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Internet Only Manual Revisions

The Centers for Medicare and Medicaid Services (CMS) introduced an addition to the Internet Only Manuals (IOM) with Pub. 100-22, Medicare Quality Reporting Incentive Programs Manual available in September 2010. Along with this new manual, the State Buy-In Manual has been reassigned to Pub. 100-24.

Source: CMS website

Magnetic Resonance Angiography

CMS has determined that it is unnecessary to have two separate national coverage determinations (NCD) for magnetic resonance angiography (MRA) as well as magnetic resonance imaging (MRI) and has therefore, removed NCD 220.3 and made revisions to NCD 220.2 to incorporate both procedures into one coverage determination.

MRA is a noninvasive diagnostic test that analyzes the amount of energy released from body tissues that are exposed to magnetic fields, a distinct application of MRI. This process allows visualization of blood vessels and quantifies the blood within the vessels. Phase contrast (PC) can measure the difference within phases of proton spins within the tissue and blood flow while measuring that flow at any given time in the cardiac cycle. Time-of-flight (TOF) measures the variance of magnetization in the tissues and blood while demonstrating the structure of the blood vessels and providing detailed information on the blood flow. Both methods can be performed as two-dimensional or three-dimensional images.

CMS has further updated this policy to indicate effective dates for specific diagnosis determination. Since November 22, 1985, MRI has been used for examination of the head, central nervous system (CNS) and spine as well as mediastinal and retroperitoneal masses that may indicate aneurysms and dissections. As of March 4, 1991, MRI was expanded to use techniques such as gating devices and surface coils to alleviate distortion of images caused by breathing and heart function. Effective March 22, 1994, MRI was covered for diagnosing disc disease.

MRA is covered for specific conditions related to blood flow within the carotid vessels of the head and neck as well as peripheral arteries in the lower extremities, abdomen, pelvis, and chest. In spite of the coverage expansions now indicated within this NCD, certain contraindications remain that will not cover the use of MRI:

- Patients with cardiac pacemakers or metallic clips on vascular aneurysms
- During viable pregnancy
- Acutely ill patients requiring life support and monitoring that uses ferromagnetic materials
- Patients with a history of claustrophobia due to length of exam and enclosed positioning within the MRI machine.

Source: Transmittal R123NCD, July 9, 2010; Medicare National Coverage Determination Manual, Pub. 100-03, chapter 1, section 220.2
Dermal Injections for Treatment of Facial Lipodystrophy Syndrome (LDS)

One last update alerted the reader to the fact that CMS had made a final decision on the use of dermal injections to treat faci lipodystrophy syndrome (FLS). This treatment is reasonable and necessary only when using dermal fillers that are FDA approved and then only for HIV patients when FLS caused by antiretroviral therapy (HAART) which may lead to the following lipid abnormalities:

- Hyperlipidemia
- Hyperglycemia
- Diabetes
- Lipodystrophy
- Heart disease

Lipodystrophy causes the abnormal distribution of fat within the body while LDS is characterized as loss of fat, particularly in the face. This gives the appearance of sunken cheeks and may lead to psychological conditions and possibly reluctance of the patient to adhere to the antiretroviral regimen to treat the primary condition expanding that health. This is a chain of events that warrants how dermal injections can improve health-related outcomes. This coverage determination further indicates that non-FDA approved fillers and fillers used for any other condition than noted above will not be covered.

Source: Transmittal R122NCD, June 4, 2010, Medicare National Coverage Determination Manual, Pub. 100-03, chapter 1, section 250.5

Definition of Ambulance Services

CMS has updated the definition of ambulance services to include basic life support (BLS)—emergency, advanced life support level 1 (ALS1)—emergency, and advanced life support level 2 (ALS2)—non-emergency. This information expands on the definitions with specific applications related to the service provided.

Basic life support and advanced life support—level 1—emergency services must fall under local 911 or equal services dispatch protocol. In the event that an area does not have a protocol established, the standards to be followed would be determined by a similar jurisdiction within the state. In the event that no similarity can be found, the standards of any other dispatch protocol in the state may be used. When dispatch is consistent with protocol standards, the beneficiary’s condition and symptoms on the scene will determine appropriate payment levels.

Advanced life support level 2 differs in application due to the provision of necessary supplies and services including the provision of at least three separate administrations of one or more medications by intravenous (i.v.), subcutaneous (s.c.), or intramuscular or subcutaneous injection, oral, sublingually, or by nebulizer does not qualify as determination of payment under the ALS2 rate. Additionally, a single dose medication administered in fractions on three separate occasions also does not qualify as determination of payment under the ALS2 rate. Criteria for multiple medication administration of the same substance must meet suitable quantity and time between administrations to meet standard medical practices guidelines.

Endotracheal intubation does qualify under the ALS2 payment rate. Therefore, it is not required to consider medication administration by this method to determine whether the payment rate falls within the ALS2 rate, which includes an endotracheal tube that was inserted before the transport.


Revisions and Re-issuance of Audiology Policies

With these revisions, CMS has clarified policies relevant to audiologist services including coverage of specific services and billing may be provided by another regulated professional. For example, audiology services must be personally furnished by an audiologist or nonphysician practitioner (NPP). Physicians also may personally provide audiologist services and technicians or other qualified staff may provide those parts of a service not requiring professional skills under the direct supervision of physician.

This policy includes important documentation requirements such as the documentation of the reason for the test on the order, on the audiological evaluation report, or in the patient’s medical record. It also includes the documentation of skilled services that indicate that the test was ordered, that the test was performed by a qualified individual. Records that justify an audiological diagnostic test must be made available to the contractor when requested.

Audiologists are not allowed to bill Medicare for services that are not audiologist services according to Medicare’s definition, except in very specific circumstances. See link at: http://www.cms.gov/PhysicianFeeSched/50_Audiology.asp.


Medical Review Procedures in the Absence of a Plan of Care and the Outcome Assessment Information Set

CMS has provided instructions relating to the review and payment of home health claims in the absence of the Outcome Assessment Information Set (OASIS) form as well as requirements pertaining to the absence of the plan of care (POC) for home health part A/B services, inpatient rehabilitation, and hospice services.

Starting January 1, 2010, home health agencies (HHAs) have been required to submit an OASIS form in order to qualify for payment under regulation 42 CFR 484.210(c). Due to this ruling, it is now acceptable for contractors to deny reimbursement based on noncompliance with this regulation. The OASIS must be specific to the individual patient as well as accurate and
current. The elements of this assessment are used to determine payment rates and document clinical needs, functional status, and use of services. The plan of care is a necessary element of quality patient care as indicated by the Medicare program and is determined by the treating physician in the treatment goals and coordinate services that will meet the needs of the patient. Section 1834(a)(2)(C) and Part B 1835(a)(2)(C) and CFR 409.43 indicate that the treating physician establishes a POC that contains the following required elements:

- History
- Initial status
- Treatment goals/anticipated outcome
- Duration of services
- Progress

Any physician not meeting these required guidelines may be denied payment by the contractor as not meeting standards set forth by the Social Security Act.

Source: Transmittal R343PI, June 18, 2010, Medicare Program Integrity Manual, Pub. 100-08, chapter 3, section 3.4.1.1

DMF MAC and the NSC MAC Procedures for Third-Party Notification of Deceased DMEPOS Supplier Associates

CMS distributes a monthly list to contractors, including durable medical equipment Medicare administrative contractors (DMF MAC) and National Supplier Clearinghouse Medicare administrative contractors (NSC MAC), which indicates deceased individuals who are recipients of the Medicare Program. The contractor will then verify the record of death and notify the supplier group associated with the deceased individual that submission of a CMS-855 is necessary to remove that individual from the supplier's enrollment records. Failure to submit this form will result in the deactivation of the supplier's Medicare billing privileges as outlined in 42 CFR 424.540(a)(2). A DMEPOS supplier has 30 calendar days to submit this form to the contractor before deactivation occurs as outlined in 42 CFR 424.57(c)(2).


Manual Reorganization to Move Content from Chapter 10 to Chapter 15

CMS has restructured the Medicare Program Integrity Manual to organize the chapters more appropriately based on content. This change affects the content of this publication because the deletion of several items in Chapter 10 as no longer pertinent to coverage specifically and are not included herein. The deletions from Chapter 10 can now be found within Chapter 15, sections 6.20, 24, 27, and 29. This can be viewed in its entirety after the effective date of September 28, 2010 at: http://www.cms.gov/Medicare/ IOM/ntndetail.aspx?fileType=mtfId&mtfId=99& secNum=3ID=1 ResetOrder=ascendingContentD-CMS019050&MeanNumPage=10

At the time of this publication, the IOM has not been updated to include these new sections.

Source: Transmittal R354PI, August 27, 2010

**Autologous Cellular Immunotherapy Treatment of Metastatic Prostate Cancer**

CMS has opened an inquiry to evaluate the effectiveness of autologous cellular immunotherapy treatment for prostate cancer. This inquiry surfaced due to Food and Drug Administration (FDA) approval of Sipuleucel T (Provenge). This product is made up of peripheral blood mononuclear cells (PBMC) taken from patients with the leukapheresis process and activated in vitro with a recombinant fusion protein. The FDA needs a sponsor to finalize postmarketing studies that determine the possible risk of stroke in patients who receive Sipuleucel T. This national coverage analysis (NCA) will determine if this therapy is reasonable and necessary under sections 1862(a)(1)(A) and/or 1862(a)(1)(E) of the Social Security Act.

Source: CMS website

**On Label and Off-Label Use of Autologous Cellular Immunotherapy Treatment of Metastatic Prostate Cancer**

CMS has announced a MEDCAC meeting to discuss the implications of on label and off label autologous cellular immunotherapy provided to patients with metastatic prostate cancer, specific to health outcomes. This discussion is linked with the current NCA pertaining to Autologous Cellular Immunotherapy Treatment of Metastatic Prostate Cancer.

Source: CMS website

**Counseling to Prevent Tobacco Use**

CMS has posted a education memo regarding coverage indicators for counseling to prevent tobacco use. It is determined that this coverage is reasonable and recommended for those adults and pregnant women classified as grade A by the U.S. Preventative Services Task Force (USPSTF).

This coverage will apply to outpatient and inpatient Medicare beneficiaries under the following circumstances:

- Those who use tobacco, whether or not the patient displays symptoms of a tobacco-related disease.
- Those who are competent and alert when counseling is provided, and
- Those who undergo counseling by a qualified physician or other practitioner recognized by Medicare.

This benefit limits coverage to two cessation attempts within a year with each attempt including a maximum of four initial intensive or intensive encounters giving a total annual benefit of up to eight encounters per Medicare beneficiary who is a tobacco user. It is up to the physician and patient to determine at which time the cessation attempt should take place. The cessation attempt should last for at least three months and intensive (over ten minutes) cessation encounters are counted for each attempt. This decision does not alter the current coverage parameters where cessation counseling less than three months is provided - this remains covered as included to the Evaluation and Management visit.

Source: CMS website

**Erythropoietic Stimulating Agents for Treatment of Anemia in Adults with CKD including Patients on Dialysis and Patients not on Dialysis**

A request has been sent to CMS to develop a national coverage determination for recombinant human erythropoietin, which is an erythropoietic stimulating agent (ESA), for the treatment of chronic kidney disease (CKD) and dialysis-related anemia. In the past, Medicare has allowed payment for the use of ESAs under specific conditions. These drugs typically
On Label and Off-Label Use of Bone Morphogenetic Proteins

CMS is currently examining evidence related to the benefits and risks of bone morphogenetic proteins (BMP). While more than 20 BMPs have been noted, only four have shown significant osteogenic properties with a primary function of increasing bone formation. Currently two recombinant BMPs have FDA approval and are available for commercial use. The use of BMPs has increased since becoming available in 2003 with primary use focused on the spine. However, there have also been numerous reports of adverse effects in conjunction with BMP use.

Source: CMS website

Changes to the Laboratory NCD Edit Software for October 2010

The laboratory codes are updated quarterly as a result of changes to NCD and coding analyses decisions. A recent transmittal announced changes to be made to the laboratory NCD code lists that will be implemented October 1, 2010. The majority of these changes are the result of the yearly update to the ICD-9-CM code set and reflect the expansion of codes from four to five digits. These changes have not yet been incorporated into the Medicare National Coverage Determinations (NCD) Coding Policy Manual and Change Report. In accordance with the Medicare Claims Processing Manual, Transmittal 2001, dated July 16, 2010, the following changes will be effective for dates of service on and after October 1, 2010.

- NCD 190.12: Bacterial Urine Cultures:
  - ICD-9-CM code 786.30 was added to the list of ICD-9-CM codes covered by Medicare.

- NCD 190.16: Post-Musculoskeletal Transplantation (PMT):
  - Code V62.85 was deleted from the list of covered ICD-9-CM codes covered by Medicare.

- NCD 190.17: Post-Thrombotic Syndrome:
  - Code 458.9 was added to the list of ICD-9-CM codes covered by Medicare.
  - Codes 458.9 and V62.85 were added to the list of Do Not Support Medical Necessity (DNS) list of ICD-9-CM codes.
  - Code 458.9 was deleted from the list of Do Not Support Medical Necessity (DNS) list of ICD-9-CM codes.

- NCD 190.18: Post-Musculoskeletal Transplantation (PMT):
  - Codes 747.10, 747.11, and 747.12 were added to the list of covered ICD-9-CM codes.
  - Code 747.10 was deleted from the list of Do Not Support Medical Necessity (DNS) list of ICD-9-CM codes.
  - Code 747.11 was deleted from the list of covered ICD-9-CM codes.
  - Code 747.12 was deleted from the list of covered ICD-9-CM codes.
  - Code 747.13 was added to the list of covered ICD-9-CM codes.
  - Code 747.14 was added to the list of covered ICD-9-CM codes.
  - Code 747.15 was added to the list of covered ICD-9-CM codes.
  - Code 747.16 was added to the list of covered ICD-9-CM codes.

- NCD 190.19: Post-Musculoskeletal Transplantation (PMT):
  - Codes 747.17, 747.18, and 747.19 were added to the list of covered ICD-9-CM codes.
  - Codes 747.17, 747.18, and 747.19 were deleted from the list of Do Not Support Medical Necessity (DNS) list of ICD-9-CM codes.

- NCD 190.20: Post-Musculoskeletal Transplantation (PMT):
  - Codes 747.20, 747.21, and 747.22 were added to the list of covered ICD-9-CM codes.
  - Codes 747.20, 747.21, and 747.22 were deleted from the list of Do Not Support Medical Necessity (DNS) list of ICD-9-CM codes.

- NCD 190.21: Post-Musculoskeletal Transplantation (PMT):
  - Codes 747.23, 747.24, and 747.25 were added to the list of covered ICD-9-CM codes.
  - Codes 747.23, 747.24, and 747.25 were deleted from the list of Do Not Support Medical Necessity (DNS) list of ICD-9-CM codes.

- NCD 190.22: Post-Musculoskeletal Transplantation (PMT):
  - Codes 747.26, 747.27, and 747.28 were added to the list of covered ICD-9-CM codes.
  - Codes 747.26, 747.27, and 747.28 were deleted from the list of Do Not Support Medical Necessity (DNS) list of ICD-9-CM codes.

- NCD 190.23: Post-Musculoskeletal Transplantation (PMT):
  - Codes 747.29, 747.30, and 747.31 were added to the list of covered ICD-9-CM codes.
  - Codes 747.29, 747.30, and 747.31 were deleted from the list of Do Not Support Medical Necessity (DNS) list of ICD-9-CM codes.

- NCD 190.24: Post-Musculoskeletal Transplantation (PMT):
  - Codes 747.32, 747.33, and 747.34 were added to the list of covered ICD-9-CM codes.
  - Codes 747.32, 747.33, and 747.34 were deleted from the list of Do Not Support Medical Necessity (DNS) list of ICD-9-CM codes.

- NCD 190.25: Post-Musculoskeletal Transplantation (PMT):
  - Codes 747.36, 747.37, and 747.38 were added to the list of covered ICD-9-CM codes.
  - Codes 747.36, 747.37, and 747.38 were deleted from the list of Do Not Support Medical Necessity (DNS) list of ICD-9-CM codes.

- NCD 190.26: Post-Musculoskeletal Transplantation (PMT):
  - Codes 747.39, 747.40, and 747.41 were added to the list of covered ICD-9-CM codes.
  - Codes 747.39, 747.40, and 747.41 were deleted from the list of Do Not Support Medical Necessity (DNS) list of ICD-9-CM codes.

- NCD 190.27: Post-Musculoskeletal Transplantation (PMT):
  - Codes 747.42, 747.43, and 747.44 were added to the list of covered ICD-9-CM codes.
  - Codes 747.42, 747.43, and 747.44 were deleted from the list of Do Not Support Medical Necessity (DNS) list of ICD-9-CM codes.

- NCD 190.28: Post-Musculoskeletal Transplantation (PMT):
  - Codes 747.45, 747.46, and 747.47 were added to the list of covered ICD-9-CM codes.
  - Codes 747.45, 747.46, and 747.47 were deleted from the list of Do Not Support Medical Necessity (DNS) list of ICD-9-CM codes.

- NCD 190.29: Post-Musculoskeletal Transplantation (PMT):
  - Codes 747.48, 747.49, and 747.50 were added to the list of covered ICD-9-CM codes.
  - Codes 747.48, 747.49, and 747.50 were deleted from the list of Do Not Support Medical Necessity (DNS) list of ICD-9-CM codes.

- NCD 190.30: Post-Musculoskeletal Transplantation (PMT):
  - Codes 747.51, 747.52, and 747.53 were added to the list of covered ICD-9-CM codes.
  - Codes 747.51, 747.52, and 747.53 were deleted from the list of Do Not Support Medical Necessity (DNS) list of ICD-9-CM codes.
NCD 190.18: Serum Iron Studies:
- Added to the list of ICD-9-CM codes covered by Medicare are 275.0, 275.01, 275.02, 275.03, 275.09, 780.39, 287.41, 287.49, 999.01, 999.03, 999.04, and 999.05.
- ICD-9-CM codes 275.01, 275.02, 275.03, 275.09, 780.39, 287.41, 287.49, 999.01, 999.03, 999.04, and 999.05 were deleted from this list.

NCD 190.20: Blood Glucose Testing:
- Added to the list of ICD-9-CM codes covered by Medicare are codes 275.01, 275.02, 275.03, 275.09, 780.39, 287.41, 287.49, 999.01, 999.03, 999.04, and 999.05.
- ICD-9-CM codes 275.01, 275.02, 275.03, 275.09, 780.39, 287.41, 287.49, 999.01, 999.03, 999.04, and 999.05 were added to the list of ICD-9-CM codes covered by Medicare for this NCD.
- Code 275.01 was deleted from the same list.

NCD 190.23: Lipid Testing:
- ICD-9-CM code 275.03 was added to the list of ICD-9-CM codes covered by Medicare for this NCD.

NCD 190.24: Osmotic Therapeutic Drug Assay:
- ICD-9-CM codes were added to the list of ICD-9-CM codes covered by Medicare for this NCD include 275.01, 275.02, 275.03, 275.09, 780.39, 287.41, 287.49, 999.01, 999.03, 999.04, and 999.05.
- Four digit ICD-9-CM code 275.01 was deleted from this list.

NCD 190.25: Uric Acid:
- ICD-9-CM codes 275.01, 275.02, 275.03, and 275.09 were added to the list of ICD-9-CM codes covered by Medicare.
- Code 275.01 has been deleted from the list of covered ICD-9-CM codes.

NCD 190.32: Gamma Glutamyl Transferase:
- Added to the list of ICD-9-CM codes covered by Medicare include 275.01, 275.02, 275.03, 275.09, 780.39, 287.41, 287.49, 999.01, and 999.05.
- Codes 275.01 and 978.0 were deleted.

NCD 190.35: Hepatitis Panel/Acute Hepatitis Panel:
- Code 780.33 has been added to the list of ICD-9-CM codes covered by Medicare for this NCD.

NCD 190.36: Focal Ocular Blood Test:
- Codes 287.41, 287.49, and 460.32 were added to the list of ICD-9-CM codes covered by Medicare for this NCD.
- Code 287.41 was deleted from the list of covered ICD-9-CM codes for this NCD.


Meaningful Use

The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 allows for incentive payments to qualified health care professionals and hospitals when they initiate certified electronic health record (EHR) technology and use it for the intention of accomplishing quality objectives. Hospitals have 24 objectives of which 14 are required core objectives and five from the menu set objectives, from which a provider may select. For stage one, eligible professionals must meet 20 objectives: 15 required core objectives and five from the menu set objectives. Hospitals have 24 objectives of which 14 are required core objectives. Like eligible provider objectives, the remaining five objects may be selected from the list of 10 menu objects.

Stage 2, estimated to be put into place in 2013, and stage 3, estimated to be phased in by 2015, will both build on this foundation and will be expanded through future rule making. Eligible providers, hospitals, and critical access hospitals will use the appropriate quality measure reporting system to attest to meeting the meaningful use guidelines.

Source: CMS Website EHR Incentive Programs

MPFS Proposed Rule Could Mean Lower Reimbursement for All

CMS released the proposed rule for the 2011 Medicare physician fee schedule (MPFS) and in addition to a conversion factor of only 0.526657, there are a number of other proposals that could have a direct significant hit on reimbursement. The rate of this hit may depend on the provider’s specialty.

Affordable Care Act Provisions

The proposed rule provides details about how CMS will implement certain provisions of the Affordable Care Act (ACA) of 2010, particularly those provisions that expand preventive services and improve payments for primary care services.

Annual Wellness Examination

The ACA expands Medicare Part B coverage by supplementing the initial preventive physical examination (IPPE) with an annual wellness visit that provides personalized preventive plan services. The personalized approach is an opportunity for both the physician and patient to concentrate their efforts on maintaining or improving the patient’s health as well as reducing the risk of chronic disease. This additional benefit will be effective on January 1, 2011, for patients who have exceeded 12 months since their last annual wellness visit or Welcome to Medicare. Patients are eligible for ACA-related services if the CPT only © 2009 American Medical Association. All Rights Reserved. November 2010
documentation of a personalized prevention plan and specifies the elements including establishment of, or update to, the patient’s:

- Medical and family history including a:
  - list of other providers and suppliers the patient may see
  - current medications list

- Recording of vital signs including the measurement of:
  - height
  - weight
  - body mass index (BMI) or waist circumference
  - blood pressure
  - other routine measurements, as applicable

- Detection of any cognitive impairment
- Review of potential risk factors for depression by using an appropriate screening instrument for individuals without a current depression diagnosis
- Review functional abilities and level of safety through use of an appropriate screening questions or a questionnaire
- Establishment of, or update to, an appropriate screening schedule for the next five to 10 years
- Establishment of, or update to, a list of risk factors and conditions (including any mental health conditions) for which interventions are recommended or underway
- Furnishing of personalized health advice and referral, as appropriate, to health education or preventive counseling services or programs.

Other elements may also be added as deemed appropriate by the HHS secretary through an NCD process. Lastly, the rule outlines likely definitions to many of these elements and also indicates that CMS is proposing the creation of two HCPCS Level II G codes for reporting this service.

**Elimination of Patient Deductible and Copayments**

The ACA further mandates the elimination of out-of-pocket expenses beneficiaries are required to pay for preventive medicine services which meet a United States Preventive Services Task Force (USPSTF) grade of A or B. Services that DO NOT meet this requirement and, therefore, are NOT subject to the waiver of the deductible and coinsurance are:

- Digital rectal examination as part of prostate screening (G0102)
- Glaucoma screening (G0117 or G0118)
- Diabetes self-management training (DSMT) (G0108 or G0109)
- Barium colon enemas for cancer screening (G0106 or G0120)

**The Bad News**

In addition to the 6.1 percent reduction of payments due to the sustainable growth rate (SGR) for all physicians across the board, other proposals may affect specific specialties. Two such proposals would implement multiple payment reductions to additional radiology services.

The rule would reduce payments for diagnostic imaging equipment used in CT and MRI imaging. The proposal would apply the multiple procedure payment reduction (MPPR) to over 100 procedures. Currently, the MPPR is applied to radiology families.

Further, the CMS is proposing to apply the MPPR to certain physical therapy services. Specifically, the agency wants to apply the 50 percent payment reduction to the PE component of the second and subsequent therapy services when multiple "always therapy" services are furnished to the same patient on the same date of service.

**Other Significant Changes**

Other changes being considered include:

- Payment incentives for:
  - primary care
  - general surgeons performing major surgery in health professional shortage areas (HPSA)

- Increased payments for certified nurse midwives

NCD 10.1.—Use of Visual Tests Prior to and General Anesthesia During Cataract Surgery (formerly CIM 35-44)

00142, 92004, 92016, 76511, 76512
Effective Date: August 1992
Benefit Category: Diagnostic Tests (other)
Physicians Services

Indications and Limitations of Coverage

A. Pre-Surgery Evaluations
Effective for Services Performed On or After 09/14/88—Cataract surgery with an intraocular lens (IOL) implant is a high-volume Medicare procedure. Along with the surgery, a substantial number of preoperative tests are available to the surgeon. In most cases, a comprehensive eye examination (ocular history and ocular examination) and a single scan to determine the appropriate pseudophakic power of the IOL are sufficient. In some cases involving a simple cataract, a diagnostic ultrasound A-scan is used. For patients with a dense cataract, an ultrasound B-scan may be used.

Accordingly, where the only diagnosis is cataract(s), Medicare does not routinely cover testing other than one comprehensive eye examination (or a combination of a brief/intermediate examination not to exceed the charge of a comprehensive examination) and an A-scan or, if medically needed, a B-scan. Claims for additional tests are denied if not reasonable and necessary unless there is an additional diagnosis and the medical need for the additional tests is fully documented.

Because cataract surgery is an elective procedure, the patient may decide not to have the surgery until later, or to have the surgery performed by a physician other than the diagnosing physician. In these situations, it may be medically appropriate for the operating physician to conduct another examination. To the extent the additional tests are considered reasonable and necessary by the correct medical staff, they are covered.

General Anesthesia—The use of general anesthesia in cataract surgery may be considered reasonable and necessary if, for particular medical indications, it is the accepted procedure among ophthalmologists in the local community to use general anesthesia for the patient's safety, if pre-existing conditions (e.g., claustrophobia, claustrophobia, claustrophobia) or the patient requires the use of intravenous sedation. In these circumstances, it may be medically appropriate for the operating physician to conduct another examination. The use of general anesthesia in cataract surgery is subject to carrier medical review. Effective date NA. (TN 5)

Revision History

03/1986—Eliminated prior references to routine coverage of assistant surgeon's services. All claims for services of assistant surgeons assisting at cataract surgery are subject to carrier medical review. Effective date NA. (TN 5)
09/1988—Provided that Medicare payment will not be routinely made for pre-cataract surgery exams other than a comprehensive eye exam and an A-scan or B-scan. Other tests will only be paid if a diagnosis in addition to cataract is present and medical need for other tests is fully documented. 09/14/1988. (TN 51)

NCD 10.2.—Transcutaneous Electrical Nerve Stimulation (TENS) for Acute Post-Operative Pain (formerly CIM 45-19)

64550, A4595, A4630, E0720–E0731
Effective Date: August 1, 1995
Benefit Category: Incident to a Physician's Professional Service
Inpatient Hospital Services
Outpatient Hospital Services
Incident to a Physician's Service

Indications and Limitations of Coverage

The use of transcutaneous electrical nerve stimulation (TENS) for the relief of acute post-operative pain is covered under Medicare. TENS may be covered whether used as an adjunct to the use of drugs, or as an alternative to drugs, in the treatment of acute pain resulting from surgery.

TENS devices, whether durable or disposable, may be used in furnishing this service. Before used for the purpose of treating acute post-operative pain, TENS devices are considered supplies. As such they may be hospital supplies furnished incident to a patient's stay and covered under Part A, or supplies incident to a physician's service when furnished in connection with surgery done on an outpatient basis, and covered under Part B.

It is expected that TENS, when used for acute post-operative pain, will be necessary for relatively short periods of time, usually 30 days or less. In cases when TENS is used for longer periods, contractors should attempt to ascertain whether TENS is no longer being used for acute pain but rather for chronic pain, in which case the TENS device may be covered as durable medical equipment as described in NCD 280.15.

Revision History

07/1995—Determined that TENS is covered under durable medical equipment benefit rather than prosthetic device benefit. Effective date 08/07/1995. (TN 78)
NCD 10.3—Inpatient Hospital Pain Rehabilitation Programs (formerly CIM 35-21)

Code each modality.

Effective Date: This is a longstanding national coverage determination. The effective date of this version has not been posted.

Benefit Category: Inpatient Hospital Services

Item/Service Description

Pain rehabilitation programs are a relatively new and innovative approach to the treatment of intractable pain. The goal of such programs is to give a patient the tools to manage and control his/her pain and thereby improve his/her ability to function independently.

A hospital level pain rehabilitation program is one that employs a coordinated multidisciplinary team to deliver, in a controlled environment, a concentrated program which is designed to modify pain behavior through the treatment of the physiological, psychological, and social aspects of pain. Such programs generally include diagnostic testing, skilled nursing, psychotherapy, structured progress withdrawal from pain medications, physical therapy and occupational therapy to restore physical fitness (mobility and endurance) to a maximal level within the constraints of a patient’s physical disability, and the use of mechanical devices and/or activities to alleviate pain or modify a patient’s reaction to it (e.g., nerve stimulator, hydrotherapy, massage, i.e., systemic muscle relaxation training, and directional activities). The nurse’s responsibility in such pain rehabilitation programs is to observe and assess, on a continuing basis, a patient’s condition and response to the program as reflected by his/her action while in the nursing unit, and to assure that the atmosphere within the unit is supportive of pain behavior. The day-to-day activities involved in carrying out the program are under the general supervision and, as needed, direct supervision of a physician.

Indications and Limitations of Coverage

Since pain rehabilitation programs of a lesser scope than that described above would raise a question as to whether the program could be provided in a less intensive setting than an inpatient hospital basis, carefully evaluate such programs to determine whether the program is, in fact, necessary. A hospital level of care. Some pain rehabilitation programs may utilize services and devices which are excluded from coverage, e.g., acupuncture (see NCD 30.8), biofeedback (see NCD 30.18), dorsal column stimulator (see NCD 230.18), and family counseling services (see NCD 270.1). In determining whether the scope of a pain program does not necessitate an inpatient hospital-care, evaluate only those services and devices which are covered. Although diagnostic tests may be an appropriate part of pain rehabilitation programs, such tests would be covered in an individual case only where they can be reasonably related to a patient’s illness, complaint, symptom, or injury and where they do not represent an unnecessary duplication of tests previously performed.

An inpatient program of 4 weeks’ duration is generally required to modify pain behavior. After this period it would be expected that any additional rehabilitation services which might be required could be effectively provided on an outpatient basis under an outpatient pain rehabilitation program (see NCD 10.5) or other outpatient program. The initial 4-week period of such an inpatient program constitutes, in effect, an evaluation period. If a patient is unable to adjust to the program within this period, it is generally concluded that it is unlikely that the program will be effective and the patient is discharged from the program. On occasion a program longer than 4 weeks may be required in a particular case. In such a case there should be documentation to substantiate that inpatient care beyond a 4-week period was reasonable and necessary. Similarly, where it appears that a patient participating in a program is being granted frequent outside passes, a question would exist as to whether an inpatient program is reasonable and necessary for the treatment of the patient’s condition.

An inpatient hospital stay for the purpose of participating in a pain rehabilitation program would be covered as reasonable and necessary to the treatment of a patient’s condition where the pain is attributable to a physical cause, the usual methods of treatment have not been successful in alleviating it, and a significant loss of function independently has resulted from the pain. Chronic pain patients often have psychological problems which accompany or stem from the physical pain and it is appropriate to include psychological treatment in the multidisciplinary approach. However, patients whose pain symptoms result from a mental condition, rather than from any physical cause, generally cannot be successfully treated in a pain rehabilitation program.

Revision History

09/1988—Changes to differentiate its scope from new NCD 10.4.

Effective Date: NA (EN 52)

NCD 10.4—Outpatient Hospital Pain Rehabilitation Programs (formerly CIM 35-21.1)

Code each modality.

Effective Date: This is a longstanding national coverage determination. The effective date of this version has not been posted.

Benefit Category: Outpatient Hospital Services

Incident to a Physicians’ Services

Item/Service Description

Some hospitals also provide pain rehabilitation programs for outpatients. In such programs, services frequently are provided in group settings even though they are being furnished pursuant to each patient’s individualized plan of treatment.

Indications and Limitations of Coverage

Coverage of services furnished under outpatient hospital pain rehabilitation programs, including services furnished in group settings under individualized plans of treatment, is available if the patient’s pain is attributable to a physical cause, the usual methods of treatment have not been successful in alleviating it, and a significant loss of ability by the patient to function independently has resulted from the pain. If a patient meets these conditions and the program provides services of the types discussed in NCD 10.4, those services provided under the program may be covered.

Noncovered services (e.g., vocational counseling, meals for outpatients, or acupuncture) continue to be excluded from coverage, and noncompliance would not be excluded in determining, in the case of
Indications and Limitations of Coverage

Autogenous epidural blood grafts are considered a safe and effective remedy for severe headaches that may occur after performance of spinal anesthesia, spinal taps or myelograms, and are covered. In the procedure blood is removed from the patient’s vein and injected into his epidural space, to seal the spinal fluid leak and stop the pain.

NCD 20.1—Vertebral Artery Surgery

(Formerly CPT 35691, 35693, 35761, 22100, 35301, 35311, 35508, 35515, 35642, 35645, 35690, 35693, 35761)

Effective Date: This is a longstanding national coverage determination. The effective date of this version has not been posted.

Benefit Category: Inpatient Hospital Services or Physicians Services

Indications and Limitations of Coverage

Obstructions which block the flow of blood through the vertebral artery can cause vertigo, visual or speech defects, ataxia, mental confusion, or symptoms of cerebral or spinal ischemia or a completed stroke. Five types of surgical procedures are performed to relieve obstructions to vertebral artery blood flow. They are:

- Vertebroplasty or vertebroplasty with vertebroplasty.
- Endarterectomy, a procedure which cleans out arteriosclerotic plaques which are inside the vertebral artery.
- Fibrous tissue—Tissue changed as a result of manipulation of the neck and head, or by trauma or injury, such as trauma or injury to the vertebral artery.
- Vertebral artery resection, a procedure which removes the vertebral artery from the spinal cord, or other structures near the spinal cord.
- Removal of atherosclerotic plaques which is inside the vertebral artery.

Contraindications to the procedure do not exist, such as coexistent obstructions of multiple cerebral vessels.

Symptoms which cause the symptoms of vertebrobasilar circulation obstruction and do necessitate surgical correction.

Reassembly which frees the artery from surrounding tissue, with or without arteriopexy (fixation of the vessel).

These procedures are medically reasonable and necessary, but only if each of the following conditions is met:

- Symptoms of vertebral artery obstruction exist;
- Other causes have been considered and ruled out;
- There is radiographic evidence of a valid vertebral artery obstruction; and
- Contraindications to the procedure do not exist, such as coexistent obstructions of multiple cerebral vessels.

Obstructions which can cause symptoms of blocked vertebral artery blood flow and which can be documented by an angiogram include:

- Intravascular obstructions—arteriosclerotic lesions within the vertebral artery or its branches.
- Extravascular obstructions—conditions which exist in relation to the vertebral artery or its branches.
- Fibrous tissue—Tissue changed as a result of manipulation of the neck and head, or by trauma or injury, such as trauma or injury to the vertebral artery.
- Vertebral artery resection, a procedure which removes the vertebral artery from the spinal cord, or other structures near the spinal cord.
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Contraindications to the procedure do not exist, such as coexistent obstructions of multiple cerebral vessels.

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Contraindications to the procedure do not exist, such as coexistent obstructions of multiple cerebral vessels.

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- Removal of atherosclerotic plaques which is inside the vertebral artery.

Contraindications to the procedure do not exist, such as coexistent obstructions of multiple cerebral vessels.

Obstructions which can cause symptoms of blocked vertebral artery blood flow and which can be documented by an angiogram include:

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- Extravascular obstructions—conditions which exist in relation to the vertebral artery or its branches.
- Fibrous tissue—Tissue changed as a result of manipulation of the neck and head, or by trauma or injury, such as trauma or injury to the vertebral artery.
- Vertebral artery resection, a procedure which removes the vertebral artery from the spinal cord, or other structures near the spinal cord.
- Removal of atherosclerotic plaques which is inside the vertebral artery.

Contraindications to the procedure do not exist, such as coexistent obstructions of multiple cerebral vessels.
this type of procedure, require specific identification of the obstruction in question and the surgical procedure performed. Also, in view of the specific coverage criteria given, develop all claims for vertebral artery surgery on a case-by-case basis.

Make payment for a surgical procedure listed above if: (1) it is reasonable and necessary for the individual patient to have the surgery performed to remove or reduce an obstruction to vertebral artery flow, and (2) the four conditions noted are met.

In all other cases, these procedures cannot be considered reasonable and necessary within the meaning of sec. 1862(a)(1) of the Act and are not reimbursable under the program.

NCD 20.2—Extracranial-Intracranial (EC-IC) Arterial Bypass Surgery
(Effective for services performed on or after March 27, 1991). (formerly CIM 35-37)

61711

Effective Date: March 27, 1991

Benefit Category: Inpatient Hospital Services

Indications and Limitations of Coverage

Extracranial-Intracranial (EC-IC) arterial bypass surgery is not a covered procedure when it is performed as a treatment for ischemic cerebrovascular disease of the carotid or middle cerebral arteries, which includes the treatment or prevention of strokes. The premise that this procedure, which bypasses narrowed arterial segments improves the blood supply to the brain and reduces the risk of having a stroke has not been demonstrated to be any more effective than medical intervention.

Accordingly, EC-IC arterial bypass surgery is not considered reasonable and necessary within the meaning of sec. 1862(a)(1) of the Act when it is performed as a treatment for ischemic cerebrovascular disease of the carotid or middle cerebral arteries.

Revision History

06/1991—Renamed to reflect current terminology for procedure and revised to provide that Medicare coverage is no longer allowed when EC-IC surgery performed to treat ischemic cerebrovascular disease of carotid or middle cerebral arteries. Effective date 03/27/1991. (TN 47)

NCD 20.3—Thoracic Duct Drainage (TDD) in Renal Transplants (formerly CIM 35-85)

38794

Effective Date: This is a longstanding national coverage determination. The effective date of this version has not been posted.

Benefit Category: Inpatient Hospital Services

Item/Service Description

Thoracic duct drainage (TDD) is an immunosuppressive technique used in renal transplantation. This procedure, which removes lymph from kidney transplant recipients as a means of achieving suppression of the immune mechanism, is currently being used both pre-transplant and post-transplant in combination with more conventional immunotherapy.

Indications and Limitations of Coverage

TDD is performed on an inpatient basis, and the inpatient stay is covered for patients admitted for treatment in advance of a kidney transplant as well as for those receiving post-transplant. TDD is a covered technique when furnished to a kidney transplant recipient or an individual approved to receive kidney transplantation in a hospital approved to perform kidney transplantation.

NCD 20.4—Implantable Automatic Defibrillators (Various Effective Dates Below)
(formerly CIM 35-85)

33202–33203, 33215–33220, 33223–33226, 33240–33249

Effective Date: January 27, 2005

Implementation Date: January 27, 2005 (Implementation QR Modifier: April 4, 2005)

Item/Service Description

A. General

The implantable automatic defibrillator is an electronic device designed to detect and treat life-threatening tachyarrhythmias. The device consists of a pulse generator and electrodes for sensing and defibrillating.

Indications and Limitations of Coverage

1. Documented episode of cardiac arrest due to ventricular fibrillation (VF), not due to a transient or reversible cause (effective July 1, 1991).

2. Documented sustained ventricular tachyarrhythmia (VT), either spontaneous or induced by an electrophysiology (EP) study, not associated with acute myocardial infarction (MI) and not due to a transient or reversible cause (effective July 8, 1999).

3. Documented familial or inherited conditions with a high risk of life-threatening VT, such as long QT syndrome or hypertrophic cardiomyopathy (effective July 1, 1999).

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