVICULAR (JOINT) (LIGAMENT) SPRAIN - CHONDROSTERNAL (JOINT) SPRAIN
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881.00 - 881.22	OPEN WOUND OF FOREARM WITHOUT COMPLICATION - OPEN WOUND OF WRIST WITH TENDON INVOLVEMENT
882.0 - 882.2	OPEN WOUND OF HAND EXCEPT FINGERS ALONE WITHOUT COMPLICATION - OPEN WOUND OF HAND EXCEPT FINGERS ALONE WITH TENDON INVOLVEMENT
883.0 - 883.2	OPEN WOUND OF FINGERS WITHOUT COMPLICATION - OPEN WOUND OF FINGERS WITH TENDON INVOLVEMENT
884.0 - 884.2	MULTIPLE AND UNSPECIFIED OPEN WOUND OF UPPER LIMB WITHOUT COMPLICATION - MULTIPLE AND UNSPECIFIED OPEN WOUND OF UPPER LIMB WITH TENDON INVOLVEMENT
885.0 - 885.1	TRAUMATIC AMPUTATION OF THUMB (COMPLETE)(PARTIAL) WITHOUT COMPLICATION - TRAUMATIC AMPUTATION OF THUMB (COMPLETE)(PARTIAL) COMPLICATED
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887.0 - 887.7	TRAUMATIC AMPUTATION OF ARM AND HAND (COMPLETE) (PARTIAL) UNILATERAL BELOW ELBOW WITHOUT COMPLICATION - TRAUMATIC AMPUTATION OF ARM AND HAND (COMPLETE) (PARTIAL) BILATERAL (ANY LEVEL) COMPLICATED
890.0 - 890.2	OPEN WOUND OF HIP AND THIGH WITHOUT COMPLICATION - OPEN WOUND OF HIP AND THIGH WITH TENDON INVOLVEMENT
891.0 - 891.2	OPEN WOUND OF KNEE LEG (EXCEPT THIGH) AND ANKLE WITHOUT COMPLICATION - OPEN WOUND OF KNEE LEG (EXCEPT THIGH) AND ANKLE WITH TENDON INVOLVEMENT

892.0 - 892.2	OPEN WOUND OF FOOT EXCEPT TOE(S) ALONE WITHOUT COMPLICATION - OPEN WOUND OF FOOT EXCEPT TOE(S) ALONE WITH TENDON INVOLVEMENT
893.0 - 893.2	OPEN WOUND OF TOE(S) WITHOUT COMPLICATION - OPEN WOUND OF TOE(S) WITH TENDON INVOLVEMENT
895.0 - 895.1	TRAUMATIC AMPUTATION OF TOE(S) (COMPLETE) (PARTIAL) WITHOUT COMPLICATION - TRAUMATIC AMPUTATION OF TOE(S) (COMPLETE) (PARTIAL) COMPLICATED
896.0 - 896.3	TRAUMATIC AMPUTATION OF FOOT (COMPLETE) (PARTIAL) UNILATERAL WITHOUT COMPLICATION - TRAUMATIC AMPUTATION OF FOOT (COMPLETE) (PARTIAL) BILATERAL COMPLICATED
897.0 - 897.7	TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL) UNILATERAL BELOW KNEE WITHOUT COMPLICATION - TRAUMATIC AMPUTATION OF LEG(S) (COMPLETE) (PARTIAL) BILATERAL (ANY LEVEL) COMPLICATED
905.1 - 905.9	LATE EFFECT OF FRACTURE OF SPINE AND TRUNK WITHOUT SPINAL CORD LESION - LATE EFFECT OF TRAUMATIC AMPUTATION
941.21	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF EAR (ANY PART)
941.31	FULL-THICKNESS SKIN LOSS DUE TO BURN (THIRD DEGREE NOS) OF EAR (ANY PART)
941.33 - 941.39	FULL-THICKNESS SKIN LOSS DUE TO BURN (THIRD DEGREE NOS) OF LIP(S) - FULL-THICKNESS SKIN LOSS DUE TO BURN (THIRD DEGREE NOS) OF MULTIPLE SITES (EXCEPT WITH EYE) OF FACE HEAD AND NECK
941.41	DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF EAR (ANY PART) WITHOUT LOSS OF EAR
941.43 - 941.48	DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF LIP(S) WITHOUT LOSS OF LIP(S) - DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF NECK WITHOUT LOSS OF NECK
941.51	DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF EAR (ANY PART) WITH LOSS OF EAR
941.53 - 941.58	DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF LIP(S) WITH LOSS OF LIP(S) - DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF NECK WITH LOSS OF NECK
942.21 - 942.59	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF BREAST - DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF OTHER AND MULTIPLE SITES OF TRUNK WITH LOSS OF A BODY PART
943.21 - 943.59	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF FOREARM - DEEP NECROSIS OF UNDERLYING

	TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF MULTIPLE SITES OF UPPER LIMB EXCEPT WRIST AND HAND WITH LOSS OF UPPER LIMB
944.21 - 944.58	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF SINGLE DIGIT (FINGER (NAIL)) OTHER THAN THUMB - DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF MULTIPLE SITES OF WRIST(S) AND HAND(S) WITH LOSS OF A BODY PART
945.21 - 945.59	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF TOE(S) (NAIL) - DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF MULTIPLE SITES OF LOWER LIMB(S) WITH LOSS OF A BODY PART
946.2 - 946.5	BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF MULTIPLE SPECIFIED SITES - DEEP NECROSIS OF UNDERLYING TISSUES DUE TO BURN (DEEP THIRD DEGREE) OF MULTIPLE SPECIFIED SITES WITH LOSS OF A BODY PART
948.00 - 948.99	BURN (ANY DEGREE) INVOLVING LESS THAN 10 PERCENT OF BODY SURFACE WITH THIRD DEGREE BURN OF LESS THAN 10 PERCENT OR UNSPECIFIED AMOUNT - BURN (ANY DEGREE) INVOLVING 90 PERCENT OR MORE OF BODY SURFACE WITH THIRD DEGREE BURN OF 90% OR MORE OF BODY SURFACE
951.4	INJURY TO FACIAL NERVE
951.6	INJURY TO ACCESSORY NERVE
955.0 - 955.3	INJURY TO AXILLARY NERVE - INJURY TO RADIAL NERVE
956.0 - 956.3	INJURY TO SCIATIC NERVE - INJURY TO PERONEAL NERVE
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997.61 - 997.62	NEUROMA OF AMPUTATION STUMP - INFECTION (CHRONIC) OF AMPUTATION STUMP
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V48.2 - V48.5	MECHANICAL AND MOTOR PROBLEMS WITH HEAD - SENSORY PROBLEM WITH NECK AND TRUNK
V49.1 - V49.77	MECHANICAL PROBLEMS WITH LIMBS - HIP AMPUTATION STATUS
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V53.8	FITTING AND ADJUSTMENT OF WHEELCHAIR
V54.01 - V54.89	ENCOUNTER FOR REMOVAL OF INTERNAL FIXATION DEVICE - OTHER ORTHOPEDIC AFTERCARE
V57.81	CARE INVOLVING ORTHOTIC TRAINING

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N/A

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N/A

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

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N/A

General Information

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1. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available to Intermediary upon request.

2. The use of Forms CMS 700/701 is not required.

3. The plan of treatment written by the patient's physician, non-physician

practitioner or by the physical therapist and signed and dated by the physician or non-physician practitioner must be included in the patient's medical record and made available to the Intermediary upon request.

4. When documenting caregiver training and education, the documentation should include the person being trained and the capacity to learn from instruction and the education should be an adjunct to active therapy with the patient.

5. The services must be furnished to an individual who is under the care of a physician or non-physician practitioner.

6. While helpful, daily notes are not required. The documentation in the medical records should have sufficient information to determine that a service was performed on specific dates, and the medical necessity of the service(s) rendered. Documentation should reflect the following:

a. An ongoing reassessment of the patient's response to treatment,

b. Progress toward predicted goals,

c. Clinical rationale for continued skilled treatment

d. Recommended changes to the plan of treatment, and

e. Service provided at the time of treatment.

Evaluation/Reevaluations

The physician, non-physician practitioner and/or physical therapist evaluation/re-evaluation assesses the area for which physical therapy treatment is being planned. It should be completed prior to beginning therapy. Evaluations typically contain the following information:

1. Reason for referral;

2. Diagnosis/condition being treated;

3. Past level of function (be specific);

4. Evaluations should contain physical and cognitive baseline data necessary for assessing rehabilitation potential and measuring progress;

5. Current level of function;

6. Measurements such as strength, ROM, pain level;

7. Treatment modalities selected for treating current illness or injury;

8. Limitations which may influence the length of treatment;

9. Short and long term goals stated in measurable terms, and their expected

date of accomplishment;

10. Frequency and duration of therapy; and

11. Functional decline that notes specific impairments resulting from the event leading to the need for therapy.

A Reevaluation may be appropriate at a planned discharge.

Plan of Treatment

Services are to be furnished according to a written plan of treatment determined by the physician, non-physician practitioner and/or the qualified physical therapist. The plan is established when it is developed (e.g., written or dictated). The signature and professional identity (e.g., MD, PT) of the person who established the plan, and the date it was established must be recorded with the plan. Establishing the plan of care is not the same as certifying the plan. The written plan of treatment must be established before active therapy begins. The written plan of treatment may be established by a physician, non-physician practitioner, or physical therapist. The written plan of treatment may not be significantly altered by a physical therapist without the written or verbal approval of a physician or non-physician practitioner.

At a minimum the plan of treatment shall contain:
· Diagnoses
· Long term treatment goals; and
· Type, amount, duration and frequency of therapy services.

Progress Notes

The written plan of treatment typically contains the following information:

1. Documentation should document any treatment variations with the associated rationale.

2. Documentation should be written using measurements and functional accomplishments. Use statements which can be used to assess the patient's response to therapy such as:

a. "Able to perform exercises as prescribed for 15 reps"

b. "Able to safely transfer from bed to wheelchair with standby assistance"

c. "Can now abduct shoulder 120 degrees"

d. "Can now bridge sufficiently to pull slacks up over hips"

3. Avoid terms such as:

a. “Doing well”

b. “Improving”

c. “Less pain”

d. “Increased range of motion”

e. “Increased strength”

f. “Tolerated treatment well.”

0rders

An order (sometimes called a referral) for therapy service, if it is documented in the medical record, provides evidence of both the need for care and that the patient is under the care of a physician. If the signed order includes a plan of care, no further certification of the plan is required. The use of an order is prudent to determine that a physician is involved in care and available to certify the plan.

Certification / Recertification

1. Content of the Physician’s Certification—No payment may be made for the outpatient physical therapy unless the physician or non-physician practitioner certifies that:

a. A plan for furnishing such services is or was established by the physician, non-physician practitioner or physical therapist and periodically reviewed by the physician or non-physician practitioner.

b. The services are or were furnished while the patient was under the care of a physician or non-physician practitioner.

c. The services are or were required by the patient.

2. The certification requirements are met when the physician certifies the plan of care. If the signed order includes a plan of care, no further certification of the plan is required. Payment is dependent on the certification of the plan of care rather than the order.

3. Certifications and recertifications by the physician or non-physician practitioner, must be on file and available to the Intermediary.

4. Certifications are required upon initiation of therapy and every 30 days thereafter for outpatient hospitals, outpatient home health, outpatient rehabilitation facilities, and skilled nursing facilities.

5. Certifications are required upon initiation of therapy and every 60 days thereafter for Comprehensive Outpatient Rehabilitation Facilities (CORF) physical therapy services. Medicare does not require a visit unless the National Coverage Determination (NCD) for a particular treatment requires it (e.g., see CMS Manual System, Pub 100-3, Medicare National Coverage Determinations Manual (Internet Only Manual)-Electrical Stimulation (ES) and Electromagnetic

Therapy for the Treatment of Wounds).

6. All certifications/recertifications must be signed and dated by the referring/attending physician or NPP. Signature means a legible identifier of any type (e.g., hand written, electronic, or signature stamp).

7. Documentation should indicate the prognosis for potential restoration of function in a reasonable and generally predictable period of time, or the need to establish a safe and effective maintenance program.

Note: The CORF services benefit does not recognize a non-physician practitioner for orders and certification.

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N/A

Utilization Guidelines back to top

N/A

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American Physical Therapy Association (APTA). Guide to Physical Therapy Practice (1998) (revised April 1999).

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A Guide to Physical Therapist Practice, American Physical Therapy Association, Copyright 1997.

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Reduction of Chronic Posttraumatic Hand Edema: A Comparison of High Voltage Pulsed Current, Intermittent Pneumatic Compression, and Placebo Treatments, Physical Therapy, vol. 70, no. 5, May 1990, pp.279-286.

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Wound, Ostomy and Continence Nurse's Society "Conservative Sharp Wound Debridement for Nurses." (1994).

Other Relevant SC Local Coverage Determination (LCD) Policies
SC Part A Hyperbaric Oxygen Therapy (HBO therapy) LCD # 98A-0016-L
SC Part A Metabolically Active Dermal Skin Substitute Dressings LCD # 03A-0010-L.
SC Part A Respiratory Therapy (Respiratory Care) LCD #04A-0003-L

Advisory Committee Meeting Notes back to top

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the Intermediary, this policy was developed in cooperation with advisory groups, with includes representatives from the physical therapy provider community. Advisory Committee Meeting Date: N/A.

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05/29/2000

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10/15/2000

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Revision #17, 01/01/2006

Revision #16, 10/01/2005

Revision #15, 08/22/2005

Revision #14, 07/05/2005

Revision #13, 06/06/2005

Revison #12, 01/10/2005

Revision #11, 11/22/2004

Revision #10, 10/01/2004

Revision #9, 07/21/2004

Revision #8, 07/02/2004

Revision #7 07/01/2004

Revision #6 11/28/2003

Revisoon #5, 10/01/2003

Revision #4, 04/01/2003

Revision #3, 10/01/2002

Revision #2, 10/10/2001

Revision #1, 07/09/2001

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Revision #17, 01/01/2006
Under CMS National Coverage Policy section of the policy Change Request 4057 was added. Under CPT/HCPCS Codes section CPT code 97504 was changed to 97760, 97520 was changed to 97761, and 97703 was changed to 97762. These changes become effective on 01/01/2006.

Revision #16, 10/01/2005
Under AMA/CPT & ADA/CDT Copyright Statement changed the copyright date to 2005. Under CMS National Coverage Policy deleted CMS Manual System, Pub 100-8, Medicare Program Integrity Manual, Chapter 13, Section 13.5.1. Under Indications and Limitations of Coverage and/or Medical Necessity section titled Community/Work Reintegration added CPT codes 97545 and 97546. This

Transesophageal Echo

LCD Information

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L6356

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TRANSESOPHAGEAL ECHOCARDIOGRAM

Contractor's Determination Number back to top

90-0044-L

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South Carolina

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For services performed on or after 11/01/1990

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For services performed on or after 08/19/2005

Revision Ending Date back to top

04/27/2006

Indications and Limitations of Coverage and/or Medical Necessity back to top

Transesophageal echocardiogram evaluations are indicated when any of the following are suspected or necessary:

- Left atrial thrombi or tumor;

- Endocarditis (when transthoracic echocardiogram is unrevealing);

- Atrial septal defect;

- Left ventricular outflow tract disease;

- Evaluation of prosthetic valve function;

- Evaluation of the descending thoracic aorta for aneurysms.

- Some valvular surgeries

Medicare covers Transesophageal echocardiogram evaluations when done for indications noted above. Other indications or diagnoses **must** be referred for physician review.

Coverage Topic back to top

Diagnostic Tests and X-Rays

Coding Information

Bill Type Codes: back to top

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.

999x	Not Applicable

Revenue Codes: back to top

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.

99999	Not Applicable

CPT / HCPCS Codes back to top

93312	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL TIME WITH IMAGE DOCUMENTATION (2D) (WITH OR WITHOUT M-MODE RECORDING); INCLUDING PROBE PLACEMENT, IMAGE ACQUISITION, INTERPRETATION AND REPORT
93313	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL TIME WITH IMAGE DOCUMENTATION (2D) (WITH OR WITHOUT M-MODE RECORDING); PLACEMENT OF TRANSESOPHAGEAL PROBE ONLY
93314	ECHOCARDIOGRAPHY, TRANSESOPHAGEAL, REAL TIME WITH IMAGE DOCUMENTATION (2D) (WITH OR WITHOUT M-MODE RECORDING); IMAGE ACQUISITION, INTERPRETATION AND REPORT ONLY

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093.0 - 093.9	ANEURYSM OF AORTA SPECIFIED AS SYPHILITIC - CARDIOVASCULAR SYPHILIS UNSPECIFIED
112.81	CANDIDAL ENDOCARDITIS
115.04	HISTOPLASMA CAPSULATUM ENDOCARDITIS
115.14	HISTOPLASMA DUBOISII ENDOCARDITIS
115.94	HISTOPLASMOSIS ENDOCARDITIS
164.1	MALIGNANT NEOPLASM OF HEART
391.0 - 393	ACUTE RHEUMATIC PERICARDITIS - CHRONIC RHEUMATIC PERICARDITIS
394.0 - 398.99	MITRAL STENOSIS - OTHER RHEUMATIC HEART DISEASES

402.00 - 402.91	MALIGNANT HYPERTENSIVE HEART DISEASE WITHOUT HEART FAILURE - UNSPECIFIED HYPERTENSIVE HEART DISEASE WITH HEART FAILURE
404.00 - 404.93	HYPERTENSIVE HEART AND KIDNEY DISEASE, MALIGNANT, WITHOUT HEART FAILURE OR CHRONIC KIDNEY DISEASE - HYPERTENSIVE HEART AND KIDNEY DISEASE, UNSPECIFIED, WITH HEART FAILURE AND CHRONIC KIDNEY DISEASE
410.00 - 410.92	ACUTE MYOCARDIAL INFARCTION OF ANTEROLATERAL WALL EPISODE OF CARE UNSPECIFIED - ACUTE MYOCARDIAL INFARCTION OF UNSPECIFIED SITE SUBSEQUENT EPISODE OF CARE
411.0 - 411.89	POSTMYOCARDIAL INFARCTION SYNDROME - OTHER ACUTE AND SUBACUTE FORMS OF ISCHEMIC HEART DISEASE OTHER
412	OLD MYOCARDIAL INFARCTION
413.0 - 413.9	ANGINA DECUBITUS - OTHER AND UNSPECIFIED ANGINA PECTORIS
414.00 - 414.9	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED TYPE OF VESSEL NATIVE OR GRAFT - CHRONIC ISCHEMIC HEART DISEASE UNSPECIFIED
415.0	ACUTE COR PULMONALE
416.0 - 416.9	PRIMARY PULMONARY HYPERTENSION - CHRONIC PULMONARY HEART DISEASE UNSPECIFIED
417.0 - 417.9	ARTERIOVENOUS FISTULA OF PULMONARY VESSELS - UNSPECIFIED DISEASE OF PULMONARY CIRCULATION
420.0 - 420.99	ACUTE PERICARDITIS IN DISEASES CLASSIFIED ELSEWHERE - OTHER ACUTE PERICARDITIS
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424.0 - 424.99	MITRAL VALVE DISORDERS - OTHER ENDOCARDITIS VALVE UNSPECIFIED
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426.0 - 426.9	ATRIOVENTRICULAR BLOCK COMPLETE - CONDUCTION DISORDER UNSPECIFIED
427.0 - 427.42	PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA - VENTRICULAR FLUTTER

427.5	CARDIAC ARREST
427.60 - 427.9	PREMATURE BEATS UNSPECIFIED - CARDIAC DYSRHYTHMIA UNSPECIFIED
428.0 - 428.9	CONGESTIVE HEART FAILURE UNSPECIFIED - HEART FAILURE UNSPECIFIED
429.0 - 429.9	MYOCARDITIS UNSPECIFIED - HEART DISEASE UNSPECIFIED
433.00 - 436	OCCLUSION AND STENOSIS OF BASILAR ARTERY WITHOUT CEREBRAL INFARCTION - ACUTE BUT ILL-DEFINED CEREBROVASCULAR DISEASE
441.00 - 441.2	DISSECTION OF AORTA ANEURYSM UNSPECIFIED SITE - THORACIC ANEURYSM WITHOUT RUPTURE
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747.0 - 747.49	PATENT DUCTUS ARTERIOSUS - OTHER ANOMALIES OF GREAT VEINS
780.01 - 780.09	COMA - ALTERATION OF CONSCIOUSNESS OTHER
780.2	SYNCOPE AND COLLAPSE
780.6	FEVER
782.3	EDEMA
782.5	CYANOSIS
785.0	TACHYCARDIA UNSPECIFIED
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785.50	SHOCK UNSPECIFIED
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786.09	ABNORMALITY OTHER
786.50 - 786.59	UNSPECIFIED CHEST PAIN - OTHER CHEST PAIN
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793.2	NONSPECIFIC ABNORMAL FINDINGS ON RADIOLOGICAL AND OTHER EXAMINATION OF OTHER INTRATHORACIC ORGANS
794.30 - 794.39	UNSPECIFIED ABNORMAL FUNCTION STUDY OF CARDIOVASCULAR SYSTEM - OTHER NONSPECIFIC ABNORMAL FUNCTION STUDY OF CARDIOVASCULAR SYSTEM
799.1	RESPIRATORY ARREST
901.0	INJURY TO THORACIC AORTA
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996.61	INFECTION AND INFLAMMATORY REACTION DUE TO CARDIAC DEVICE IMPLANT AND GRAFT
996.71	OTHER COMPLICATIONS DUE TO HEART VALVE PROSTHESIS
V42.2	HEART VALVE REPLACED BY TRANSPLANT
V43.21	HEART REPLACED BY HEART ASSIST DEVICE
V43.22	HEART REPLACED BY FULLY IMPLANTABLE ARTIFICIAL HEART
V43.3	HEART VALVE REPLACED BY OTHER MEANS

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N/A

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N/A

XX000	Not Applicable

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N/A

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CMS Pub. 100-3, Medicare National Coverage Determinations, Chapter 1, Section 20.15

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This policy does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from .

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05
Annual CPT, HCPCS, ICD-9-CM update review 02/16/2006

04
01/01/2004
Revised wording to Carriers Manual references; Addition of 5th digit to ICD-9 code V43.21, V43.22

Appendix A – Contacts & References

Baptist Easley Hospital

Title	Name	Phone
Administrative Director, Cardiac Services	Brian Finley	442-7433
Manager, Cardiac Services	Clay Sweet	442-7699
Business Analyst	Jennifer Knight	442-7905
Administrative Coordinator	Susan Graham	442-7360
Cardiac Catheterization Laboratory	Clay Sweet	442-7699
Echo Department	Donna Earnhardt	442-7465
EKG Department	Gladys Hill	442-7698
Respiratory Department	Clay Sweet	442-7699
Stress Test Department	Michael Murphy	442-8672
Scheduling Coordinator	Nickki Whitten	442-8668

Palmetto GBA (Medicare Contractor for South Carolina)

Website @ www.pgba.com

Choose: “Providers”, “Part A Intermediary”

“South Carolina”

CMS (Centers for Medicare & Medicaid Services)

Website @ www.cms.hhs.gov/coverage/default.asp