2020

Medical Billing Training: Certified Professional Biller (CPB™)

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Chapter 7

Medical Necessity

Health insurance companies only cover services they define as medically necessary. Medical necessity is defined differently by different entities.

According to § 1862(a)(1)(A) of the Social Security Act, Medicare will not cover services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

The American Medical Association's (AMA) Model Managed Care Contract contains a definition of medically necessary services as "Healthcare services or procedures that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician or other healthcare provider."

Basically, medical necessity is a decision made by a health plan as to whether a treatment, test, or procedure is necessary for a patient's health or to treat a diagnosed medical problem.

Medicare releases National Coverage Determinations (NCDs) and the Medicare Administrative Contractors (MACs) release Local Coverage Determinations (LCDs) to state whether an item or service will be considered medically necessary. The National Correct Coding Initiative (NCCI) is released by the Centers for Medicare & Medicaid Services (CMS) to indicate codes considered to be bundled for procedures and services deemed necessary to accomplish a major procedure. Medically Unlikely Edits (MUEs) are released by CMS to indicate the number of units that can be reported for a service or procedure on the same day.

The objectives for this chapter include:

- Understanding the purpose of the NCCI
- Recognize the modifiers that are applicable with NCCI edits
- Determine how Medicaid utilizes the NCCI edits differently from CMS
- Identify the purpose of NCDs
- Understand LCDs and how they differ from NCDs

National Correct Coding Initiative (NCCI/CCI)

NCCI, also shortened to CCI, is an automated edit system used to indicate specific CPT® code pairs and whether they can be reported on the same date of service for the same beneficiary by the same provider. CMS implemented the NCCI to promote correct coding methodologies and to control improper assignment of codes resulting in inappropriate reimbursement. NCCI coding policies are based on:

- analysis of standard medical and surgical practice
- coding conventions included in CPT®
- coding guidelines developed by national medical specialty societies through the CPT® Advisory Committee (committee members include representatives of major medical societies)
- local and national coverage determinations
- a review of current coding practices

The edits are updated quarterly by CMS, and the policy manual is updated annually.

NCCI is used by professional coders and billers to determine codes considered by CMS to be bundled for procedures and services deemed necessary to accomplish a major procedure. Bundled procedure codes are not reported separately. The components of a bundled procedure are included in the comprehensive procedure code.

BILLING TIP

Beware: reporting bundled procedure codes in addition to the major procedure code is characterized as unbundling and, if repeated with enough frequency, could be considered an act of fraud.

Local CMS carriers, (Medicare Administrative Contractors) began using the NCCI edits on January 1, 1996. Since October 2010, the Patient Protection and Affordable Care Act § 6507 (ACA) required state Medicaid programs to incorporate NCCI methodologies into their claims processing. Many commercial health plans also utilize the NCCI edits in their claims processing.

MACs are entities (third party payers, insurance companies) that contract with the federal government to adjudicate and process claims in the geographical region for which they have been given jurisdiction. The MAC is responsible for making coverage decision policies and protecting the integrity of the Medicare program. Each MAC and the jurisdiction they are responsible for may have differing policies.

BILLING TIP

It is critical for billers to know what jurisdiction they are in and the policies of the MAC responsible for processing claims in that jurisdiction. The contracts can be reassigned periodically to a different MAC, which can cause the policies to change.

NCCI edits were originally developed to assist MACs in processing Medicare Part B claims. In August of 2000, NCCI edits were added to the Outpatient Code Editor (OCE) to assist MACs in processing Part B claims for outpatient hospital services.

The NCCI includes two types of edits:

1. Procedure to Procedure (PTP) edits

   PTP edits apply to code pairs that should not be billed together because one service inherently includes the other. In certain situations, an appropriate modifier may be allowed and used.

   Mutually exclusive edits (MEE) are included in the PTP edits. These edits include code pairs that, for clinical reasons, are unlikely to be performed on the same patient on the same date of service. For example, two different types of laboratory testing that would produce the same result as one test.

2. Medically Unlikely Edits (MUEs)

   MUEs indicate a maximum number of Units of Service (UOS) allowable under most circumstances for a single CPT® or HCPCS Level II code billed by a provider on a single date of service for a beneficiary.

The NCCI is composed of two provider-type choices of code pair edits and three provider-type choices of MUEs.

PTP Code Pair Edits

- NCCI Edits—Practitioners: code pair edits applied to claims submitted by physician, non-physician practitioners, and Ambulatory Surgery Centers (ASCs).
- NCCI Edits—Hospital: code pair edits applied to Types of Bills (TOBs) subject to the OCE—Hospitals, Skilled Nursing Facilities, Home Health Agencies, Outpatient Physical Therapy and Speech-Language Pathology Providers, and Comprehensive Outpatient Rehabilitation Facilities.
- MUEs

1. Practitioner MUEs: All physician and other practitioner claims are subject to these edits.
2. Durable Medical Equipment (DME) Supplier MUEs: These edits are applied to claims submitted to DME MACs. (At this time, this file will include HCPCS A-B and E-V codes, in addition to HCPCS codes under the DME MAC jurisdiction.)
3. Facility Outpatient MUEs: Claims for TOB 13X, 14X, and Critical Access Hospitals (85X) are subject to these edits.

Many NCCI edits are based on the standards of medical/surgical care. Services integral to another service are considered component parts of the more comprehensive service. The comprehensive codes are placed in column 1 and the component codes in column 2. Some services integral to many procedures include:

- Cleaning, shaving, and prepping of skin
- Draping and positioning the patient
- Insertion of urinary catheter
- Surgical approach
- Surgical cultures
- Surgical closure

According to the NCCI Policy Manual, there are general principles that can be applied to the edits:

1. The component (column 2) service is an accepted standard of care when performing the comprehensive (column 1) service.
2. The component service is usually necessary to complete the comprehensive service.
3. The component service is not a separately distinguishable procedure when performed with the comprehensive service.

Specific examples of services that are not separately reportable because they are components of more comprehensive services include:

Medical: Since a cardiac stress test (codes 93015-93018) includes multiple electrocardiograms, an electrocardiogram (code 93005 or 93010) is not separately reportable.

Surgical: Since a myringotomy (code 69421) requires access to the tympanic membrane (ear drum) through the external auditory canal (EAC), removal of impacted cerumen (code 69210) from the EAC is not separately reportable.

The component elements of the preoperative and postoperative work for each procedure are included component services of that procedure as a standard of medical/surgical practice. These include:

- insertion of a central venous access device
- cardiopulmonary monitoring
- exposure and exploration of the surgical field

Consider this portion of the table:

Column 1/Column 2 Edits						
Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
11042	10060		19960101	*	1	Standards of medical / surgical practice
11042	11000		19960101	*	1	Standards of medical / surgical practice
11042	11001		19960101	19960101	9	Standards of medical / surgical practice
11042	11008		20160701	*	1	CPT® code book or CMS manual coding instructions
11042	11010		19980101	*	1	Mutually exclusive procedures
11042	11011		19980101	*	1	Mutually exclusive procedures
11042	11040	*	19960101	20101231	1	HCPCS/CPT® procedure code definition
11042	11041	*	19960101	20101231	1	HCPCS/CPT® procedure code definition
11042	11719		19990401	*	1	Standards of medical/ surgical practice
11042	11720		19980101	*	1	Standards of medical surgical practice
11042	11721		19980101	*	1	Standards of medical/ surgical practice
11043	62320		20170101	*	0	Standards of medical/ surgical practice
11043	62321		20170101	*	0	Standards of medical/ surgical practice

The Correct Coding file formats continue to include a Correct Coding Modifier (CCM) indicator (carrier only) for both the Comprehensive/Component Table. This indicator determines whether a CCM causes the code pair to bypass the edit. This indicator will be either "0," "1," or "9." The definitions of each are:

0 = A CCM is not allowed and will not bypass the edits.

1 = A CCM is allowed and will bypass the edits.

9 = This indicator means that an NCCI edit does not apply to this PTP code pair. The edit for this PTP code pair was deleted retroactively.

Reference the table for the examples

Code 11043, *Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq. cm or less* can never be billed with codes 62320, *Injection(s), of diagnostic or therapeutic substance(s)…cervical or thoracic*, or 62321, *Injection(s), of diagnostic or therapeutic substance(s)…cervical or thoracic; with imaging guidance.* Because the CCM indicator is 0, no modifier can be used to bypass the edits. In other words, you cannot bill these two codes together.

Code11042, *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 square cm or less* may be billed with code 11720, *Debridement of nail(s) by any method(s); 1 to 5*, by appending modifier 59 if supported by the documentation. This is supported with the CCM indicator 1. The modifier is added to the column 2 code (in this case code 11720).

Code11042, *Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 square cm or less* and code 11001, *Debridement of extensive eczematous or infected skin; each additional 10% of the body surface* have an indicator of 9. This indicator means that an NCCI edit does not apply.

BILLING TIP

When a payer denies a procedure or service as inclusive to (or included in) another procedure, first review the bundling edits to see if these two procedures are bundled. If a modifier is allowed, separate the two procedures and make sure documentation is available to support the billing of both procedures. Many payers utilize the NCCI edits and add their own edits to the NCCI edits. The provider's contract with the insurance payer may also stipulate bundling edits.

Section Review 7.1

1. Based on this portion of the NCCI table, which statement is correct?

Column 1/Column 2 Edits						
Column 1	**Column 2**	*** = In existence prior to 1996**	**Effective Date**	**Deletion Date *=no data**	**Modifier 0=not allowed 1=allowed 9=not applicable**	**PTP Edit Rationale**
11042	11000		19960101	*	1	Standards of medical/surgical practice

   A. 11000 can never be reported with 11042
   B. When 11042 is reported, 11000 should be reported as an add-on code
   C. 11000 can be reported with 11042 when circumstances qualify for an NCCI modifier
   D. NCCI edits do not apply to the code pair 11042 & 11000

2. Which of the following statements is TRUE about medical necessity?

   A. Medical necessity is determined by the physician that provides care to the patient.
   B. Medicare will reimburse for any services provided by the physician.
   C. Medical necessity is a determination that decides if a service has been reported on the correct claim form.
   D. Medical necessity is a determination made by the payer to decide if a service is necessary for treatment or to diagnose a patient.

3. Who were the NCCI edits originally developed to be used by?

   A. Commercial Carriers
   B. Medicare Administrative Contractors
   C. Self-pay patients
   D. Medicare beneficiaries

4. The NCCI edits have Column 1 and Column 2 codes and provide an indicator to determine whether a modifier can be used. Which indicator is used to tell the biller a modifier is never allowed?

   A. 0
   B. 1
   C. 9
   D. A

5. Services that are a standard of medical/surgical practice are:

   A. Integral and included in the procedure
   B. Separately billable
   C. Can use a modifier to allow reimbursement
   D. Depend on documentation

Modifiers and NCCI Edits

HCPCS Level II or CPT® modifiers may be used to bypass the NCCI edits in certain circumstances when appropriate. It is important as a biller to understand modifier usage. This allows for proper appeals to be filed when warranted and to understand when a write-off should be done instead. The reimbursement process will be delayed if an appropriate modifier was warranted but not appended. Not understanding correct modifier usage will cause an initial denial and require extra work to rebill and receive appropriate payment.

The modifiers that may be used to bypass the NCCI edits include:

- Anatomic modifiers: E1-E4, FA, F1-F9, TA, T1-T9, LT, RT, LC, LD, RC, LM, RI
- Global surgery modifiers: 24, 25, 57, 58, 78, 79
- Other modifiers: 27, 59, 91, XE, XS, XP, XU

Modifiers 76 *Repeat procedure or service by same physician or other qualified healthcare professional*, and 77 *Repeat procedure or service by another physician or other qualified healthcare professional* are not NCCI edit modifiers and cannot be used to bypass edits.

- E1-E4 describe upper and lower, right and left eyelids (different anatomic sites)
- FA, F1-F9 describe left and right hands, and specific fingers of each (different anatomic sites)
- TA, T1-T9 describe left and right foot with each specific toe of each (different anatomic sites)

EXAMPLE

A patient has a complete, permanent removal of a deformed toenail on bilateral great toes. Code 11750 was billed twice, one for each toe and the claim was denied as a duplicate. By adding modifier TA (left great toe) and T5 (right great toe) to indicate different anatomic sites (duplication of code), the claim should be paid.

The NCCI Policy Manual discusses NCCI modifiers 25, 58, and 59 specifically.

Modifier 25

Modifier 25, *Significant, separately identifiable evaluation and management service by the same physician or other qualified healthcare professional on the same day of the procedure or other service*

This modifier is appended to minor procedures with either 000 or 010 global days, or procedures not covered by global surgery rules (XXX global indicator). A separate E/M should not be billed automatically with a minor procedure or an XXX procedure. The pre-procedure, intra-procedure, and post-procedure work are included. The Medicare Global Surgery rules also prohibit the reporting of an E/M service for the work associated with the decision to perform a minor procedure whether the patient is new or established.

EXAMPLE

A patient sees his family provider for follow up of his hypertension, hyperlipidemia, and depression. He also has a skin lesion he wants the provider to look at. The provider performs a detailed history, and detailed exam, and moderate medical decision making (99214) for the hypertension, hyperlipidemia, and depression. In addition, the provider looks at the lesion on his arm. The skin lesion is slightly irritated and erythematous. The provider determines it is a benign neoplasm and removes it with an excised diameter of 1.8 cm (11402).

The NCCI edits show:

Column1/Column 2 Edits						
Column 1	**Column 2**	*** = In existence prior to 1996**	**Effective Date**	**Deletion Date *=no data**	**Modifier 0=not allowed 1=allowed 9=not applicable**	**PTP Edit Rationale**
11402	99214		20130701	*	1	CPT® Manual or CMS manual coding instructions

The CCM modifier 1 indicates the two codes can be reported together if a modifier applies. In this case, both an evaluation and management service (99214) and the procedure (11402) were significant, separately identifiable services. The codes that should be assigned are 11402, 99214-25. Modifier 25 may only be appended to E/M codes, not procedure codes. Modifier 25 indicates the evaluation and management service was separately identifiable from the work performed for the procedure. Otherwise, the E/M code is typically denied as inclusive to the procedure. When appending modifier 25, documentation must support two separately identifiable services.

In the above situation, the diagnosis code used for the procedure and the diagnosis used for the E/M code will be different. This will support medical necessity and the use of modifier 25. The use of a different diagnosis code is not required for modifier 25 but does apply in this situation. Ensure that the correct diagnosis code is attached to the correct CPT® code. For this example, report the following:

99214-25	I10, E78.5, F32.9
11402	D23.60

BILLING TIP

The NCCI edits state, "In general E&M services on the same date of service as the minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure and should not be reported separately as an E&M service." This statement supports the necessity for the evaluation and management service to be separate from the surgical procedure to be reported separately.

Modifier 58

Modifier 58, *Staged or related procedure or service by the same physician or other qualified healthcare professional during the postoperative period*. The NCCI Policy Manual addresses the use of modifier 58 with endoscopic procedures. A diagnostic procedure resulting in a decision to perform an open procedure is separately reportable, unless it is a "scout" endoscopy to assess anatomic landmarks and/or extent of disease.

The NCCI does not contain all edits regarding bundling of laparoscopic procedures into open procedures because the number of possible code combinations is too great. The policy manual states that the basic principle that any planned endoscopic procedure that fails and is converted to an open procedure is not separately reportable. It does not matter whether there is an NCCI edit.

Diagnostic endoscopies are also not separately reportable with another endoscopic procedure of the same organ(s) when performed at the same encounter, or with a surgical endoscopic procedure of the same body cavity when performed at the same encounter.

EXAMPLE

A patient is brought to the surgical suite for a laparoscopic appendectomy. After the procedure is initiated, the procedure is converted to an open appendectomy. The appropriate code assignment is 44950, *Appendectomy, only*. Code 44970, *Laparoscopy, surgical, appendectomy,* according to the NCCI edits would not be reported in addition.

Column1/Column 2 Edits						
Column 1	**Column 2**	*** = In existence prior to 1996**	**Effective Date**	**Deletion Date *=no data**	**Modifier 0=not allowed 1=allowed 9=not applicable**	**PTP Edit Rationale**
44950	44970		20130101	*	0	CPT® code book or CMS manual coding instructions

According to the NCCI edits, code 44970 is included in code 44950. The CCM 0 indicates it is not allowed under any circumstance.

CMS (Medicare, Medicaid, federal payers) does not pay for two procedures when a laparoscopic procedure is converted to an open procedure. CMS will reimburse for the most extensive procedure. This is reflected by the inclusion of the Column 2 code (44970, laparoscopic) stating it is bundled into the Column 1 code (44950, open appendectomy).

Modifier 59

Modifier 59 *Distinct procedural service*

The NCCI Policy Manual reiterates the CPT® code book's definition: "Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate, it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. Note: Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25." If one of the specific anatomic modifiers (RT, LT, E1-E4, etc.) may be assigned, it should be used instead of modifier 59.

Effective January 1, 2015 from Pub 100-20, Transmittal 1422

CMS has defined four new HCPCS modifiers to selectively identify subsets of modifier 59 Distinct *Procedural Service*. These are in the CPT® manual in Appendix A as Level II HCPCS/National Modifiers and are referred to as X[ESPU] modifiers. The abbreviation represents the separate Encounter, Structure, Practitioner, and Unusual service.

They are listed as follows:

XE - Separate Encounter: A service that is distinct because it occurred during a separate encounter. (This modifier is used to describe a separate encounter on the same date of service.)

XS - Separate Structure: A service that is distinct because it was performed on a separate organ/structure.

XP - Separate Practitioner: A service that is distinct because it was performed by a different practitioner.

XU - Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service.

These modifiers are subsets of modifier 59 and are used to be more descriptive or more specific than modifier 59. CMS will continue to recognize the use of modifier 59. Beginning January 1, 2015 CMS began accepting either the X[ESPU] modifiers or modifier 59. However, they encourage migration of the modifiers. There will be NCCI edits that will specify that the X[ESPU] modifiers would be more appropriate, thereby making the claim payable with X[ESPU] modifiers and not with modifier 59.

BILLING TIP

The X[ESPU] modifiers are more specific than modifier 59. Both modifiers should never be used on the same claim form.

EXAMPLE

A physician performs a colonoscopy. She removes one lesion in the splenic flexure by hot biopsy forceps (45384) and another lesion in the descending colon by snare technique (45385).

Column 1/Column 2 Edits						
Column 1	**Column 2**	*** = In existence prior to 1996**	**Effective Date**	**Deletion Date *=no data**	**Modifier 0=not allowed 1=allowed 9=not applicable**	**PTP Edit Rationale**
45385	45384		20040101	*	1	Mutually exclusive procedures

According to the NCCI edit, the hot biopsy forceps removal (45384) is considered inclusive to the snare removal. However, the CCM 1 indicates a modifier can be used to bypass the edits if supported by the documentation. Because the lesions were at different sites, modifier 59 is appropriate. The correct code assignment would be 45384-59, Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps, and 45385, Colonoscopy, flexible; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique. If the payer recognizes the subset of modifier 59, modifier XS would be appropriate to show the separate structure or location.

EXAMPLE OF XU MODIFIER

Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
17000	11102		20190101	*	1	CPT® code book or CMS manual coding instructions

A physician performs a biopsy of a skin lesion on the right side of the patient's forehead (11102) and uses cryotherapy to destroy a lesion in the left side of the patient's forehead (17000).

NCCI edits Column 2 code 11102 is a component of (included in) Column 1 code 17000. As seen above, a modifier is allowed. Based on the X[ESPU] modifier guidelines XU would be appropriate to indicate the lesions, although on the same body part, are not overlapping or are not on contiguous locations. The provider reports codes 17000, 11102-XU.

Medicaid and NCCI

As stated earlier, the ACA requires Medicaid to utilize the NCCI edits. CMS allows states to deactivate edits that conflict with state laws, regulations, administrative rules, payment policies, and/or level of operational readiness.

The Medicaid NCCI program consists of six methodologies:

1. A methodology with Procedure-to-Procedure (PTP) edits for practitioner and ambulatory surgical center (ASC) services
2. A methodology with PTP edits outpatient hospital services
3. A methodology with PTP edits for durable medical equipment
4. A methodology with MUEs for practitioner and ASC services
5. A methodology with MUEs for outpatient hospital services for hospitals
6. A methodology with MUEs for durable medical equipment

The Medicaid NCCI edits apply only to Medicaid fee-for-service claims reimbursed for HCPCS/CPT® codes.

Each of the Medicaid NCCI methodologies has four components:

1. A set of edits
2. Definitions of types of claims subject to the edits
3. A set of claim adjudication rules for applying the edits
4. A set of rules for addressing provider appeals of denied payments for services based on the edits

Medically Unlikely Edits (MUEs)

To help reduce the paid claims error rate for Medicare Part B claims, CMS developed Medically Unlikely Edits (MUEs). MUEs define the maximum units of service that a provider would report, under most circumstances, for a single beneficiary, on a single date of service, for a specific HCPCS/CPT® code.

BILLING TIP

If a code is denied for MUE, the Advanced Beneficiary Notice is not applicable, and the patient cannot be billed.

Below is a portion of the MUE table.

HCPCS/CPT® Code	Practitioner Services MUE Values	MUE Adjudication Indicator	MUE Rationale
52648	1	2 Date of Service Edit: Policy	Anatomic Consideration
52649	1	2 Date of Service Edit: Policy	Anatomic Consideration
52700	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
53000	1	2 Date of Service Edit: Policy	Anatomic Consideration
53010	1	2 Date of Service Edit: Policy	Anatomic Consideration
53020	1	2 Date of Service Edit: Policy	Anatomic Consideration
53025	1	2 Date of Service Edit: Policy	Anatomic Consideration
53040	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure
53060	1	3 Date of Service Edit: Clinical	Anatomic Consideration
53080	1	3 Date of Service Edit: Clinical	Nature of Service/Procedure

HCPCS/CPT® Code—This indicates the HCPCS Level II code or CPT® code.

Practitioner Services MUE Values—This indicates the number of units that may be billed for the HCPCS Level II code or CPT® code.

MUE Adjudication Indicator (MAI)—This indicates the type of MUE and its basis. An MAI of 2 indicates an edit for which the MUE is based on regulation or sub-regulatory instructions (policy), including the instruction that is inherent in the code descriptor or its applicable anatomy. An MAI of 3 indicates an edit for which the MUE is based on clinical information, such as billing patterns, prescribing instructions, or other information. MAI 3 is the most common per day edit.

MUE Rationale—This specifies the adjudication indicator as to whether it is due to anatomic consideration, nature of service, code descriptor or CPT® instruction, clinical data, or CMS policy.

In looking at the table above, CPT® code 52648 *Laser vaporization of prostate, including control of postoperative bleeding, complete,* can only be billed with one unit of service. It carries an MAI of 2, meaning the edit is due to policy. The rationale indicates the policy is due to anatomic consideration (a man only has one prostate).

The MUE Table can be found on the CMS website: https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/MUE.html

National Coverage Determinations (NCD) and Local Coverage Determinations (LCD)

The Medicare Coverage Database is a searchable database that contains all Medicare National Coverage Determinations (NCDs), National Coverage Analyses (NCAs), Local Coverage Determinations (LCDs), local articles, and other information. NCAs include proposed NCD decisions. The NCD is intended to be used by Medicare Contractors, providers, and other healthcare professionals.

NCDs' statutory and policy framework are based on § 1862 of Title XVIII of the Social Security Act and Medicare regulations and rulings. The NCD Manual indicates whether specific medical services, items, treatment procedures, or technologies can be paid for by Medicare. All decisions of denial of coverage are based on §1862(a)(1) of the Act unless otherwise specifically noted.

Medicare contractors are required to follow NCDs unless an NCD does not specifically exclude or limit an indication or circumstance, or if the item or service is not mentioned at all in either the NCD or a Medicare manual. In such circumstances, the Medicare contractor can make an LCD. NCDs and LCDs are updated as they are published.

An LCD is mandated at the Medicare Administrative Contractor (MAC) level. The guidelines given are only applicable to that specific MAC's jurisdiction. Medicare contractors develop the LCDs when there is no NCD or when there is a need to further define an NCD. Chapter 13 of the Medicare Program Integrity Manual contains the guidelines for LCD development. When there is an NCD and an LCD for the same procedure, the NCD takes precedence.

To see the differences, review the NCD and LCD below regarding magnetic resonance imaging.

National Coverage Determination for MRI

(Rev.135, Issued: 09-22-11, Effective: 07-07-11/02-24-11(CR 7296), Implementation: 09-26-11)

A. General

1. Method of Operation

Magnetic Resonance Imaging (MRI), formerly called nuclear magnetic resonance (NMR), is a non-invasive method of graphically representing the distribution of water and other hydrogen-rich molecules in the human body. In contrast to conventional radiographs or computed tomography (CT) scans, in which the image is produced by X-ray beam attenuation by an object, MRI can produce images by several techniques. In fact, various combinations of MRI image production methods may be employed to emphasize characteristics of the tissue or body part being examined. The basic elements by which MRI produces an image are the density of hydrogen nuclei in the object being examined, their motion, and the relaxation times, and the period of time required for the nuclei to return to their original states in the main, static magnetic field after being subjected to a brief additional magnetic field. These relaxation times reflect the physical-chemical properties of tissue and the molecular environment of its hydrogen nuclei. Only hydrogen atoms are present in human tissues in sufficient concentration for current use in clinical MRI.

Magnetic Resonance Angiography (MRA) is a non-invasive diagnostic test that is an application of MRI. By analyzing the amount of energy released from tissues exposed to a strong magnetic field, MRA provides images of normal and diseased blood vessels, as well as visualization and quantification of blood flow through these vessels.

2. General Clinical Utility

Overall, MRI is a useful diagnostic imaging modality that can demonstrate a wide variety of soft-tissue lesions with contrast resolution equal or superior to CT scanning in various parts of the body with high levels of tissue contrast resolution without injected iodinated radiological contrast agents. Recent advances in technology have resulted in development and Food and Drug Administration (FDA) approval of new paramagnetic contrast agents for MRI which allow even better visualization in some instances. Multislice imaging and the ability to image in multiple planes, especially sagittal and coronal, have provided flexibility not easily available with other modalities. Because cortical (outer layer) bone and metallic prostheses do not cause distortion of MR images, it has been possible to visualize certain lesions and body regions with greater certainty than has been possible with CT. The use of MRI on certain soft tissue structures for the purpose of detecting disruptive, neoplastic, degenerative, or inflammatory lesions has now become established in medical practice.

Phase contrast (PC) and time-of-flight (TOF) are some of the available MRA techniques at the time these instructions are being issued. PC measures the difference between the phases of proton spins in tissue and blood and measures both the venous and arterial blood flow at any point in the cardiac cycle. TOF measures the difference between the amount of magnetization of tissue and blood and provides information on the structure of blood vessels, thus indirectly indicating blood flow. Two-dimensional (2D) and three-dimensional (3D) images can be obtained using each method.

Contrast-enhanced MRA (CE-MRA) involves blood flow imaging after the patient receives an intravenous injection of a contrast agent. Gadolinium, a non-ionic element, is the foundation of all contrast agents in use. Gadolinium affects the way in which tissues respond to magnetization, resulting in better visualization of structures when compared to un-enhanced studies. Unlike ionic (for example, iodine-based) contrast agents used in conventional contrast angiography (CA), allergic reactions to gadolinium are extremely rare. Additionally, gadolinium does not cause the kidney failure occasionally seen with ionic contrast agents. Digital subtraction angiography (DSA) is a computer-augmented form of CA that obtains digital blood flow images as contrast agent courses through a blood vessel. The computer "subtracts" bone and other tissue from the image, thereby improving visualization of blood vessels. Physicians elect to use a specific MRA or CA technique based upon clinical information from each patient.

B. Nationally Covered MRI and MRA Indications

1. MRI

Although several uses of MRI are still considered investigational and some uses are clearly contraindicated (see subsection C), MRI is considered medically efficacious for a number of uses. Use the following descriptions as general guidelines or examples of what may be considered covered rather than as a restrictive list of specific covered indications. Coverage is limited to MRI units that have received FDA premarket approval, and such units must be operated within the parameters specified by the approval. In addition, the services must be reasonable and necessary for the diagnosis or treatment of the specific patient involved.

a. Effective November 22, 1985, MRI is useful in examining the head, central nervous system, and spine. Multiple sclerosis can be diagnosed with MRI and the contents of the posterior fossa are visible. The inherent tissue contrast resolution of MRI makes it an appropriate standard diagnostic modality for general neuroradiology.

b. Effective November 22, 1985, MRI can assist in the differential diagnosis of mediastinal and retroperitoneal masses, including abnormalities of the large vessels such as aneurysms and dissection. When a clinical need exists to visualize the parenchyma of solid organs to detect anatomic disruption or neoplasia, this can be accomplished in the liver, urogenital system, adrenals, and pelvic organs without the use of radiological contrast materials. When MRI is considered reasonable and necessary, the use of paramagnetic contrast materials may be covered as part of the study. MRI may also be used to detect and stage pelvic and retroperitoneal neoplasms and to evaluate disorders of cancellous bone and soft tissues. It may also be used in the detection of pericardial thickening. Primary and secondary bone neoplasm and aseptic necrosis can be detected at an early stage and monitored with MRI. Patients with metallic prostheses, especially of the hip, can be imaged to detect the early stages of infection of the bone to which the prosthesis is attached.

c. Effective March 22, 1994, MRI may also be covered to diagnose disc disease without regard to whether radiological imaging has been tried first to diagnose the problem.

d. Effective March 4, 1991, MRI with gating devices and surface coils, and gating devices that eliminate distorted images caused by cardiac and respiratory movement cycles are now considered state of the art techniques and may be covered. Surface and other specialty coils may also be covered, as they are used routinely for high resolution imaging where small limited regions of the body are studied. They produce high signal-to-noise ratios resulting in images of enhanced anatomic detail.

2. MRA (MRI for Blood Flow)

Currently covered indications include using MRA for specific conditions to evaluate flow in internal carotid vessels of the head and neck, peripheral arteries of lower extremities, abdomen and pelvis, and the chest. Coverage is limited to MRA units that have received FDA premarket approval, and such units must be operated within the parameters specified by the approval. In addition, the services must be reasonable and necessary for the diagnosis or treatment of the specific patient involved.

a. Head and Neck

Effective April 15, 2003, studies have proven that MRA is effective for evaluating flow in internal carotid vessels of the head and neck. However, not all potential applications of MRA have been shown to be reasonable and necessary. All the following criteria must apply in order for Medicare to provide coverage for MRA of the head and neck.

- MRA is used to evaluate the carotid arteries, the circle of Willis, the anterior, middle, or posterior cerebral arteries, the vertebral or basilar arteries or the venous sinuses;

- MRA is performed on patients with conditions of the head and neck for which surgery is anticipated and may be found to be appropriate based on the MRA. These conditions include tumor, aneurysms, vascular malformations, vascular occlusion or thrombosis. Within this broad category of disorders, medical necessity is the underlying determinant of the need for an MRA in specific diseases. The medical records should clearly justify and demonstrate the existence of medical necessity; and
- MRA and CA are not expected to be performed on the same patient for diagnostic purposes prior to the application of anticipated therapy. Only one of these tests will be covered routinely unless the physician can demonstrate the medical need to perform both tests.

b. Peripheral Arteries of Lower Extremities

Effective April 15, 2003, studies have proven that MRA of peripheral arteries is useful in determining the presence and extent of peripheral vascular disease in lower extremities. This procedure is non-invasive and has been shown to find occult vessels in some patients for which those vessels were not apparent when CA was performed. Medicare will cover either MRA or CA to evaluate peripheral arteries of the lower extremities. However, both MRA and CA may be useful in some cases, such as:

- A patient has had CA and this test was unable to identify a viable run-off vessel for bypass. When exploratory surgery is not believed to be a reasonable medical course of action for this patient, MRA may be performed to identify the viable runoff vessel; or
- A patient has had MRA, but the results are inconclusive.

c. Abdomen and Pelvis

i. Pre-operative Evaluation of Patients Undergoing Elective Abdominal Aortic Aneurysm (AAA) Repair

Effective July 1, 1999, MRA is covered for pre-operative evaluation of patients undergoing elective AAA repair if the scientific evidence reveals MRA is considered comparable to CA in determining the extent of AAA, as well as in evaluating aortoiliac occlusion disease and renal artery pathology that may be necessary in the surgical planning of AAA repair. These studies also reveal that MRA could provide a net benefit to the patient. If preoperative CA is avoided, then patients are not exposed to the risks associated with invasive procedures, contrast media, end-organ damage, or arterial injury.

ii. Imaging the Renal Arteries and the Aortoiliac Arteries in the Absence of AAA or Aortic Dissection

Effective July 1, 2003, MRA coverage is expanded to include imaging the renal arteries and the aortoiliac arteries in the absence of AAA or aortic dissection. MRA should be obtained in those circumstances in which using MRA is expected to avoid obtaining CA, when physician history, physical examination, and standard assessment tools provide insufficient information for patient management and obtaining an MRA has a high probability of positively affecting patient management. However, CA may be ordered after obtaining the results of an MRA in those rare instances where medical necessity is demonstrated.

d. Chest

i. Diagnosis of Pulmonary Embolism

Current scientific data has shown that diagnostic pulmonary MRAs are improving due to recent developments such as faster imaging capabilities and gadolinium-enhancement. However, these advances in MRA are not significant enough to warrant replacement of pulmonary angiography in the diagnosis of pulmonary embolism for patients who have no contraindication to receiving intravenous iodinated contrast material. Patients who are allergic to iodinated contrast material face a high risk of developing complications if they undergo pulmonary angiography or computed tomography angiography. Therefore, Medicare will cover MRA of the chest for diagnosing a suspected pulmonary embolism when it is contraindicated for the patient to receive intravascular iodinated contrast material.

ii. Evaluation of Thoracic Aortic Dissection and Aneurysm

Studies have shown that MRA of the chest has a high level of diagnostic accuracy for pre-operative and post-operative evaluation of aortic dissection of aneurysm. Depending on the clinical presentation, MRA may be used as an alternative to other non-invasive imaging technologies, such as transesophageal echocardiography and CT. Generally, Medicare will provide coverage only for MRA or for CA when used as a diagnostic test. However, if both MRA and CA of the chest are used, the physician must demonstrate the medical need for performing these tests.

While the intent of this policy is to provide reimbursement for either MRA or CA, CMS is also allowing flexibility for physicians to make appropriate decisions concerning the use of these tests based on the needs of individual patients. CMS anticipates, however, low utilization of the combined use of MRA and CA. As a result, CMS encourages contractors to monitor the use of these tests and, where indicated, require evidence of the need to perform both MRA and CA.

C. Contraindications and Nationally Non-Covered Indications

1. Contraindications

The MRI is not covered when the following patient-specific contraindications are present:

MRI is not covered for patients with cardiac pacemakers or with metallic clips on vascular aneurysms unless the Medicare beneficiary meets the provisions of the following exceptions:

Effective July 7, 2011, the contraindications will not apply to pacemakers when used according to the FDA-approved labeling in an MRI environment, or

Effective February 24, 2011, CMS believes the evidence is promising, although not yet convincing, that MRI will improve patient health outcomes if certain safeguards are in place to ensure that the exposure of the device to an MRI environment adversely affects neither the interpretation of the MRI result nor the proper functioning of the implanted device itself. We believe that specific precautions (as listed below) could maximize benefits of MRI exposure for beneficiaries enrolled in clinical trials designed to assess the utility and safety of MRI exposure. CMS determines that MRI will be covered by Medicare when provided in a clinical study under section 1862(a)(1)(E) (consistent with section 1142 of the Act) through the Coverage with Study Participation (CSP) form of Coverage with Evidence Development (CED) if the study meets the criteria in each of the three paragraphs below:

The approved prospective clinical study of MRI must, with appropriate methodology, address one or more aspects of the following questions:

1. Do results of MRI in implanted permanent pacemaker (PM)/implantable cardioverter defibrillator (ICD) beneficiaries with implanted cardiac devices affect physician decision making related to:

    a. Clinical management strategy (for example, in oncology, toward palliative or curative care);

    b. Planning of treatment interventions; or

    c. Prevention of unneeded diagnostic studies or interventions, or preventable exposures?

2. Do results of MRI in PM/ICD beneficiaries with implanted cardiac devices affect patient outcomes related to:

    a. Survival;

    b. Quality of life; or

    c. Adverse events during and after MR scanning?

In addition, the prospective clinical study of MRI must include safety criteria for all participants. Required safety measures for such studies, as further explained in guidance documents from professional societies must include, but are not limited to:

1. MRI should be done on a case-by-case and site-by-site basis.
2. MRI scan sequences, field intensity, and field(s) of exposure should be selected to minimize risk to the patient while gaining needed diagnostic information for diagnosis or for managing therapy.
3. MRI scanning should be done only if the site is staffed with individuals with the appropriate radiology and cardiology knowledge and expertise on hand.
4. Implanted device patients who are candidates for recruitment for an MRI clinical study should be advised that life-threatening arrhythmias might occur during MRI and serious device malfunction might occur, requiring replacement of the device.
5. Radiology and cardiology personnel and a fully stocked crash cart should be readily available throughout the procedure in case a significant arrhythmia develops during the examination that does not terminate with the cessation of the MRI study. The cardiologist should be familiar with the patient's arrhythmia history and the implanted device. A programmer that can be used to adjust the device as necessary should be readily available.
6. All such patients should be actively monitored for cardiac and respiratory function throughout the examination. At a minimum, ECG and pulse oximetry should be used. Visual and verbal contact with the patient must be maintained throughout the MRI scan. The patient should be instructed to alert the MRI staff on hand to any unusual sensations, pains, or to any problems.
7. At the conclusion of the examination, the cardiologist should examine the device to confirm that the function is consistent with its pre-examination state.
8. Follow-up should include a check of the patient's device at a time remote (1–6 weeks) after the scan to confirm appropriate function.
9. If the implanted device manufacturer has indicated additional safety precautions appropriate for safe MRI performance, these must be included in the study protocol.

The clinical study must adhere to the following standards of scientific integrity and relevance to the Medicare population:

a. The principal purpose of the research study is to test whether a particular intervention potentially improves the participants' health outcomes.

b. The research study is well supported by available scientific and medical information or it is intended to clarify or establish the health outcomes of interventions already in common clinical use.

c. The research study does not unjustifiably duplicate existing studies.

d. The research study design is appropriate to answer the research question being asked in the study.

e. The research study is sponsored by an organization or individual capable of executing the proposed study successfully.

f. The research study follows all applicable federal regulations concerning the protection of human subjects found at 45 CFR Part 46. If a study is regulated by the FDA, it must comply with 21 CFR Parts 50 and 56.

g. All aspects of the research study are conducted according to appropriate standards of scientific integrity (see http://www.icmje.org).

h. The research study has a written protocol that clearly addresses, or incorporates by reference, the standards listed here as Medicare requirements for CED coverage.

i. The clinical research study is not designed to exclusively test toxicity or disease pathophysiology in healthy individuals. Trials of all medical technologies measuring therapeutic outcomes as one of the objectives meet this standard only if the disease or condition being studied is life threatening as defined in 21 CFR § 312.81(a) and the patient has no other viable treatment options.

j. The clinical research study is registered on the https://ClinicalTrials.gov website by the principal sponsor/investigator prior to the enrollment of the first study subject.

k. The research study protocol specifies the method and timing of public release of all pre-specified outcomes to be measured, including release of outcomes if outcomes are negative or study is terminated early. The results must be made public within 24 months of the end of data collection. If a report is planned to be published in a peer reviewed journal, then that initial release may be an abstract that meets the requirements of the International Committee of Medical Journal Editors (http://www.icmje.org). However, a full report of the outcomes must be made public no later than three years after the end of data collection.

l. The research study protocol must explicitly discuss subpopulations affected by the treatment under investigation, particularly traditionally underrepresented groups in clinical studies, how the inclusion and exclusion criteria effect enrollment of these populations, and a plan for the retention and reporting of said populations in the trial. If the inclusion and exclusion criteria are expected to have a negative effect on the recruitment or retention of underrepresented populations, the protocol must discuss why these criteria are necessary.

m. The research study protocol explicitly discusses how the results are or are not expected to be generalizable to the Medicare population to infer whether Medicare patients may benefit from the intervention. Separate discussions in the protocol may be necessary for populations eligible for Medicare due to age, disability, or Medicaid eligibility.

Consistent with section 1142 of the Act, the Agency for Healthcare Research and Quality (AHRQ) supports clinical research studies that CMS determines meet the above-listed standards and address the above-listed research questions.

- MRI during a viable pregnancy is also contraindicated at this time.
- The danger inherent in bringing ferromagnetic materials within range of MRI units generally constrains the use of MRI on acutely ill patients requiring life support systems and monitoring devices that employ ferromagnetic materials.
- In addition, the long imaging time and the enclosed position of the patient may result in claustrophobia, making patients who have a history of claustrophobia unsuitable candidates for MRI procedures.

2. Nationally Non-Covered Indications

CMS has determined that MRI of cortical bone and calcifications, and procedures involving spatial resolution of bone and calcifications, are not considered reasonable and necessary indications within the meaning of section 1862(a)(1)(A) of the Act and are therefore non-covered.

D. Other

Effective June 3, 2010, all other uses of MRI or MRA for which CMS has not specifically indicated coverage or non-coverage continue to be eligible for coverage through individual local contractor discretion.

Source: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_part4.pdf

Local Coverage Determination (LCD): MRI and CT Scans of the Head and Neck (L35175)

Links in PDF documents are not guaranteed to work. To follow a web link, please use the MCD Website.

Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATE(S)
Noridian Healthcare Solutions, LLC	A and B MAC	02101 - MAC A	J - F	Alaska
Noridian Healthcare Solutions, LLC	A and B MAC	02102 - MAC B	J - F	Alaska
Noridian Healthcare Solutions, LLC	A and B MAC	02201 - MAC A	J - F	Idaho
Noridian Healthcare Solutions, LLC	A and B MAC	02202 - MAC B	J - F	Idaho
Noridian Healthcare Solutions, LLC	A and B MAC	02301 - MAC A	J - F	Oregon
Noridian Healthcare Solutions, LLC	A and B MAC	02302 - MAC B	J - F	Oregon
Noridian Healthcare Solutions, LLC	A and B MAC	02401 - MAC A	J - F	Washington
Noridian Healthcare Solutions, LLC	A and B MAC	02402 - MAC B	J - F	Washington
Noridian Healthcare Solutions, LLC	A and B MAC	03101 - MAC A	J - F	Arizona
Noridian Healthcare Solutions, LLC	A and B MAC	03102 - MAC B	J - F	Arizona
Noridian Healthcare Solutions, LLC	A and B MAC	03201 - MAC A	J - F	Montana
Noridian Healthcare Solutions, LLC	A and B MAC	03202 - MAC B	J - F	Montana
Noridian Healthcare Solutions, LLC	A and B MAC	03301 - MAC A	J - F	North Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03302 - MAC B	J - F	North Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03401 - MAC A	J - F	South Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03402 - MAC B	J - F	South Dakota
Noridian Healthcare Solutions, LLC	A and B MAC	03501 - MAC A	J - F	Utah
Noridian Healthcare Solutions, LLC	A and B MAC	03502 - MAC B	J - F	Utah
Noridian Healthcare Solutions, LLC	A and B MAC	03601 - MAC A	J - F	Wyoming
Noridian Healthcare Solutions, LLC	A and B MAC	03602 - MAC B	J - F	Wyoming

LCD Information

Document Information

LCD ID
L35175

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For services performed on or after 10/01/2015

LCD Title

Revision Effective Date

MRI and CT Scans of the Head and Neck

Proposed LCD in Comment Period
N/A

Source Proposed LCD
DL35175

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For services performed on or after 10/01/2019

Revision Ending Date
N/A

Retirement Date
N/A

Notice Period Start Date
08/23/2018

Notice Period End Date
10/07/2018

CMS National Coverage Policy

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

Title XVIII of the Social Security Act, Section 1862(a)(1)(A) allows coverage and payment for only those services

that are considered reasonable and necessary.

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

Title XVIII of the Social Security Act, Section 1862(a)(1)(D) prohibits Medicare payment for services and items that are experimental or investigational.

CMS publication 100-3, *Medicare National Coverage Determinations*, Sections 220.1 "Computerized Tomography", and 220.2-220.2.B.2d and Section 220.2.C-220.2.D "Magnetic Resonance Imaging".

Denies coverage of MRI for:

1. Imaging of cortical bone and calcification;
2. Procedures involving spatial resolution of bone or calcification;
3. MRI is not covered for patients with metallic clips on vascular aneurysms

CMS publication 100-04 *Medicare Claims* Processing Manual Chapter 13 Section 40.

Denies coverage of MRI for:

1. Measurement of blood flow and spectroscopy

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Note: Providers should seek information related to National Coverage Determinations (NCD) and other Centers for Medicare & Medicaid Services (CMS) instructions in CMS Manuals. This LCD only pertains to the contractor's discretionary coverage related to this service.

This policy addresses standard CT and MR imaging. *Magnetic Resonance Angiography (MRA) is not addressed in this policy.*

Computerized Tomography (CT)
Computerized tomography (CT scanning) uses the attenuation of an x-ray beam by an object in its path to create cross-sectional images. As x-rays pass through planes of the body, the photons are detected and recorded as they exit from different angles. Computers process the signals to produce a cross-sectional view of the body. The signal data may be subjected to a variety of post-acquisitional processing algorithms to obtain a multiplanar view of the anatomy.

The use of the CT scan must be found medically appropriate considering the patient's symptoms and preliminary diagnosis.

A. A CT scan is considered reasonable and necessary for the patient when the diagnostic exam is medically appropriate given the patient's symptoms and preliminary (or provisional) diagnosis.
B. CT scans (as opposed to MRI evaluations) are used effectively in the following situations or conditions:

1. Patients who are not suitable candidates for MRI evaluation:
    a. Because of a pacemaker or intracranial metallic objects
    b. Because of extreme obesity
    c. Because of an inability to lie still
2. Patients whose condition requires the visualization of fine bone detail or calcification
3. Patients with the following conditions
    a. Acute CNS Hemorrhage
    b. Strokes or encephalomalacia
    c. New onset seizures, particularly if a focal component is present (contrast agent is appropriate for these patients)
    d. Intracranial (sic) lesions large enough to cause increased intracranial pressure (CT scan is useful to determine gross margins between tumor and edematous brain)

C. There is no general rule that requires other diagnostic tests to be tried before CT scanning is used. However, in individual cases it may be determined that use of a CT scan as the initial diagnostic test was not reasonable and necessary because it was not supported by the patient's symptoms or complaints as stated on the claim.

D. CT imaging has not been useful in general for the evaluation of headache or dizziness and should be reserved for the patient whose presentation indicates a focal problem or who has experienced a significant change in symptomatology.

E. A CT scan for the diagnosis of headache (ICD-10 code G44.1) can be allowed for the following:
    1. After a head injury to rule out intracranial bleeding
    2. Headache unusual in duration (greater than two weeks) not responding to medical therapy, to rule out the possibility of a tumor
    3. A headache characterized by sudden onset and severity to rule out the possibility of an aneurysm, bleeding and/or arteriovenous malformation

F. A CT Scan may be ordered without contrast, with contrast, or without contrast followed by contrast. Contrast administration is not without risk to the patient, and for some conditions, adds little or no benefit to the patient. The general indications for use of contrast CT scanning (as opposed to non-contrast scanning) are to:
    1. Assess perfusion (e.g. CVA)
    2. Characterize a specific lesion
    3. Detect defects in blood/brain barrier (e.g. infarct, tumor, infection, vasculitis)
    4. Detect neovascularity (tumor), and
    5. For staging of known lung cancer, breast cancer, and lymphomas likely to metastasize early to the brain

G. Intravenous contrast generally adds no information to CT scans done secondary to head trauma. Additional symptoms suggesting a possible intracranial bleed may justify the use of contrast. These symptoms should be documented in the medical record, and if appropriate, included in the diagnostic codes listed on the claim.

H. More than one contrast CT scan per episode of illness adds no information with the following exceptions:
    1. CVA
    2. Non-traumatic hemorrhage
    3. TIA
    4. Post-operative scan for residual tumor or post operative complication
    5. Known brain tumor/metastases with a change in mental status or other evidence of CNS change

Magnetic Resonance Imaging (MRI)

Magnetic Resonance Imaging (MRI) is a non-invasive diagnostic scanning technique that employs a powerful and highly uniform static magnetic field, rather than ionizing radiation, to produce images. Fluctuations in the strength of the magnetic field alter the motion and relaxation times of hydrogen molecules, which are related to the density of molecules and reflect the physicochemical properties of the tissues. Reconstructed images can be displayed in multiple planes to facilitate analysis. **See national non-coverage in CMS section above.**

Coverage is limited to those CT and MRI machines that have received pre-market approval by the FDA. Such units

must be operated within the parameters specified by the approval.

Inconclusive findings on a CT scan may warrant a MRI study and, conversely, findings of a MRI study may be further clarified (under certain circumstances) with a subsequent CT scan. The information provided by the two modalities may be complementary.

Cancer Staging. Clinicians commonly use CT and MRI of the brain when metastatic involvement is suspected.

Non-covered indications: esophagus, oropharynx, and prostate, and non-melanoma skin cancer in the absence of symptoms of brain involvement. "Certain tumors almost never metastasize to the brain parenchyma. These include carcinomas of the esophagus, oropharynx, and prostate, and non-melanoma skin cancers." (DeVita, Chapter 52.1) Accordingly, the related diagnoses found in the following diagnosis code list do not justify brain scans for "staging" purposes unless a patient has signs or symptoms suggesting brain involvement. Covered: In contrast, for those malignancies that commonly metastasize to the brain, staging in the absence of neurological findings may be appropriate.

Payment will be allowed for reasonable and necessary scans of different areas of the body that are performed on the same day and are not subject to this policy.

Summary of Evidence

NA

Analysis of Evidence
(Rationale for Determination)

NA

General Information

Associated Information

N/A

Sources of Information

See Bibliography.

Bibliography

1. Medicare Consultants
2. Other contractor's policies
3. DeVita, et al, eds, Cancer, *Principles and Practice of Oncology*, 6th edition, Philadelphia, Lippincott-Raven, 2001

Revision History Information

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
10/01/2019	R13	10/01/2019 - At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.	• Revisions Due To Code Removal
10/01/2019	R12	As required by CR 10901, all billing and coding information has been moved to the companion article, this article is linked to the LCD. 10/01/19 At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.	• Revisions Due To Code Removal
10/01/2019	R11	Effective 10/07/2018, G25.0 added as this is a covered indication. Effective 10/01/2019, the following ICD-10 codes were added an deleted and code description was changed per the 2019 annual update Added: • H81.4 - Vertigo of central origin • R11.15 - Cyclical vomiting syndrome unrelated to migraine • S02.121A - Fracture of orbital roof, right side, initial encounter for closed fracture • S02.121B - Fracture of orbital roof, right side, initial encounter for open fracture • S02.121D - Fracture of orbital roof, right side, subsequent encounter for fracture with routine healing • S02.121G - Fracture of orbital roof, right side, subsequent encounter for fracture with delayed healing • S02.121K - Fracture of orbital roof, right side, subsequent encounter for fracture with nonunion • S02.121S - Fracture of orbital roof, right side, sequela • S02.122A - Fracture of orbital roof, left side, initial encounter	• Request for Coverage by a Supplier • Creation of Uniform LCDs Within a MAC Jurisdiction • Revisions Due To ICD-10-CM Code Changes

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		for closed fracture • S02.122B - Fracture of orbital roof, left side, initial encounter for open fracture • S02.122D - Fracture of orbital roof, left side, subsequent encounter for fracture with routine healing • S02.122G - Fracture of orbital roof, left side, subsequent encounter for fracture with delayed healing • S02.122K - Fracture of orbital roof, left side, subsequent encounter for fracture with nonunion • S02.122S - Fracture of orbital roof, left side, sequela • S02.831A - Fracture of medial orbital wall, right side, initial encounter for closed fracture • S02.831B - Fracture of medial orbital wall, right side, initial encounter for open fracture • S02.831D - Fracture of medial orbital wall, right side, subsequent encounter for fracture with routine healing • S02.831G - Fracture of medial orbital wall, right side, subsequent encounter for fracture with delayed healing • S02.831K - Fracture of medial orbital wall, right side, subsequent encounter for fracture with nonunion • S02.831S - Fracture of medial orbital wall, right side, sequela • S02.832A - Fracture of medial orbital wall, left side, initial encounter for closed fracture • S02.832B - Fracture of medial orbital wall, left side, initial encounter for open fracture • S02.832D - Fracture of medial orbital wall, left side, subsequent encounter for fracture with routine healing • S02.832G - Fracture of medial orbital wall, left side, subsequent encounter for fracture with delayed healing • S02.832K - Fracture of medial orbital wall, left side, subsequent encounter for fracture with nonunion • S02.832S - Fracture of medial orbital wall, left side, sequel • S02.841A - Fracture of lateral orbital wall, right side, initial encounter for closed fracture • S02.841B - Fracture of lateral orbital wall, right side, initial encounter for open fracture • S02.841D - Fracture of lateral orbital wall, right side, subsequent encounter for fracture with routine healing • S02.841G - Fracture of lateral orbital wall, right side, subsequent encounter for fracture with delayed healing • S02.841K - Fracture of lateral orbital wall, right side, subsequent encounter for fracture with nonunion • S02.841S - Fracture of lateral orbital wall, right side, sequela • S02.842A - Fracture of lateral orbital wall, left side, initial encounter for closed fracture • S02.842B - Fracture of lateral orbital wall, left side, initial	

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		encounter for open fracture • S02.842D - Fracture of lateral orbital wall, left side, subsequent encounter for fracture with routine healing • S02.842G - Fracture of lateral orbital wall, left side, subsequent encounter for fracture with delayed healing • S02.842K - Fracture of lateral orbital wall, left side, subsequent encounter for fracture with nonunion • S02.842S - Fracture of lateral orbital wall, left side, sequel • Z86.003 - Personal history of in-situ neoplasm of oral cavity, esophagus and stomach • Z86.005 - Personal history of in-situ neoplasm of middle ear and respiratory system • Z86.006 - Personal history of melanoma in-situ • Z86.007 - Personal history of in-situ neoplasm of skin Deleted: Deleted from Group 1: • H81.41 Vertigo of central origin, right ear • H81.42 Vertigo of central origin, left ear • H81.43 Vertigo of central origin, bilateral Code Description Change • From G43.A0 - Cyclical vomiting, not intractable to G43.A0 - Cyclical vomiting, in migraine, not intractable • From G43.A1 - Cyclical vomiting, intractable to G43.A1 - Cyclical vomiting, in migraine, intractable • From M50.120 - Mid-cervical disc disorder, unspecified to M50.120 - Mid-cervical disc disorder, unspecified level • From Z45.42 - Encounter for adjustment and management of neuropacemaker (brain) (peripheral nerve) (spinal cord) to Z45.42 - Encounter for adjustment and management of neurostimulator 09/12/19 At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy.	
10/08/2018	R10	11/29/18 At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and	• Creation of Uniform LCDs Within a MAC

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy. LCD revised to add ICD-10 code C15.5.	Jurisdiction
10/08/2018	R9	10/23/18 At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy. LCD revised to make editorial changes to B3d and H4 in the Coverage Indications, Limitations and/or Medical Necessity section. Added C15.3, C15.4 and C15.8, C85.90, C88.0, D32.9, E22.9, E23.7, E87.1, F80.1, G44.021, G62.89, H40.052, H40.053, H91.91-H91.93, H95.89, I60.9, I61.9, I63.20, I63.549, I63.9, I77.74, I82.C21, J36, J38.01, J38.02, J39.0, L02.811, M41.82, M43.22, M47.13, M50.03, M50.10, M50.20, M50.23, M54.2, Q40.9, R13.0, R13.10, R26.9, R29.898, R40.20, R43.9, S06.9X9A, S06.9X9D, S06.9X9S, S09.90XA, S09.90XD, S09.90XS, S19.9XXA, S19.9XXD, S19.9XXS. Moved F32.81 & F32.89 from Group 2 to Group 1, deleted all other Groups 2 and 3 codes as they are already listed in Group 1 and updated the CMS National Coverage Policy section.	• Request for Coverage by a Practitioner (Part B) • Other (Updated per CMS Guidelines.)
10/08/2018	R8	09/06/2018 - At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy. This LCD is effective 10/08/18 to all allow for the required 45-day Notice period when a Draft policy finalizes. The Notice Period started on 8/23/18 and ends on 10/07/18. However, the Annual ICD-10 Code Update is effective 10/01/2018. The following codes were added and deleted to Group 1, Group 2 and revised from Group 1 will be effective on 10/01/2018. **Added to Group 1:** C43.111, C43.112, C43.121, C43.122, C4A.111, C4A.112, C4A.121, C4A.122, C44.1121. C44.1122, C44.1191, C44.1192, C44.1221, C44.1222, C44.1291, C44.1292,	• Revisions Due To ICD-10-CM Code Changes

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		C44.1921, C44.1922, C44.1991, C44.1992, D03.111, D03.112, D03.121, D03.122, D04.111, D04.112, D04.121, D04.122, D22.111, D22.112, D22.121, D22.122, D23.111, D23.112, D23.121, D23.122, E75.26, F53.0, F53.1, G51.31, G51.32, G51.33, H02.23A, H02.23B, H02.23C, H57.811, H57.812, H57.813, H57.819, H57.89, I63.81, I63.89, I67.850, I67.858, T81.40XA*, T81.40XD*, T81.40XS*, T81.41XA*, T81.41XD*, T81.41XS*, T81.42XA*, T81.42XD*, T81.42XS*, T81.43XA*, T81.43XD*, T81.43XS*, T81.44XA*, T81.44XD*, T81.44XS*, T81.49XA*, T81.49XD* and T81.49XS* **Added to Group 2:** F53.0 and F53.1 **Deleted from Group 1:** C43.11, C43.12, C4A.11, C4A.12, C44.112, C44.119, C44.122, C44.129, C44.192, C44.199, D03.11, D03.12, D04.11, D04.12, D22.11, D22.12, D23.11, D23.12, F53, G51.3, H57.8, I63.8, T81.4XXA*, T81.4XXD* and T81.4XXS* **Deleted from Group 2:** F53 **Revised from Group 1:** I63.333, I63.343, M50.01, M50.21, M50.31, M50.81 and M50.91	
10/08/2018	R7	0717/18 - At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy. Added and deleted the following ICD-10 codes in Group 1 related to 2018 annual ICD-10 updates and Response to Comments. All added codes are considered within the indications of the LCD. Added: • C96.21 • C96.22 • C96.29 • D47.02 • G12.23 • G12.24 • G12.25 • H54.0X33 • H54.0X34	• Creation of Uniform LCDs Within a MAC Jurisdiction

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		• H54.0X35 • H54.0X43 • H54.0X44 • H54.0X45 • H54.0X53 • H54.0X54 • H54.0X55 • H54.1131 • H54.1132 • H54.1141 • H54.1142 • H54.1151 • H54.1152 • H54.1213 • H54.1214 • H54.1215 • H54.1223 • H54.1224 • H54.1225 • H54.2X11 • H54.2X12 • H54.2X21 • H54.2X22 • H54.413A • H54.414A • H54.415A • H54.42A3 • H54.42A4 • H54.42A5 • H54.511A • H54.512A • H54.52A1 • H54.52A2 • I63.513 • I63.523 • I63.533 • P91.811 • P91.819 • P91.88 • S02.40AA • S02.40AB • S02.40AD • S02.40AG • S02.40AK • S02.40AS • S02.40BA • S02.40BB	

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		• S02.40BD • S02.40BG • S02.40BK • S02.40BS • S02.40CA • S02.40CB • S02.40CD • S02.40CG • S02.40CK • S02.40CS • S02.40DA • S02.40DB • S02.40DD • S02.40DG • S02.40DK • S02.40DS • S02.40EA • S02.40EB • S02.40ED • S02.40EG • S02.40EK • S02.40ES • S02.40FA • S02.40FB • S02.40FD • S02.40FG • S02.40FK • S02.40FS Deleted: • C96.2 • D47.0 • H54.0 • H54.11 • H54.12 • H54.2 • H54.41 • H54.42 • H54.51 • H54.52 • S06.1X7D • S06.1X7S • S06.1X8D • S06.1X8S • S06.2X7D • S06.2X7S	

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		• S06.2X8D • S06.2X8S • S06.307D • S06.307S • S06.308D • S06.308S • S06.317D • S06.317S • S06.318D • S06.318S • S06.327D • S06.327S • S06.328D • S06.328S • S06.337D • S06.337S • S06.338D • S06.338S • S06.347D • S06.347S • S06.348D • S06.348S • S06.357D • S06.357S • S06.358D • S06.358S • S06.367D • S06.367S • S06.368D • S06.368S • S06.377D • S06.377S • S06.378D • S06.378S • S06.387D • S06.387S • S06.388D • S06.388S • S06.4X7S • S06.4X8S • S06.5X7D • S06.5X7S • S06.5X8D • S06.5X8S • S06.6X7D • S06.6X7S • S06.6X8D	

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		• S06.6X8S • S06.817D • S06.817S • S06.818D • S06.818S • S06.827D • S06.827S • S06.828D • S06.828S • S06.897D • S06.897S • S06.898D • S06.898S • S06.9X7D • S06.9X7S • S06.9X8D • S06.9X8S	
10/01/2017	R6	08/24/2017: At this time 21st Century Cures Act will apply to new and revised LCDs that restrict coverage which requires comment and notice. This revision is not a restriction to the coverage determination; and, therefore not all the fields included on the LCD are applicable as noted in this policy. Effective DOS 10/01/**2016** the following ICD-10-CM codes were added: • S02.40AA • S02.40AB • S02.40AD • S02.40AG • S02.40AK • S02.40AS • S02.40BA • S02.40BB • S02.40BD • S02.40BG • S02.40BK • S02.40BS • S02.40CA • S02.40CB • S02.40CD • S02.40CG • S02.40CK • S02.40CS • S02.40DA	• Revisions Due To ICD-10-CM Code Changes • Reconsideration Request

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		• S02.40DB • S02.40DD • S02.40DG • S02.40DK • S02.40DS • S02.40EA • S02.40EB • S02.40ED • S02.40EG • S02.40EK • S02.40ES • S02.40FA • S02.40FB • S02.40FD • S02.40FG • S02.40FK • S02.40FS Effective DOS 10/01/**2017** the following ICD-10-CM codes were added, deleted and had a description change: Added: • C96.21 • C96.22 • C96.29 • D47.02 • G12.23 • G12.24 • G12.25 • H54.0X33 • H54.0X34 • H54.0X35 • H54.0X43 • H54.0X44 • H54.0X45 • H54.0X53 • H54.0X54 • H54.0X55 • H54.1131 • H54.1132 • H54.1141 • H54.1142 • H54.1151 • H54.1152 • H54.1213	

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		• H54.1214 • H54.1215 • H54.1223 • H54.1224 • H54.1225 • H54.2X11 • H54.2X12 • H54.2X21 • H54.2X22 • H54.413A • H54.414A • H54.415A • H54.42A3 • H54.42A4 • H54.42A5 • H54.511A • H54.512A • H54.52A1 • H54.52A2 • I63.323 • I63.333 • I63.513 • I63.523 • I63.533 C96.2 was deleted from Group 1 D47.0 was deleted from Group 1 E85.8 was deleted from Group 1 H54.0 was deleted from Group 1 H54.11 was deleted from Group 1 H54.12 was deleted from Group 1 H54.2 was deleted from Group 1 H54.41 was deleted from Group 1 H54.42 was deleted from Group 1 H54.51 was deleted from Group 1 H54.52 was deleted from Group 1 S06.1X7D was deleted from Group 1 S06.1X7S was deleted from Group 1 S06.1X8D was deleted from Group 1 S06.1X8S was deleted from Group 1 S06.2X7D was deleted from Group 1 S06.2X7S was deleted from Group 1 S06.2X8D was deleted from Group 1 S06.2X8S was deleted from Group 1 S06.307D was deleted from Group 1 S06.307S was deleted from Group 1 S06.308D was deleted from Group 1	

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		S06.308S was deleted from Group 1 S06.317D was deleted from Group 1 S06.317S was deleted from Group 1 S06.318D was deleted from Group 1 S06.318S was deleted from Group 1 S06.327D was deleted from Group 1 S06.327S was deleted from Group 1 S06.328D was deleted from Group 1 S06.328S was deleted from Group 1 S06.337D was deleted from Group 1 S06.337S was deleted from Group 1 S06.338D was deleted from Group 1 S06.338S was deleted from Group 1 S06.347D was deleted from Group 1 S06.347S was deleted from Group 1 S06.348D was deleted from Group 1 S06.348S was deleted from Group 1 S06.357D was deleted from Group 1 S06.357S was deleted from Group 1 S06.358D was deleted from Group 1 S06.358S was deleted from Group 1 S06.367D was deleted from Group 1 S06.367S was deleted from Group 1 S06.368D was deleted from Group 1 S06.368S was deleted from Group 1 S06.377D was deleted from Group 1 S06.377S was deleted from Group 1 S06.378D was deleted from Group 1 S06.378S was deleted from Group 1 S06.387D was deleted from Group 1 S06.387S was deleted from Group 1 S06.388D was deleted from Group 1 S06.388S was deleted from Group 1 S06.4X7S was deleted from Group 1 S06.4X8S was deleted from Group 1 S06.5X7D was deleted from Group 1 S06.5X7S was deleted from Group 1 S06.5X8D was deleted from Group 1 S06.5X8S was deleted from Group 1 S06.6X7D was deleted from Group 1 S06.6X7S was deleted from Group 1 S06.6X8D was deleted from Group 1 S06.6X8S was deleted from Group 1 S06.817D was deleted from Group 1 S06.817S was deleted from Group 1 S06.818D was deleted from Group 1 S06.818S was deleted from Group 1	

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		S06.827D was deleted from Group 1 S06.827S was deleted from Group 1 S06.828D was deleted from Group 1 S06.828S was deleted from Group 1 S06.897D was deleted from Group 1 S06.897S was deleted from Group 1 S06.898D was deleted from Group 1 S06.898S was deleted from Group 1 S06.9X7D was deleted from Group 1 S06.9X7S was deleted from Group 1 S06.9X8D was deleted from Group 1 S06.9X8S was deleted from Group 1 T14.90 was deleted from Group 1 I63.211 descriptor was changed in Group 1 I63.212 descriptor was changed in Group 1 I63.22 descriptor was changed in Group 1 S04.031A descriptor was changed in Group 1 S04.032A descriptor was changed in Group 1 S04.039A descriptor was changed in Group 1 S04.041A descriptor was changed in Group 1 S04.042A descriptor was changed in Group 1 S04.049A descriptor was changed in Group 1	
10/01/2016	R5	LCD updated to add the A & D 7th characters to ICD-10-CM codes T20.211-T20.212, T20.22X-T20.27X, T20.29X, T20.311-T20.312, T20.32X-T20.327X, T20.39X, T20.511-T20.512, T20.52X-T20.57X, T20.59X, T20.611-T20.612, T20.62X-T20.67X, T20.69X, T20.711-T20.712, T20.72X-T20.77X, and T20.729X in Group 1 effective DOS 10/01/2015.	• Reconsideration Request
10/01/2016	R4	Effective 10/01/2015 LCD revised to add the 7th character 'D' to S06.0X0D, S06.0X1D, S06.0X2D, S06.0X3D, S06.0X4D S06.0X5D, S06.0X6D, S06.0X7D, S06.0X8D, S06.0X9D. S06.1X0D, S06.1X1D, S06.1X2D, S06.1X3D, S06.1X4D. S06.1X5D, S06.1X6D, S06.1X7D, S06.1X8D, S06.1X9D, S06.2X0D S06.2X1D, S06.2X2D, S06.2X3D, S06.2X4D, S02.2X5D, S06.2X6D, S06.2X7D, S06.2X8D, S06.2X9D, S06.300D, S06.301D, S06.302D, S06.303D, S06.304D, S06.305D, S06.306D, S06.307D, S06.308D, S06.309D, S06.310D, S06.311D, S06.312D, S06.313D, S06.314D, S06.315D, S06.316D, S06.317D, S06.318D, S06.319D, S06.320D, S06.321D, S06.322D, S06.323D, S06.324D, S06.325D, S06.326D, S26.327D, S06.328D, S06.329D, S06.330D, S06.331D,	• Revisions Due To ICD-10-CM Code Changes • Reconsideration Request • Other (Clarify use of some possible dental ICD-10-CM codes.)

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		S06.332D S06.333D, S06.334D, S06.335D, S06.336D, S06.337D, S06.338D, S06.339D, S06.340D, S06.341D, S06.342D, S06.343D, S06.344D, S06.345D, S06.346D, S06.347D, S06.348D, S06.349D, S06.350D, S06.351D, S06.352D, S06.353D, S06.354D, S06.355D, S06.356D, S06.357D, S06.358D, S06.359D, S06.360D, S06.361D, S06.362D, S06.363D, S06.364D, S06.365D, S06.366D, S06.367D, S06.368D, S06.369D, S06.370D, S06.371D, S06.372D, S06.373D, S06.374D, S06.375D, S06.376D, S06.377D, S06.378D, S06.379D, S06.380D, S06.381D, S06.382D, S06.383D, S06.384D, S06.385D, S06.386D, S06.387D, S06.388D, S06.389D, S06.5X0D, S06.5X1D, S06.5X2D, S06.5X3D, S06.5X4D, S06.5X5D, S06.5X6D, S06.5X7D, S06.5X8D, S06.5X9D, S06.6X0D, S06.6X1D, S06.6X2D, S06.6X3D, S06.6X4D, S06.6X5D, S06.6X6D, S06.6X7D, S06.6X8D, S06.6X9D, S06.810D, S06.811D, S06.812D, S06.813D, S06.814D, S06.815D, S06.816D, S06.817D, S06.818D, S06.819D, S06.820D, S06821D, S06.822D, S06.823D, S06.824D, S06.825D, S06.826D, S06.827D, S06.828D, S06.829D, S06.890D, S06.891D, S06.892D, S06.893D, S06.894D, S06.895D, S06.896D, S06.897D, S06.898D, S06.899D, S06.9X0D, S06.9X1D, S06.9X2D, S06.9X3D, S06.9X4D, S06.9X5D, S06.9X6D, S06.9X7D, S06.9X8D and S06.9X9D. The ICD-10-CM codes added with this revision effective 10/01/2015 S06.0X2D, S06.0X3D, S06.0X4D S06.0X5D, S06.0X6D, S06.0X7D, S06.0X8D are deleted effective 10/01/2016 and **cannot** be displayed in this LCD version due to the application of the 2017 ICD-10 annual code update. Noridian will ensure these codes **will** be payable through 09/30/2016. Added Effective 8/11/16, E08.630*, E09.630*, E13.630*, K04.8*, M26.00*, M26.01*, M26.02*, M26.03*, M26.04*, M26.05*, M26.06*, M26.07*, M26.09*, M26.10*, M26.11, M26.12, M26.19*, M26.50*, M26.51*, M26.52*, M26.53*, M26.54*, M26.55*, M26.56*, M26.57*, M26.59*, M26.69*, S02.5XXA*, S02.5XXB*, S03.2XXA* and S03.2XXS* **may be** considered routine dental services. Providers must have documentation available for review to support these services are reasonable and necessary and not routine dental services to the Group 1: Medical Necessity ICD-10 Codes Asterisk Explanation section. **Effective 10/01/2016** this LCD is also revised to add ICD-10-CM codes to D47.Z2, D49.511, D49.512, D49.519, D49.59, I60.2, M26.601, M26.602, M26.603, M26.611, M26.612, M26.613,	

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		M26.621, M26.622, M26.623, M26.631, M26.632, M26.633, M50.021, M50.022, M50.023, M50.120, M50.121, M50.122, M50.123, M50.221, M50.222, M50.223, M50.321, M50.322, M50.32, M50.821, M50.822, M50.823, M50.921, M50.922, M50.9233, S02.101A, S02.101B, S02.101D, S02.101K, S02.101S, S02.102A, S02.102B, S02.102D, S02.102K, S02.102S, S02.31XA, S02.31XB, S02.31XD, S02.31XK, S02.31XS, S02.32XA, S02.32XB, S02.32XD, S02.32XK, S02.32XS, S02.611A, S02.611B, S02.611D, S02.611K, S02.611S, S02.612A, S02.612B, S02.612D, S02.612K, S02.612S, S02.621A, S02.621B, S02.621D,,S02.621K, S02.621S, S02.622A, S02.622B, S02.622D, S02.622K, S02.622S, S02.631A, S02.631B, S02.631D, S02.631K, S02.631S, S02.632A, S02.632B, S02.632D, S02.632K, S02.632S, S02.641A, S02.641B, S02.641D, S02.641K, S02.641S, S02.642A, S02.642B, S02.642D, S02.642K, ,S02.642S, S02.651A S02.651B, S02.651D, S02.651K, S02.651S, S02.652A, S02.652B, S02.652D, S02.652K, S02.652S, S02.671A, S02.671B, S02.671D, S02.671K, S02.671S, S02.672A, S02.672B, S02.672D, S02.672K, S02.672S, S02.81XA, S02.81XB, S02.81XD, S02.81XK, S02.81XS, S02.82XA, S02.82XB, S02.82XD, S02.82XK, S02.82XS, S03.01XA, S03.02XA, S03.03XA, T85.810A, T85.818A, T85.820A, T85.828A, T85.830A, T85.838A, T85.840A, T85.848A, T85.850A, T85.858A, T85.860A, T85.868A, T85.890A and T85.898A to Group 1 and F32.81 and F32.89 were added to Group 2. T**Effective 10/01/2016,** ICD-10-CM codes are deleted D49.5, E08.321, E08.329. E08.331, E08.339 E08.341, E08.349, E08.351, E08.359, E09.321 1E09.329, E09.331, E09.339, E09.341, E09.349, E09.351, E09.359, E10.351, E10.359, E11.351, E11.359, E13.321, E13.329, E13.331, E13.339, E13.341, E13.349, E13.351, E13.359, H34.811, H34.812, H34.813, H34.819, H34.831, H34.832, H34.833, H34.839, I60.20, I60.21, I60.22, I69.01, I69.11, I69.21, I69.31, I69.81, I69.91, I97.62, M26.60, M26.61 M26.62, M26.63, M50.02, M50.12, M50.22, M50.32, M50.82, M50.92, S02.10XA, S02.10XB, S02.10XD, S02.10XK, S02.10XS, S02.3XXA, S02.3XXB, S02.3XXD, S02.3XXK, S02.3XXS S02.61XA, S02.61XB, S02.61XD, S02.61XK, S02.61XS, S02.62XA, S02.62XB, S02.62XD, S02.62XK, S02.62XS, S02.63XA, S02.63XB, S02.63XD, S02.63XK, S02.63XS, S02.64XA, S02.64XB, S02.64XD, S02.64XK, S02.64XS, S02.65XA, S02.65XB, S02.65XD, S02.65XK, S02.65XS, S02.67XA, S02.67XB, S02.67XD, S02.67XK, S02.67XS, S02.8XXA, S02.8XXB S02.8XXD, S02.8XXK, S02.8XXS, S03.0XX, S03.4XXA, S06.0X2A, S06.0X2S, S06.0X3A, S06.0X3S, S06.0X4A, S06.0X4S,	

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
		S06.0X5A, S06.0X5S, S06.0X6A, S06.0X6S, S06.0X7A, S06.0X7S, S06.0X8A, S06.0X8S, T85.81XA, T85.82XA, T85.83XA, T85.84XA, T85.85XA, T85.86XA and T85.89XA from Group 1. Effective 10/01/2016 the following ICD-10 code descriptions were changed in the ICD-10 Codes that Support Medical Necessity field: C81.11, C81.21, C81.28, C81.29, C81.31, C81.38, C81.39, C81.41, C81.48, C81.49, C81.71, C81.78, C81.79, D3A.094, D3A.095, D3A.096, D78.21, D78.22, G97.51, G97.52, H59.311, H59.312, H59.313, H59.319, H59.321, H59.322, H59.323 H59.329, H95.41 H95.42 I97.610 I97.611 I97.618 I97.820 I97.821 J95.830, J95.831 L76.21 L76.22 P02.1 S02.110A S02.110B S02.110D S02.110K S02.110S S02.111A S02.111B S02.111D S02.111K S02.111S S02.112A S02.112B S02.112D S02.112K S02.112S S02.118A S02.118B S02.118D S02.118K S02.118S S02.400A S02.400B S02.400D S02.400K S02.400S S02.401A S02.401B S02.401D S02.401K S02.401S S02.402A S02.402B S02.402D S02.402K S02.402S S02.600A S02.600B S02.600D S02.600K S02.600S T85.110A T85.111A T85.112A T85.120A T85.121A T85.122A T85.190A T85.191A T85.192A T85.610A T85.620A T85.630A and T85.690A. LCD number L35177 JFA retired effective October 01, 2016 and combined into JFB LCD number L35175. JFA and JFB contract numbers will have the same final MCD LCD number and remain an Active LCD.	
10/01/2015	R3	R3 LCD revised to add ICD 10 codes R41.89, R53.81, R53.83, S02.0XXD, S02.10XD, S02.110D, S02.111D, S02.112D, S02113D, S02.118D, S02.119D, S02.19XD, S02.2XXD, S02.3XXD, S02.400D, S02.401D, S02.402D, S02.411D, S02.412D, S02.413D, S02.42XD, S02.5XXD, S02600D, S02.609D, S02.61XD, S02.62XD, S02.63XD, S02.64XD, S02.65XD, S02.66XD, S02.67XD, S02.69XD, S02.8XXD, S02.91XD, S02.92XD, Z85.01, Z85.020, Z85.028, Z85.030, Z85.038, Z85.040, Z85.048, Z85.05, Z85.07, Z85.060, Z85.068, Z85.110, Z85.118, Z85.12, Z85.21, Z85.22, Z85.230, Z85.238, Z85.3, Z85.41, Z85.42 , Z85.43, Z85.44, Z85.47, Z85.48, Z85.51, Z85.520, Z85.528, Z85.53 and Z85.54 to Group 1 Codes that Support Medical Necessity.	• Creation of Uniform LCDs Within a MAC Jurisdiction • Reconsideration Request
10/01/2015	R2	LCD revised to add ICD 10 codes R20.0, R20.1, R20.2, R20.3 R20.8 and H92.02 to Group I only. Note: In Revision 1 Revision History Explanation - ICD-10 codes C45.0 and C45.2 were also added when this revision was made	• Revisions Due To ICD-10-CM Code Changes

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION	REASON(S) FOR CHANGE
10/01/2015	R1	The LCD is revised to add ICD10 codes C34.00-C41.9 in group 1 only. The effective date remains 10/1/15.	• Revisions Due To ICD-10-CM Code Changes

Associated Documents

Attachments

N/A

Related Local Coverage Documents

Article(s)
A57215 - Billing and Coding: MRI and CT Scans of the Head and Neck
A56067 - Response to Comments: MRI and CT Scans of Head and Neck
LCD(s)
DL35175
- (MCD Archive Site)

Related National Coverage Documents

N/A

Public Version(s)

Updated on 09/19/2019 with effective dates 10/01/2019 - N/A
Updated on 09/19/2019 with effective dates 10/01/2019 - N/A
Updated on 12/06/2018 with effective dates 10/08/2018 - 09/30/2019
Updated on 11/02/2018 with effective dates 10/08/2018 - N/A
Updated on 09/06/2018 with effective dates 10/08/2018 - N/A
Updated on 08/16/2018 with effective dates 10/08/2018 - N/A
Updated on 08/24/2017 with effective dates 10/01/2017 - 10/07/2018
Some older versions have been archived. Please visit the MCD Archive Site to retrieve them.

Keywords

- MRI, CT, Head, Brain, Neck,
- 70450
- 70460
- 70470
- 70480
- 70481
- 70482
- 70486
- 70487
- 70488
- 70490

- 70491
- 70492
- 72125
- 72126
- 72127
- 70336
- 70540
- 70542
- 70543
- 70551
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- 70553
- 70557
- 70558
- 70559
- 72141
- 72142
- 72156

Source: https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35175&ver=58&NCDId=298&ncdver=1&SearchType=Advanced&CoverageSelection=Both&NCSelection=NCD&ArticleType=Ed%7cKey%7cSAD%7cFAQ&PolicyType=Final&s=-%7c5%7c6%7c66%7c67%7c44&KeyWord=Computed+Tomography&KeyWordLookUp=Doc&KeyWordSearchType=Exact&kq=true&bc=IAAAACABAAAA&

Section Review 7.2

1. Based on this portion of the NCCI table and the scenario below, which modifier is appropriate to report?

Column 1	Column 2	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable	PTP Edit Rationale
64479	20610	20010701	*	1	Misuse of column two code with column one code

The provider performs a transforaminal epidural with imaging guidance into the left side of the thoracic spine (64479). He also performs an aspiration/injection into the left trochanteric bursa (20610).

A. XU
B. XS
C. XS, 59
D. No modifier is allowed based on the CCM indicator.

2. What is an MUE?

A. A medical necessity edit
B. Edits showing the maximum number of times a procedure can be performed for one beneficiary in a lifetime
C. Edits showing the maximum number of times a provider can perform the procedure in one date of service
D. Edits showing the maximum number of times a procedure can be performed for one beneficiary in one date of service.

3. A patient has a breast biopsy with placement of localization device (19083) with subsequent mastectomy (19301) at the same session after the biopsy is proven to be malignant. What modifier would be used for this scenario?

   A. 59
   B. 58
   C. 25
   D. 78

4. Coverage determination L35175 for magnetic resonance imaging includes coverage guidelines (shown above). Which of the following is supported in these guidelines?

   A. Patients with extreme obesity are suitable candidates for MRI evaluation.
   B. Patients with pacemakers or intracranial metallic objects are NOT suitable candidates for MRI.
   C. Patients who have an inability to lie still are suitable candidates for MRI.
   D. MRI is best for patients whose condition requires the visualization of fine bone detail or calcification.

5. NCCI policy specifically discusses what 3 modifiers?

   A. 58, 59, 78
   B. 25, 58, 59
   C. LT, RT, 25
   D. 27, 59, 91

Glossary

Local Coverage Determination (LCD)—Decision made by a fiscal intermediary (FI) or a Medicare carrier about the services and items that are reasonable and necessary. LCD also decides if a particular service should be covered on an intermediary-wide or a carrier-wide basis, and it makes decisions about the service that is reasonable and necessary for certain diagnoses and procedure.

Medicare Administrative Contractor (MAC)—A company under contract with the federal government to handle claims processing for Medicare services.

Medical necessity—A decision made by a health plan as to whether a treatment, test, or procedure is necessary for a patient's health or to treat a diagnosed medical condition.

Medically Unlikely Edits (MUE)—Part of NCCI edits that places limits on the frequency that individual codes can be billed on a single date of service by a single provider for a single beneficiary.

Modifier—A two-character code that affects the meaning of another code.

National Correct Coding Initiative (NCCI/CCI)—The National Correct Coding Initiative (NCCI) is a CMS program designed to prevent improper payment of procedures that should not be submitted together.

National Coverage Determination (NCD)—Nationwide determination as to whether Medicare will pay for an item or service.

Outpatient Code Editor (OCE)—Software that edits outpatient hospital claims to detect incorrect billing data and determine if the Ambulatory Surgery Center (ASC) limit should apply to each claim and reviews each HCPCS and ICD-10-CM code for validity and coverage.

Resources for NCCI Edits

CMS HCPCS Webpage
https://www.cms.gov/Medicare/Coding/MedHCPCSGenInfo/index.html
This webpage provides background information, coding updates and transmittals, and coding process and criteria information for the Healthcare Common Procedure Coding System (HCPCS) code set.

CMS Help with File Formats and Plug-Ins
https://www.cms.gov/About-CMS/Agency-Information/About-website/Help.html
Where possible, CMS posts information in open-standard, accessible formats (for example, HTML). However, there are some areas of the website where specialized media must be used and plug-ins or special viewers may be needed to access the content. This webpage provides a list of file types that are used on the website as well as further information on getting the plug-ins.

CMS Outpatient Code Editor (OCE) Webpage
https://www.cms.gov/Medicare/Coding/OutpatientCodeEdit/index.html
This webpage provides an overview of the OCE, as well as information on the OCE versions and updates.

CMS Questions
https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/index.html
Further information about NCCI edits and MUEs can be found in this searchable list of commonly-asked questions and answers available on the CMS website.

"CPT® Professional"
https://commerce.ama-assn.org/store/ui
CPT® codes are defined in the American Medical Association's (AMA's) "CPT® Professional" which is updated and published annually. Use this webpage to purchase hard copy or electronic versions of the "CPT® Professional."

Internet-Only Manual (IOM) Pub 100-04
"Medicare Claims Processing Manual"
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c23.pdf
Chapter 23 is entitled "Fee Schedule Administration and Coding Requirements." Section 20.9, "Correct Coding Initiative (CCI)," provides instructions regarding implementation of NCCI edits and MUEs including information on modifiers.

MLN Matters® Articles
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/index.html
Quarterly updates (and corresponding information) to the NCCI are published as Medicare Learning Network® (MLN) Matters® articles. Select the year and search for the word initiative to return all quarterly updates.

Modifier 59 Article
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/downloads/modifier59.pdf
This article provides information about CPT® Modifier 59, an important NCCI-associated modifier that is often used incorrectly.

"Medicare Claim Review Programs"
https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/index.html
https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c01.pdf

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pim83c03.pdf

The National Correct Coding Initiative in Medicaid
https://www.medicaid.gov/medicaid/program-integrity/ncci/edit-files/index.html
The CMS National Correct Coding Initiative (NCCI) promotes national correct coding methodologies and reduces improper coding, which may result in inappropriate payments of Medicare Part B claims and Medicaid claims. The Medicaid NCCI program has significant differences from the Medicare NCCI program. The National Correct Coding Initiative in Medicaid webpage provides information and resources about NCCI policies under the Medicaid program.

"National Correct Coding Initiative Policy Manual for Medicare Services"
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html
The manual is available in the Downloads section at the bottom of the National Correct Coding Initiative Edits page on the CMS website. The manual serves as a reference tool for correct coding and to explain the rationale for NCCI edits.

Quarterly Provider Updates

CMS Quarterly Provider Updates can be located at:
https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html
CMS offers a free email subscription service, which provides notifications electronically when new information is available.
https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_11966

The Quarterly Provider Updates electronic mailing list notifies subscribers via email immediately of any regulations or program instructions released during the quarter that affect Medicare providers, including transmittals of the quarterly updates to the NCCI.

Quarterly PTP and MUE Version Update Changes
https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Version_Update_Changes.html
Quarterly changes to the Column 1/Column 2 and MUE tables can be found on the Quarterly PTP and MUE Version Update Changes webpage.

Change Request 8853
https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1421OTN.pdf
Change Request 8853 provides information about Medically Unlikely Edits (MUEs) and the MUE Adjudication Indicator (MAI).