Welcome to Practice Management Institute’s Webinar and Audio Conference Training. We hope that the information contained herein will give you valuable tips that you can use to improve your skills and performance on the job. Each year, more than 40,000 physicians and office staff are trained by Practice Management Institute. For 30 years, physicians have relied on PMI to provide up-to-date coding, reimbursement, compliance and office management training. Instructor-led classes are presented in 400 of the nation’s leading hospitals, healthcare systems, colleges and medical societies.

PMI provides a number of other training resources for your practice, including national conferences for medical office professionals, self-paced certification preparatory courses, online training, educational audio downloads, and practice reference materials. For more information, visit PMI’s web site at www.pmiMD.com

Please be advised that all information in this program is provided for informational purposes only. While PMI makes all reasonable efforts to verify the credentials of instructors and the information provided, it is not intended to serve as legal advice. The opinions expressed are those of the individual presenter and do not necessarily reflect the viewpoint of Practice Management Institute. The information provided is general in nature. Depending on the particular facts at issue, it may or may not apply to your situation. Participants requiring specific guidance should contact their legal counsel.

CPT® is a registered trademark of the American Medical Association.
Welcome to PMI’s Webinar Presentation

Brought to you by:
Practice Management Institute®
pmiMD.com

Meet the Presenter…

Debbie Forde
CPC, CMC, CMCO, CPCO, CPMA
President, Your MedSource, Inc.

On the topic:
NCDs – LCDs Medical Policies: How to Use Them to Get Paid
NCDs - LCDs
Medical Policies
How to Use Them to Get Paid

Topics

- National Coverage Determinations
- Local Coverage Determinations
- Medical Policies
National Coverage Determinations

- NCDs are developed by CMS to describe the circumstances for Medicare coverage nationwide for a specific medical service procedure or device. NCDs generally outline the medical conditions for which a service is considered to be covered or not covered and is usually issued as a program instruction.
- NCDs and LCDs are tools to help providers submit correct claims.
- CMS develops these coverage determinations as standards of what is considered medically necessary.

Medical Necessity

- CMS and the MACs establish these determinations to ensure the services provided are medically necessary by evaluating if they are:
  - Ordered and performed by qualified personnel.
  - The service meets the patients needs but it not over utilized more that what is medically necessary.
  - The service is performed in the appropriate place of service for the patients needs and medical condition.
  - The service is in accordance with the standard of medical practice for the condition being treated.
Local Coverage Determinations

- Local Coverage Determinations is a decision by a Medicare Administrative Contractor (MAC) whether to cover a particular service on a MAC wide basis.
- When there is no NCD, an LCD can be established.

Medical Policies

- Medical Policies are the decisions made within a particular insurance on what they consider medically necessary pertaining to certain procedures. They are not always exactly the same as the LCDs and NCDs but normally they are very close.
Why are NCD developed?

- If LCDs are not consistent with each other.
- It’s a new service that is medically advanced and does not have a similar service that is covered.
- It’s a controversial service.
- Potential for overuse or rapid diffusion of the service exists.

Information found in NCDs

- Procedure codes and/or
- Covered and/or non-covered diagnosis codes
- Changes/History of NCDs
- Detailed Information:
  - Benefit Category
  - Medical necessity and/or limitations and indications of coverage
  - Service and item descriptions.
  - Claims Processing Instructions
National Coverage Determinations

National Coverage Determinations can be found on the CMS website at:


Above is the link listing the NCDs in alphabetic order.
How to look up an NCD

- The “quick search” for NCD can be found at the below link:


Quick Search

- Under Quick Search you will enter the name of the procedure or the cpt code and click on “search by type” If there is a policy for the procedure, the title of the NCD will appear in blue. Click on this title for the details of what is considered medically necessary.
Specifcics of NCDs

- NCDs can be very specific in the requirements in which they consider a procedure to be medically necessary. As on the 3 following slides the criteria of what they expect a patient with osteoarthritis to be defined as.

- An example of the requirements for arthroscopic debridement for osteoarthritic knee. They have to present with more than pain alone: i.e., 1) mechanical symptoms that include, but are not limited to, locking, snapping or popping 2) limb and knee joint alignment, and 3) less severe and/or early degenerative arthritis, remain at local contractor discretion.
**Description Information**

**Benefit Category:**
- Inpatient hospital services
- Professional services

**Note:** This may not be an exhaustive list of all applicable Medicare benefit categories for this item or service.

**Procedure Description:**
Arthroscopy is a surgical procedure that allows the direct visualization of the interior joint space. In addition to providing visualization, arthroscopy enables the repair of joint problems that might arise from the use of damage or irritation. Arthroscopy may involve either small or large volume suction irrigation of the knee by arthroscopy. Although generally performed to reduce pain and improve function, current practice does not recognize the benefit of irrigation alone for the reduction of mechanical symptoms. Arthroscopy also provides the removal of any loose bodies from the interior joint space; a procedure termed débridement. When used alone or in combination with irrigation, arthroscopy can be used to treat osteoarthritis of the knee. Osteoarthritis is a chronic degenerative disease of the knee. The American Academy of Orthopaedic Surgeons defines osteoarthritis as degeneration of the cartilage of the knee as presenting with pain, and meeting at least 5 of the following criteria:
- Over 50 years of age
- Less than 20 minutes of morning stiffness
- Daytime swelling or tenderness
- Tenderness of the quadriceps
- Pain with motion
- Pain with weight bearing or active motion

**Indications and Limitations of Coverage:**

A. Nationally Covered Indications:
- Not applicable.

B. Nationally Noncovered Indications:

The clinical effectiveness of arthroscopic lavage and arthroscopic débridement for the severe osteoarthritis knee has not been verified by scientifically controlled studies. After thorough discussions with clinical investigators, the orthopedic community, and other interested parties, CMS determined that the following procedures are not considered reasonable or necessary in treatment of the osteoarthritis knee and are not covered by the Medicare program:
- Arthroscopic lavage used alone for the osteoarthritis knee.
- Arthroscopic débridement for osteoarthritis patients presenting with knee pain only.
- Arthroscopic débridement and lavage with or without débridement for patients presenting with severe osteoarthritis (the severe osteoarthritis is defined in the Medicare classification code, grades III and IV). Osteoarthritis in the most common joint involved is considered a clinical diagnosis that classifies the severity of joint damage of the knee by compartments and grades. Grade I is defined as softening or thinning of joint cartilage. Grade II is defined as fragmentation or fusion in an area <1 cm. Grade III is defined as fragmentation or fusion in an area >1 cm. Grade IV refers to cartilage erosion down to the bone. Grades III and IV are characteristic of severe osteoarthritis.

C. Other:

Apart from the noncovered indications above for arthroscopic lavage and/or arthroscopic débridement of the osteoarthritis knee, all other indications of débridement for the subpopulation of patients without severe osteoarthritis of the knee who present with symptoms other than pain alone (e.g., 21D, 39C) present with symptoms that include but are not limited to, decreased range of motion and reduced physical activity, and/or knee pain with daily activities and at rest, which may improve with débridement. The Medicare benefit is limited to specific indications, and not to a broader construct. Medicare beneficiaries may require submission of one of all of the following documents to define the patient's knee condition:
- Operative notes
- Copies of imaging results
- Arthroscopy results

(This NCD last reviewed June 2004.)

**Transmittal Information**

**Transmittal Number:**
14

**Coverage Transmittal Link:**

**Revision History**

6/25: Arthroscopic lavage allowed for treatment of osteoarthritis of knee, and arthroscopic débridement for presentation of knee pain only or arthroscopic débridement and lavage with or without débridement for patients with severe osteoarthritis of knee are rescinded. All other indications of débridement for subpopulation of patients without severe osteoarthritis of knee who present with symptoms other than pain alone remain at contractor discretion.
Effective date 6/25/08. Implementation date 7/1/08. (TN 144 (OCR 221))

**National Coverage Analyses (NCAs)**

**National Coverage Analyses (NCAs)**

This NCD has been or is currently being reviewed under the National Coverage Determination process. The following are existing associations with NCAs, from the National Coverage Analyses database:
- Clinical consideration for Arthroscopy for the Osteoarthritis Knee (CAO-69176)
Local Coverage Determinations

- LCDs are found on the MACs websites. The Novitas LCDs are found at: [http://novitas-solutions.com](http://novitas-solutions.com)
- You’ll click on your jurisdiction area.
- Then LCD/Policy Search
Information Found in LCDs

- LCD Information
- CMS National Coverage Policies
- Coding Information
- History Information (Previous Changes)
- Contractor Information
- Coverage Guideline
- Related Documents
- General Information

Enter the code or description, search

Medical Policy Search Tool

Welcome to the New Medical Policy Search Tool, which allows you to search LCDs including ICD-10 versions, Billing & Coding Articles, and National Coverage Determinations (NCDs). Search Results from the CMS website will open in a new browser tab or window, and may take a few moments to load.

Enter your search term(s):

NCDs

Match Any Term(s)

Which type of policy do you want to search?

- Local Coverage Determinations (LCDs)
- Billing & Coding Articles
- National Coverage Determinations (NCDs)

Choose your state:

Texas

Date of Service (optional)

Search
Note the “drafted” policies have DL in front of them.

The established policies have the L in front of them.

You will use the established policy.

Click on the established policy.

Click on the license agreement.
This LCD supplements but does not replace, modify or supersedes existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for pain management services. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersedes applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for pain management services and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies regarding pain management services are found in the following Internet-Only Manuals (IOMs) published on the CMS Web site.
Covered Diagnosis

- In addition to the medical conditions previously noted, the correct diagnosis code must also be used when billing for any services listed on the LCD. If these codes are not used, the claim will be denied for medical necessity. Often when a practice received these denials they will have the physician write letters and try to do appeals through the billing department. The list of the allowed diagnosis codes should be checked FIRST.

Examples of allowed diagnosis codes:

- ICD-10 Codes that Support Medical Necessity
  
  **Group 1 Paragraph: Note:** Medicare is only establishing limited coverage for CPT codes 64633, 64634, 64635 and 64636 as listed above. All other CPT codes included in this policy will not be subject to limited coverage at this time because there are numerous reasonable and necessary conditions that warrant their application. An appropriate ICD-10-CM code must be submitted with each claim, coded to the highest level of specificity for that date of service.
<table>
<thead>
<tr>
<th>ICD-10 Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M43.00</td>
<td>Spondylolysis, site unspecified</td>
</tr>
<tr>
<td>M43.01</td>
<td>Spondylolysis, occipito-atlanto-axial region</td>
</tr>
<tr>
<td>M43.02</td>
<td>Spondylolysis, cervical region</td>
</tr>
<tr>
<td>M43.03</td>
<td>Spondylolysis, cervicothoracic region</td>
</tr>
<tr>
<td>M43.04</td>
<td>Spondylolysis, thoracic region</td>
</tr>
<tr>
<td>M43.05</td>
<td>Spondylolysis, thoracolumbar region</td>
</tr>
<tr>
<td>M43.06</td>
<td>Spondylolysis, lumbar region</td>
</tr>
<tr>
<td>M43.07</td>
<td>Spondylolysis, lumbosacral region</td>
</tr>
<tr>
<td>M43.08</td>
<td>Spondylolysis, sacral and sacrococcygeal region</td>
</tr>
<tr>
<td>M43.09</td>
<td>Spondylolysis, multiple sites in spine</td>
</tr>
<tr>
<td>M43.10</td>
<td>Spondylolisthesis, site unspecified</td>
</tr>
<tr>
<td>M43.11</td>
<td>Spondylolisthesis, occipito-atlanto-axial region</td>
</tr>
<tr>
<td>M43.12</td>
<td>Spondylolisthesis, cervical region</td>
</tr>
<tr>
<td>M43.13</td>
<td>Spondylolisthesis, cervicothoracic region</td>
</tr>
<tr>
<td>M43.14</td>
<td>Spondylolisthesis, thoracic region</td>
</tr>
<tr>
<td>M43.15</td>
<td>Spondylolisthesis, thoracolumbar region</td>
</tr>
<tr>
<td>M43.16</td>
<td>Spondylolisthesis, lumbar region</td>
</tr>
<tr>
<td>M43.17</td>
<td>Spondylolisthesis, lumbosacral region</td>
</tr>
<tr>
<td>M43.18</td>
<td>Spondylolisthesis, sacral and sacrococcygeal region</td>
</tr>
<tr>
<td>M43.19</td>
<td>Spondylolisthesis, multiple sites in spine</td>
</tr>
<tr>
<td>M47.10</td>
<td>Other spondylosis with myelopathy, site unspecified</td>
</tr>
</tbody>
</table>

**Following the LCD**

- Some of the requirements of the LCD require the physician to follow certain guidelines before the procedure is allowed. This can include treatments such as physical therapy.
- A patient has to meet the MAC or CMS guidelines in order for a service to be payable. The service can still be performed but may not be payable by Medicare. The Advanced Beneficiary Notice will need completed and charge should be submitted with the appropriate modifier.
Modifiers for non-covered services:

<table>
<thead>
<tr>
<th>CLAIM REPORTING MODIFIERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The chart below provides the claim reporting modifiers associated with ABN use.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Modifier</th>
<th>When to Use the Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>GA</td>
<td>Water of Liability Statement Issued as Required by Payer Policy, Individual Case</td>
</tr>
<tr>
<td></td>
<td>Report when you issue a mandatory ABN for a service as required and it is on file. You do not need to submit a copy of the ABN, but you must have it available on request.</td>
</tr>
<tr>
<td>GX</td>
<td>Notice of Liability Issued, Voluntary Under Payer Policy</td>
</tr>
<tr>
<td></td>
<td>Report when you issue a voluntary ABN for a service Medicare does not cover because it is statutorily excluded or is not a Medicare benefit. You may use this modifier in combination with modifier GY.</td>
</tr>
<tr>
<td>GY</td>
<td>Item or Service Statutorily Excluded, Does Not Meet the Definition of Any Medicare Benefit</td>
</tr>
<tr>
<td></td>
<td>Report that Medicare statutorily excludes the item or service, or the item or service does not meet the definition of any Medicare benefit. You may use this modifier in combination with modifier GX.</td>
</tr>
<tr>
<td>GZ</td>
<td>Item or Service Expected to Be Denied As Not Reasonable and Necessary</td>
</tr>
<tr>
<td></td>
<td>Report when you expect Medicare to deny payment of the item or service due to lack of medical necessity and no ABN was issued.</td>
</tr>
</tbody>
</table>

It is not appropriate to bill Medicare knowingly for a non-covered service.

- Coverage Guidance

- Coverage Indications, Limitations, and/or Medical Necessity

  Notice: It is not appropriate to bill Medicare for services that are not covered (as described by this entire LCD) as if they are covered. When billing for non-covered services, use the appropriate modifier.

  **Patient controlled analgesia** - The postoperative insertion of an intravenous catheter and preprogramming of a patient-activated delivery system to control the first several days of postoperative pain.

  **Epidural anesthesia** - The insertion of a catheter allowing access to the epidural space for the purpose of injecting anesthetic or narcotic medication.

  **Nerve blocks** - Nerve blocks are temporary interruptions of conduction in peripheral nerves or nerve trunks created by the injection of local anesthetic solutions. Somatic and sympathetic nerves may be injected. In the diagnostic mode, this procedure can help differentiate a nerve that is a pathway for the conduction of pain impulses, to determine the type of nerve conducting the pain, to distinguish between central and peripheral origins of pain, and to evaluate the potential benefit of other neurolytic procedures or surgical lysis of a nerve. In a therapeutic mode, the procedure may be used for the treatment of painful conditions that respond to this modality (i.e., celiac block for the treatment of pain related to GI neoplasms), or to prevent pain following procedures.
Denial for Medical Necessity when there is not an LCD

- Not all procedures have LCDs but a service can still be denied for medical necessity.
- Look at other guidelines such as:
  - NCCI Edits
  - Medically Unlikely Edits
  - Internet Only Manuals
  - Medicare Learning Network Articles
  - Physician Fee Schedule

NCCI and Medically Unlikely Edits

National Correct Coding Initiative

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The NCCI developed its coding policies based on coding conventions defined in the American Medical Association’s CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual). The Coding Policy Manual should be utilized by carriers and FOAs as a general reference tool that explains the rationale for NCCI edits.

Carriers implemented NCCI Procedure-to-Procedure (PTP) edits within their claim processing systems for dates of service on or after January 1, 1996 and began implementing Medically Unlikely (MUE) edits on January 1, 2007. A corresponding set of PTP edits is incorporated into the outpatient code editor (OCED) for ORFS and therapy providers (Part B billed) to verify correct designation of Code (CPT/HCPCS), correct outpatient rehabilitation facilities (OPRFs), outpatient physical therapy and speech language pathology providers (OPTPs), and correct claims for home health agencies (HHAs) billing under Title 22, 23, 70, 74, 74A. Corresponding MUE edits are similarly implemented within the Fiscal Intermediary Standard System (FISS).

The purpose of the NCCI Procedure-to-Procedure (PTP) edits is to prevent improper payment when incorrect code combinations are reported. The NCCI assigns a table of edits for physiatrists/physical and a table of edits for outpatient hospital services. The Column One-Column Two Correct Coding Edits table and the Mutually Exclusive Edits table have been combined into one table and include PTP code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual. The purpose of the NCCI MUE program is to prevent improper payment.
Training Your Physicians and Billing Staff

- The LCDs and NCDs help the physicians and their coding and billing staff understand the coverage, payments and denial reasons of the services their physicians are providing.
- The billing and coding staff should share the information they find in the LCDs and NCDs with their physicians.

LCDs Additional Information

- Drafts are initially posted for LCDs in January, May and September.
- I recommend not printing out the LCD but referring to the website each time you look up coverage unless printing it out for an initial meeting with the physician.
Inquiries for Changes to an LCD

A request for a change to an LCD can be submitted by:
- Anyone interested
- Physicians/Providers
- Patients/Beneficiaries

The request can only be submitted on a FINAL LCD

Submission Requirements

- The submission must be in writing.
- Include the language the person requesting would like to see added or deleted from the LCD.
- The submission must include justification such as new evidence that supports the request.
- Only full articles will be accepted.
- Verifying the information being used to support the change has not already been considered under the Sources of Information section found in the LCD.

The request will be decided within 30 days with an explanation if the request is considered invalid.
Submission Approval

► The final decision within 90 days.
► The person making the request will be notified.

► Decisions can include:
  ► Change as requested - changed to a more or less restrictive policy
  ► No changes
  ► Retire the policy

For Novitas Solutions:

Office of the Contractor
Medical Director
Novitas Solutions
JL or JH Medical Affairs Department
2020 Technology Pkwy, Ste 100
Mechanicsburg, PA 17050
Fax: 717-526-6389
JL Email: vicki.Kurland@novitas-solutions.com
JH Email: patricia.reidenbach@novitas-solutions.com
Medical Policies

Each of the major carriers have policies similar to the LCDs which are their guidelines that physicians must follow to make sure their services are payable and considered medically necessary.

Blue Cross Blue Shield of Texas

- Blue Cross and Blue Shield’s medical policies can be found on their website under the provider tab.
- Under the provider section you will go to Standard & Requirements
- Then to Medical Policies and click Agree
- Then you are able to review the Medical Policies as show on the below slides.
- All active and pending policies are shown here.
Medical Policies

- The Medical Policies for the insurance companies also show the ICD 10 codes to be used with specific CPT codes in addition to the medical guidelines the physician must follow.
- The policies HAVE to be followed in order for the claims to be paid. Documentation is key in establishing medical necessity.
- When you received rejections for medical necessity the same guidelines apply as with Medicare. You must look up the policy.
- Be familiar with the policies for each insurance company that apply to your specialty.
Medical Policies

Medical Policies are based on data from the peer-reviewed scientific literature, from criteria developed by specialty societies and from guidelines adopted by other health care organizations. Medical Policies are used to make benefit coverage determinations. In the event of conflict between a Medical Policy and any plan document, the Plan document will govern.

ACTIVE POLICIES
- View all Active Policies

PENDING POLICIES
- View all Pending Policies

UPDATES
- View all Updated Policies

DRAFT POLICIES
- View all Draft Policies

---

Medical Policies - All Active Policies

There are currently 851 document(s).

<table>
<thead>
<tr>
<th>Title</th>
<th>Policy Number</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accelerated Breast Irradiation after Breast</td>
<td>R2AD050.017</td>
<td>07-16-2016</td>
</tr>
<tr>
<td>Conserving Surgery for Early Stage Breast Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acne Management</td>
<td>THE301.029</td>
<td>03-15-2015</td>
</tr>
<tr>
<td>Acoustic Cardiography</td>
<td>MEC202.012</td>
<td>11-01-2015</td>
</tr>
<tr>
<td>Acoustic Respiratory Management (ARMM)</td>
<td>MEC201.037</td>
<td>07-01-2015</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>SUMT02.005</td>
<td>03-15-2016</td>
</tr>
<tr>
<td>Adjuvant Immunotherapy</td>
<td>THE301.024</td>
<td>06-01-2015</td>
</tr>
<tr>
<td>Advanced Therapies for Pharmacologic Treatment of</td>
<td>R0901.056</td>
<td>02-01-2015</td>
</tr>
<tr>
<td>Pulmonary Hypertension</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Airway Clearance Devices</td>
<td>DME101.027</td>
<td>07-01-2015</td>
</tr>
<tr>
<td>Ambulatibility (Limb)</td>
<td>R0001.077</td>
<td>09-01-2015</td>
</tr>
<tr>
<td>Allergic Management</td>
<td>MEC206.001</td>
<td>01-01-2016</td>
</tr>
<tr>
<td>Alternative Modes of Nutrition in the Outpatient</td>
<td>MEC200.011</td>
<td>06-01-2015</td>
</tr>
<tr>
<td>and Home Setting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance and Medical Transport Services</td>
<td>ADM1001.005</td>
<td>07-15-2015</td>
</tr>
</tbody>
</table>

25
Example CPT/ICD10

The following codes may be applicable to this medical policy and may not be all inclusive.

CPT Codes
- 123456, 678901, 234567, 890123, 345678, 456789, 567890, 678901

ICD-10-CM Diagnosis Codes
- J45, J46, J47, J48

ICD-10-PCS Procedure Codes
- K00, K01, K02, K03, K04

Example of Medical Policy

11. Any aspect of the Lifestyle Eating and Performance (LEEP) program, including the Mediation Glucose Test (MGT), used to identify "delayed food allergies" and treatments, which includes dietary manipulation and/or supplementation in herbs.

Allergy Therapy

Allergy immunotherapy may be considered medically necessary in patients with documented hypersensitivity that cannot be managed by medications and avoidance.

Subcutaneous Immunotherapy

Subcutaneous immunotherapy using Omalizumab, omalizumab, or ragweed may be considered medically necessary, when used according to FDA labeling, for the treatment of severe allergic rhinitis when the following conditions are met:

- Patient has a history of severe respiratory symptoms related to hay fever or occupational or environmental allergens.
- Patient has a documented positive specific skin test or specific immunoglobulin E (sIgE) test.
- Allergens must be confirmed by positive skin test or in vitro testing for specific sIgE antibodies to the species contained in the product.
- Omalizumab is for use in adults and children 12 years of age and older.
- Patient's symptoms are inadequately controlled by appropriate pharmacotherapy or avoidance.

Sublingual immunotherapy, a technique of allergy immunotherapy, is considered experimental, investigational, and/or experimental for all other uses.

The following methods of allergy immunotherapy are considered experimental, investigational, and/or experimental for the treatment of food, insects, chemicals, pollens, and other allergies including the preparation of and administration of immunotherapy:

1. Provocative and desensitization therapy: using intradermal and subcutaneous routes. AND
2. Non-FDA approved subcutaneous immunotherapy (SLIT) and application of natural or enzymatically altered allergens. AND
3. Topical, local, or injection of allergen directly to the target organ creating the allergy response, such as the nose for allergic rhinitis. AND
4. Oral submucosal immunotherapy (sublingual immunotherapy); limited to the allergen. AND
5. Nonspecific immunotherapy, solutions of peptone and water or corrections containing specific antigens, to produce skin reactions of the allergies at the injection site.
Aetna’s Medical Policies can be found at:

https://www.aetna.com/health-care-professionals/clinical-policy-bulletins/medical-clinical-policy-bulletins.html#
Navigating Aetna Website

For Aetna you will go to their Medical Clinical Policy Bulletin and type in the policy you’re looking for. This will bring up the policies related to that subject. Aetna is also very detailed in their coverage requirements.
Read Your Provider Emails!

Cigna Medical Policies

- Cigna’s Medical Policies is found at: [http://www.cigna.com/healthcare-professionals/](http://www.cigna.com/healthcare-professionals/)
- You will then go to Resources - Clinical Payment and Reimbursement Policies
- This will take you to the screen where you can choose Coverage Policies.
- You will find the medical policy here.
Cigna Policies

► Cigna policies are also very detailed in what is considered medically necessary.

► Cigna does give the ICD 10 codes that must be used for a procedure to be covered.
Coverage Policies

Cigna HealthCare Coverage Policies are used to assist in interpreting standard health coverage plan provisions. Select one of the links below to access Cigna’s medical or pharmacy guidelines, references and information.

Bronze Coverage Policies

Medical and Administrative A-Z Index

Here you can browse alphabetically or by keyword for a Cigna coverage policy. View Documents

Supporting Websites

In certain markets, Cigna develops utilization management of specific services, including biologic care. Medical and specialty pharmacy and radiology services. In those situations, this product guideline may be useful in support medical necessity and other coverage determinations.

- onCure Solutions (High Tech Imaging, Radiation Therapy, and Musculoskeletal Services)
- homepages
- onCure Solutions
- onCure Solutions
- onCure Solutions

Additional Information

- The terms of an individual patient's coverage plan document (Group Service Agreement [GSA], Evidence of Coverage, Summary Plan Description [SPD], or similar document) may apply separately from the standard Cigna plans. Some health benefits policies are listed in a coverage plan document or in the Cigna Web site. If there is a discrepancy between the terms of these coverage policies and the information on the Web site, the policy in the individual’s plan document always controls.
- Coverage determinations are made on a case-by-case basis. The information in this product guideline document is subject to change.
- Any regulatory, legal, or other changes in coverage policies or related policies may be subject to change without notice. Additional policies may be developed in response to health care needs or to improve the health of Cigna members.
- When a policy is altered, the effective date of the change will be noted on the Web site. The effective date of the policy change will be noted on the policy document. Additional policies may be developed as needed or may be withdrawn from the plan. The information in this product guideline is subject to change without notice.
- Cigna reserves the right to modify, suspend, or cancel any coverage policy at any time. The material contained herein is intended to be an overview of the coverage policies and is not intended to be a complete description of all the services provided, nor does it include all the policies and procedures that may apply.
- To the extent that the information provided here is incorrect or out of date, the information contained in the Cigna Web site shall govern. The Cigna Web site is updated regularly.
- Cigna is not responsible for any errors or omissions in the information provided.

Medical and Administrative A-Z Index

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

- Screening Mammography (C12)
- Sea Lift, Aircraft, Helicopter Life and Standing Devices (C34)
- Sensory and Auditory Integration Therapy (C120)
- Sensory Testing for Infants with the Newborn (C121)
- Shoulder Arthroplasty (C120)
- Shoulder Surgery (C120)
- Shoulder/Elbow and Open Procedures (C120)
- Speech, Language, and Communication (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
- Speech Therapy (C120)
## Cigna Medical Coverage Policy

### Somatosensory Evoked Potentials

<table>
<thead>
<tr>
<th>Table of Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage Policy</td>
</tr>
<tr>
<td>General Information</td>
</tr>
<tr>
<td>Coding/Billing Information</td>
</tr>
<tr>
<td>References</td>
</tr>
</tbody>
</table>

### Hypertrophic Cardiomyopathy

#### Non-Invasive Vascular Testing

#### Cigna Medical Coverage Policy

Effective Date: 05/12/2015
Next Review Date: 05/12/2016
Coverage Policy Number: 0122

**Coverage Policy**

Cigna covers somatosensory evoked potentials (SEPs) as medically necessary when prior diagnostic testing has failed to confirm a diagnosis for any of the following:

- Carpal tunnel syndrome
- Meralgia paresthetica
- Multiple sclerosis and other demyelinating diseases (e.g., adrenoleukodystrophy, adrenomyeloneuropathy, metachromatic leukodystrophy, and Pelizaeus-Merzbacher disease)
- Spinal cord degeneration

### ICD-9-CM Diagnosis Codes

#### Descriptions

<table>
<thead>
<tr>
<th>ICD-9-CM Diagnosis Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E64.2</td>
<td>Sciatica, unspecified, e.g., lumbar, lower extremity, unspecified.</td>
</tr>
<tr>
<td>E64.3</td>
<td>Sciatica, unspecified, e.g., lumbar, lower extremity, unspecified.</td>
</tr>
<tr>
<td>E64.8</td>
<td>Sciatica, unspecified, e.g., lumbar, lower extremity, unspecified.</td>
</tr>
</tbody>
</table>

#### E64.2

- Sciatica, unspecified, e.g., lumbar, lower extremity, unspecified.

#### E64.3

- Sciatica, unspecified, e.g., lumbar, lower extremity, unspecified.

#### E64.8

- Sciatica, unspecified, e.g., lumbar, lower extremity, unspecified.

### ICD-10-CM Diagnosis Codes

#### Descriptions

<table>
<thead>
<tr>
<th>ICD-10-CM Diagnosis Codes</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M54.0</td>
<td>Malignant neoplasm of other and unspecified parts of nervous system, spinal cord</td>
</tr>
<tr>
<td>M54.2</td>
<td>Secondary malignant neoplasm of brain and spinal cord</td>
</tr>
<tr>
<td>M54.3</td>
<td>Benign neoplasm of brain and other parts of nervous system, spinal cord</td>
</tr>
<tr>
<td>M54.4</td>
<td>Neoplasms of uncertain behavior of brain and spinal cord</td>
</tr>
<tr>
<td>M54.5</td>
<td>Neurofibromatosis</td>
</tr>
<tr>
<td>M54.6</td>
<td>Menigitis</td>
</tr>
<tr>
<td>M54.7</td>
<td>Spinal cord disease</td>
</tr>
<tr>
<td>M54.8</td>
<td>Syringomyelia and syringobulbia</td>
</tr>
</tbody>
</table>
UnitedHealthcare Medical Policies

UHC’s medical policies are found at:

https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=ca174ccb4726b010VgnVCM100000c520720a

This screen has both the medical and reimbursement policies.
UnitedHealthcare®
MEDICAL POLICY

EPIDURAL STERIOD AND FACET INJECTIONS FOR SPINAL PAIN

Policy Number: 2011100AV
Effective Date: December 1, 2015

Table of Contents

EFFECTIVE DATES

1. BENEFIT CONSIDERATIONS
2. ELIGIBILITY CRITERIA
3. APPLICABLE CODES
4. MEDICAL NEEDED
5. CLINICAL EVIDENCE
6. U.S. FOOD AND DRUG ADMINISTRATION
7. CENTER FOR MEDICARE AND MEDICAID SERVICES
8. PAYMENT
9. POLICY HISTORY/REVISION INFORMATION

INSTRUCTIONS FOR USE

This Medical Policy is intended to assist UnitedHealthcare providers and their staff in determining medical necessity. It is not intended to impose restrictions on your practice. UnitedHealthcare reserves the right to change, modify, update, or otherwise amend any of the following Information. All policies and determinations are subject to the interpretation, discretion, and administration of UnitedHealthcare. UnitedHealthcare will not be held liable for any injuries, losses, expenses, costs, or charges directly or indirectly related to the use of this Information.

UnitedHealthcare may also set or adjust policies through the healthcare community, such as the NCDs and NCDExclusions. UnitedHealthcare makes no guarantees, representations, or warranties of any kind, either express or implied, as to the accuracy, completeness, reliability, or the quality of the Information. UnitedHealthcare makes no recommendation to the provider. UnitedHealthcare does not guarantee the accuracy, reliability, or quality of the Information. The Information should not be used as the sole or primary basis for any conclusions or decisions. The Information may be used in conjunction with independent professional medical judgment. The Information provided is for informational purposes and does not constitute medical advice.

ICD-10 CM diagnosis and ICD-10 PCS (important procedures) codes are listed for informational purposes only and do not indicate that UnitedHealthcare will pay for services or that services will be covered. The Information must be used in conjunction with independent professional medical judgment. UnitedHealthcare will not be held liable for any injuries, losses, expenses, costs, or charges directly or indirectly related to the use of this Information.

ICD-10 codes that are not accepted for services provided prior to October 1, 2015, are not listed. UnitedHealthcare will not be held liable for any injuries, losses, expenses, costs, or charges directly or indirectly related to the use of this Information.

ICD-10 codes that are not accepted for services provided prior to October 1, 2015, are not listed. UnitedHealthcare will not be held liable for any injuries, losses, expenses, costs, or charges directly or indirectly related to the use of this Information.
UnitedHealthcare’s Medical Policies are also very detailed. Note the policy for Epidural Steroid and Facet Injections is 32 pages.

They also give the CPT and diagnosis codes that are reimbursable.

DESCRIPTION OF SERVICES Pain in the lower back or low back pain is a common concern, affecting up to 90% of Americans at some point in their lifetime. The vast majority of episodes are mild and self-limited. Up to 50% of affected persons will have more than one episode. Low back pain is not a specific disease; rather it is a symptom that may occur from a variety of different processes. Management of back pain that is persistent and disabling despite the use of recommended conservative treatment is challenging. Epidural steroid injections, and facet joint injections and blocks have been employed in the treatment of back pain, as an alternative to more invasive interventions. (Chou et al. 2009). Spinal stenosis is described by the National Institute of Arthritis and Musculoskeletal and Skin Diseases (NIAMS) as follows: "...Spinal stenosis is a narrowing of spaces in the spine (backbone) that results in pressure on the spinal cord and/or nerve roots. This disorder usually involves the narrowing of one or more of three areas of the spine: (1) the canal in the center of the column of bones (vertebral or spinal column) through which the spinal cord and nerve roots run, (2) the canals at the base or roots of nerves branching out from the spinal cord, or (3) the openings between vertebrae (bones of the spine) through which nerves leave the spine and go to other parts of the body. The narrowing may involve a small or large area of the spine. Pressure on the lower part of the spinal cord or on nerve roots branching out from that area may give rise to pain or numbness in the legs. Pressure on the upper part of the spinal cord (that is, the neck area) may produce similar symptoms in the shoulders, or even the legs..."
Information in Medical Policies

► CLINICAL EVIDENCE Ultrasound Guidance Galiano et al. (2007) compared ultrasound guided facet joint injections with CT-controlled interventions in a prospective randomized clinical trial. Forty adult patients with chronic low back pain were evenly assigned either to an ultrasound or CT-group. The primary outcomes were accuracy and time to final needle placement. Of the patients randomized to ultrasound, 18 were judged to be feasible for an ultrasound approach. In 16 of these patients, the facet joints were clearly visible. In the 2 patients not judged to be feasible for the ultrasound approach, CT placement was performed due to inability to visualize the facet joint. For the ultrasound group, the space to be injected was identified within 5mm of the joint space. All of the needle placements were confirmed by CT. The duration of procedure and radiation dose was 14.3 +/- 6.6 minutes and 14.2 +/- 11.7 mGy.cm in the ultrasound group, and 22.3 +/- 6.3 minutes and 364.4 +/- 213.7 mGy.cm in the CT group. Both groups showed an effect from facet joint injections, demonstrating accurate needle placement. No difference between groups was detected. The authors concluded that the ultrasound approach to the facet joints is feasible and has minimal risk in the large majority of patients and results in a significant time and radiation dose reduction. The study is limited by small sample size. In addition, if the depth of the facet joint is greater than 8cm, visualization is not feasible with ultrasound. CT guidance is reliable and straightforward in 100% of patients regardless of their physical constitution. The fact that CT requires multiple imaging slices accounts for the increase in radiation exposure. Another study by Galiano et al. (2005) was limited to cadaver studies.

Information in Medical Policies

► Professional Societies American College of Radiology (ACR): Current recommendations from the ACR regarding diagnosis of causes of chronic back pain state that facet injection is useful for patients with multilevel disease diagnosed by any imaging modality to identify the specific level(s) producing symptoms. (Daffner, 2005) American Society of Interventional Pain Physicians (ASIPP): Evidence-Based Practice Guidelines in the Management of Chronic Spinal Pain state that during the diagnostic phase, a patient may receive 2 injections at intervals of no sooner than one week or preferably 2 weeks. In the therapeutic phase (after the diagnostic phase is completed), the suggested frequency would be 2-3 months or longer between injections, provided that ≥ 50% relief is obtained for 8 weeks. For medial branch neurotomy, the suggested frequency would be 6 months or longer (maximum of 2 times per year) between each procedure, provided that 50% or greater relief is obtained for 10 to 12 weeks. (Manchikanti et al., 2009)
Professional Societies American Society of Anesthesiologists (ASA): As of 2010, the ASA has not issued a statement specifically on the use of epidural steroids for the management of low back pain and/or sciatica. However, the ASA Task Force on Pain Management issued more general practice guidelines for chronic pain management. The 2010 ASA guidelines recommended that: Epidural steroid injections with or without local anesthetics may be used as part of a multimodal treatment regimen to provide pain relief in selected patients with radicular pain or radiculopathy. Transforaminal epidural injections should be performed with appropriate image guidance to confirm correct needle position and spread of contrast before injecting a therapeutic substance.

American Academy of Neurology (AAN): In 2007 (Armon, 2007), the Therapeutics and Technology Assessment Subcommittee of the AAN released an assessment addressing the use of epidural steroid injections (ESIs) to treat radicular lumbosacral pain. • Epidural steroid injections may result in some improvement in radicular lumbosacral pain when determined between 2 and 6 weeks following the injection, compared to control treatment (Level C, Class I to III evidence). The average magnitude of effect is small, and the generalizability of the observation is limited by the small number of studies, limited to highly selected patient populations, the few techniques and doses studied, and variable comparison treatments. • In general, epidural steroid injections for radicular lumbosacral pain have shown no impact on average impairment of function, on need for surgery, or on long-term pain relief beyond 3 months. Their routine use for these indications is not recommended (Level B, Class I to III evidence). • Data on use of epidural steroid injections to treat cervical radicular pain are inadequate to make any recommendation (Level U).
American Society of Interventional Pain Physicians (ASIPP): Guidelines on chronic spinal pain from the American Society of Interventional Pain Physicians reported by Manchikanti et al (2013) state that the evidence for caudal epidural, interlaminar epidural, and transforaminal epidural injections is good in managing disc herniation or radiculitis; fair for axial or discogenic pain without disc herniation, radiculitis or facet joint pain with caudal and lumbar interlaminar epidural injections, and limited with transforaminal epidural injections; fair for spinal stenosis with caudal, interlaminar, and transforaminal epidural injections; and fair for post surgery syndrome with caudal epidural injections and limited with transforaminal epidural injections. The guideline noted further, the recommendation for epidural injections for disc herniation is that one of the 3 approaches may be used; for spinal stenosis any of the 3 approaches are recommended; whereas for axial or discogenic pain, either lumbar interlaminar or caudal epidural injections are recommended. However for transforaminal the evidence is limited for axial or discogenic pain and post surgery syndrome. Regarding cervical interlaminar epidural injections, the guideline noted the evidence is good for cervical disc herniation or radiculitis; whereas it is fair for axial or discogenic pain, pain of spinal stenosis, and pain of post cervical surgery syndrome. Cervical interlaminar epidural injections are recommended for patients with chronic neck and upper extremity pain secondary to disc herniation, spinal stenosis, and post cervical surgery syndrome.

Applying the knowledge.

- Look up the information on the Medicare and the major carrier websites on the procedures you perform most in your practice.
- Educate your physicians and billing & coding staff on the policies.
- Inform patients if they wish to proceed with a procedure that is not covered by their policy because of medical necessity, they will be liable for the charge. (signed ABN).
- Use these policies to appeal your claims when you’ve followed their guidelines.
Q & A

Presenter:

- Debbie Forde, CPC, CMC, CMCO, CPCO, CPMA