



## Medicare Hospital Version

### KEY CONCEPTS OUTLINE

#### Module 3: Medical Necessity and Limitations on Liability Notices

- I. Overview of Medicare Coverage
  - A. In order to be covered by Medicare, items and services must:
    1. Fall into a Medicare benefit category;
    2. Not be statutorily excluded;
    3. Be reasonable and necessary; and
    4. Meet other Medicare program requirements for payment. <Medicare Program Integrity Manual, Chapter 3 § 3.6.2.1>
  - B. Coverage guidance:
    1. The Social Security Act defines Medicare benefit categories and exclusions, supplemented by regulatory guidance (e.g., 42 C.F.R. §§ 409, 410) and sub-regulatory guidance (e.g., the *Medicare Benefit Policy Manual*) published by CMS.
    2. In some cases, CMS publishes National Coverage Determinations (NCDs), discussed later in this module, specifying the circumstances under which an item or service is reasonable and necessary. <Medicare Program Integrity Manual, Chapter 3 § 3.6.2.2>
    3. If there is no NCD, MACs may publish Local Coverage Determinations (LCDs), discussed later in this module, specifying the circumstances under which an item or service is reasonable and necessary. <Medicare Program Integrity Manual, Chapter 3 § 3.6.2.2>
    4. If there is no NCD or LCD applicable to an item or service, contractors determine if it is reasonable and necessary based on the following criteria:
      - a. It is safe and effective;
      - b. It is not experimental or investigational;

- c. It is appropriate, including duration and frequency;
- d. It is furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the beneficiary's condition or to improve the function of a malformed body member;
- e. It is furnished in a setting appropriate to the beneficiary's medical needs and condition;
- f. It is ordered and furnished by qualified personnel; and
- g. It meets, but does not exceed, the beneficiary's medical need. <Medicare Program Integrity Manual, Chapter 3 § 3.6.2.2>

## II. National and Local Coverage Policies

### A. Medicare Coverage Database

1. CMS hosts a comprehensive coverage website entitled the Medicare Coverage Database where they publish National and Local Coverage Determinations and related documents. CMS publishes a helpful guide entitled "How to Use the Medicare Coverage Database".

Link: Coverage Database (NCDs, NCAs, LCDs) under Medicare-Related Sites – General

2. Types of Documents on the Medicare Coverage Database

- a. National Coverage Determinations (NCDs)
  - i. NCDs describe national Medicare coverage policy and generally provide the conditions under which an item or service is considered to be covered. <Medicare Program Integrity Manual, Chapter 13 § 13.1.1>
  - ii. NCDs are binding on all Medicare contractors and in most cases on ALJs in the appeals process. <42 C.F.R. 405.1060; Medicare Program Integrity Manual, Chapter 13 § 13.1.1>
- b. National Coverage Analyses (NCAs) and Decision Memoranda

CMS publishes NCAs and Decision Memoranda describing CMS coverage decisions and providing the **clinical basis and rationale** of the decisions, including **clinical evidence and studies**.

- i. NCAs and Coverage Decision Memoranda are not binding on Medicare Contractors or ALJs, but CMS directs contractors to consider them in their medical review activities. <Medicare Program Integrity Manual, Chapter 12 § 13.1.1>
- c. Coding Analyses for Labs (CALs), Medicare Evidence Development & Coverage Advisory Committee (MEDCAC) Meeting minutes, Technology Assessments (TAs) and Medicare Coverage Documents (MCDs)
  - i. CALs, MEDCAC meeting minutes, TAs, and MCDs provide additional guidance on national Medicare coverage policies and decisions.
- d. Local Coverage Determination (LCDs)
  - i. MACs publish LCDs to describe local coverage policy and as educational tools to assist and furnish guidance to providers within their jurisdiction. <Medicare Program Integrity Manual, Chapter 13 § 13.1.3>
  - ii. LCDs are not binding on Medicare contractors or ALJs, beyond the contractor that established them. Regulations require contractors and ALJs give substantial deference to LCDs applicable to a case and if they do not follow an LCD, explain why in their decision letter. <42 C.F.R. 405.1062>
- e. Local Coverage Articles
  - i. MACs publish coverage articles addressing local coverage, coding, billing, medical review, and claims considerations. The articles may include newly developed educational materials, coding instructions, or clarification of existing billing or claims policy.

## B. Laboratory NCD Manual

1. CMS publishes laboratory NCDs, along with additional coding and coverage information in a “*Lab NCD Manual*” entitled *Medicare National Coverage Determination (NCD) Coding Policy Manual and Change Report, Clinical Diagnostic Laboratory Services*.

Link: [Clinical Diagnostic Laboratory NCD Manual under Medicare -Related Sites - General](#)

2. The *Lab NCD Manual* contains a list of “Non-covered ICD-10-CM Codes for All Lab NCD Edits” that are never covered by Medicare for a diagnostic laboratory service, included in the materials behind the outline. <*Lab NCD Manual*>

### III. Coverage of Services Related to Clinical Trials, Registries and Studies

#### A. Coverage with Evidence Development (CED)

1. Coverage with Evidence (CED) policies are NCDs with a trial or registry component required for coverage and cover items or services on the condition they are furnished in the context of approved clinical studies or with the collection of additional clinical data through a registry. <Guidance for the Public, Industry, and CMS Staff; Coverage with Evidence Development Document, Issued on November 20, 2014; 88 Fed. Reg. 22258>

Link: Coverage with Evidence Development (CED) under Medicare-Related Sites – General

Use links on the left navigation to access an information page for each item or service covered under CED.

2. The routine costs of items and services, associated with services covered under CED, are also covered if the items or services are generally covered for Medicare beneficiaries. <Guidance for the Public, Industry, and CMS Staff; Coverage with Evidence Development Document, Issued on November 20, 2014>

#### B. Routine Costs of Qualifying Clinical Trials under NCD 310.1

1. Medicare covers and pays routine costs of qualifying clinical trials under NCD 310.1 and for the diagnosis and treatment of complications related to the clinical trial. <NCD 310.1, Medicare Claims Processing Manual, Chapter 32 § 69.1>
  - a. Clinical trials deemed automatically qualified for coverage of their routine costs:
    - i. Trials funded by NIH, CDC, AHRQ, CMS, DOD, and VA;
    - ii. Trials supported by centers or cooperative groups funded by NIH, CDC, AHRQ, CMS, DOD, and VA;
    - iii. Trials conducted under an investigational new drug (IND) application reviewed by the FDA;
    - iv. Drug trials exempt from an IND and meeting specified criteria. <NCD 310.1>
  - b. Clinical trials qualify for coverage of routine costs when the lead principal investigator certifies that the trial meets the qualifying criteria set out by a multi-agency panel. <NCD 310.1>

### C. Investigational Device Exemption (IDE) Studies

1. Medicare covers the routine care items and services furnished in CMS-approved Category A (Experimental) or B (Nonexperimental/investigational) IDE studies and the device in CMS-approved Category B IDE studies. <42 C.F.R. § 405.211; *Medicare Claims Processing Manual*, Chapter 32 § 68>
  - a. CMS-approved IDE studies can be verified on the CMS website.

Link: Approved IDE Studies under Medicare-Related Sites – General

### D. Billing for Services Related to Clinical Trials, Registries and Studies

1. The following should be reported on claims for services covered under CED, routine costs of clinical trials, and related to IDE Studies:
  - a. Condition code 30 (“Qualifying Clinical Trials”); and
  - b. Value code D4 with the eight-digit clinical trial number of the study the service is covered under, as specified on clinicaltrials.gov, the Approved IDE Studies webpage, or the CED webpage; and
  - c. ICD-10 code Z00.6 (“Encounter for examination for normal comparison and control in clinical research program”); and
  - d. For outpatient claims, as appropriate:
    - i. Modifier -Q0 (“Investigational clinical service provided in a clinical research study that is an approved clinical research study”)
    - ii. Modifier -Q1 (“Routine clinical service provided in a clinical research study that is an approved clinical research study”). <*Medicare Claims Processing Manual*, Chapter 32 §§ 68.1, 69.5, 69.6>
2. For devices under Category B IDE studies, bill the Category B IDE number with revenue code 0624 with an appropriate covered charge amount. <*Medicare Claims Processing Manual*, Chapter 32 § 68.2>
  - a. If the IDE device is provided at no cost report a token charge amount, Condition Code 53, and Value Code FD with the amount of the credit (e.g., the retail cost of the device). <*Medicare Claims Processing Manual*, Chapter 32 § 68.4>

#### IV. Coverage by Medicare Advantage Plans (under Part C)

- A. When interpreting traditional Medicare coverage criteria for prior authorization, case management, or claim payment for basic benefits, MA plans must comply with:
1. National Coverage Determinations (NCDs);
  2. Local Coverage Determinations (LCDs) in the geographic area in which services are covered under the MA plan (the plan's service area); and
  3. Other general coverage and benefit conditions in traditional Medicare laws, including criteria for determining whether an item or service is a benefit. <42 C.F.R. § 422.101(b)(1)-(3)>
- B. Examples of coverage determinations that would not comply with the above requirements include:
1. Restricting access to a Medicare covered item or service unless another item or service is furnished first, if not specifically required in NCD or LCD (e.g., an x-ray prior to authorizing an MRI otherwise covered under an LCD that does not require a prior x-ray). <88 Fed. Reg. 22188>; or
  2. Denying ordered care based on considerations other than failure to meet coverage criteria, when care can be delivered in more than one setting or provider type (e.g., denying covered SNF care ordered by the attending physician and redirecting the patient to home health care). <88 Fed. Reg. 22190>
- C. MA plans may establish their own internal coverage criteria when coverage criteria are not fully established by Medicare statutes, regulations, NCDs, or LCDs. <42 C.F.R. § 422.101(b)(6)>
1. Coverage criteria is considered not fully established if:
    - a. There is no NCD, LCD, Medicare statute or regulation setting forth coverage criteria; or
    - b. The NCD or LCD explicitly allows for coverage in circumstances beyond the specific indications in the NCD or LCD; or
    - c. Additional, unspecified criteria are needed to interpret or supplement general coverage provisions consistently,
      - i. The plan must show the additional criteria provide clinical benefits that are highly likely to outweigh any clinical harm, including from delay or decreased access. <42 C.F.R. § 422.101 (b)(6)(i)>

2. MA plan internal coverage policies must be publicly accessible and based on current evidence available in widely used treatment guidelines or clinical literature published in peer-reviewed journals. <42 C.F.R. § 422.101(b)(6)>
3. For internal coverage policies, the plan must provide, in a publicly accessible way, the following:
  - a. The coverage criteria used, and a summary of evidence considered in the development of the criteria;
  - b. A list of sources of the evidence;
  - c. An explanation of the rationale that supports adoption of the criteria, including the general provisions being supplemented or interpreted; and
  - d. An explanation of how the additional criteria provide clinical benefit highly likely to outweigh any clinical harm. <42 C.F.R. § 422.101(b)(6)(ii)>
- D. If an MA plan approves an item or service through prior authorization, or pre-service determination of coverage, or payment, the plan may not:
  1. Deny coverage later on the basis of a lack of medical necessity; and
  2. May not reopen the decision except for good cause or if there is reliable evidence of fraud or similar fault. <42 Fed. Reg. § 422.138>
- E. If an MA plan expects to make a partially or fully adverse medical necessity decision, the determination must be reviewed by a physician or other appropriate health care professional with expertise in the field of medicine or health care at issue, including knowledge of Medicare coverage criteria. <42 C.F.R. § 422.566 (d)>
  1. The physician or health care professional need not be in the same specialty or subspecialty as the treating physician. <42 C.F.R. § 422.566 (d)>
- F. MA plan Coverage and Payment for Services Related to Clinical Trials, Registries and Studies
  1. MA plans are responsible for coverage and payment of services covered under CED, similar to any other NCD, subject to a “significant cost” determination for new NCDs with CED. <88 Fed. Reg. 22258-59>
    - a. A “significant cost” determination is made for any new NCD or legislative change, and services that meet the “significant cost” criteria are paid by traditional Medicare until the contract/plan year in which payment adjustments takes into account the cost of the newly covered service. <42 C.F.R. § 422.109 (c), (d)>

## 2. Routine Costs of Qualifying Clinical Trials under NCD310.1

- a. Traditional (fee-for-service) Medicare pays for the routine costs of qualifying clinical trials covered under NCD 310.1 for MA plan enrollees. <42 C.F.R. § 422.109(e); 88 Fed. Reg. 22257>
- b. MA plan enrollees are not charged traditional Part A or B deductibles and only pay the plans in-network cost share for the qualifying clinical trial item (or item of the same category as the clinical trial item), which must be credited to their max-out-of-pocket (MOOP) spending. <42 C.F.R. § 433.109 (e)(2) and (3); 88 Fed. Reg. 22257>
  - i. MA plans must pay the difference between the plans in-network cost share and traditional Medicare cost share. <42 C.F.R. § 433.109 (e)(3); 88 Fed. Reg. 22257>
- c. MA plan may not require prior authorization for participation in a Medicare-qualified clinical trial or create impediments to an enrollee's participation in a clinical trial. <42 C.F.R. § 433.109(e)(5)>
- d. MA plans must also pay for services necessary to diagnose a condition covered by a qualifying clinical trial, most follow-up care after the clinical trial, and services already covered by the plan. <42 C.F.R. § 422.109(c)(2); 88 Fed. Reg. 22257>

## 3. Category A and B IDE Studies

- a. MA plans pay for the routine care items and services in CMS-approved Category A and B IDE studies and the devices in CMS-approved Category B IDE studies because they are covered Medicare services. <42 C.F.R. § 422.109 (f); 88 Fed. Reg. 22258>

## V. Prior Authorization by Medicare Advantage plans

### A. Medicare Advantage plans may only use prior authorization for:

1. Verifying the presence of diagnoses or other medical criteria that are the basis for the coverage determination for the specific item or service;
2. For basic benefits, to ensure an item or service is medically necessary under NCDs, LCDs, traditional Medicare coverage and benefit conditions, or plan policies if coverage is not fully established under traditional Medicare policies; or
3. For supplemental benefits, to ensure the service or benefit is clinically appropriate. <42 C.F.R. § 422.138>

- B. MA plans must make medical necessity determinations based on the circumstances of the specific individual, as opposed to using an algorithm or software that doesn't account for an individual's circumstances. <88 Fed. Reg. 22195>
- C. An MA plan that uses utilization management policies and procedures, including prior authorization, must establish a Utilization Management (UM) committee led by the plan's medical director. <42 C.F.R. § 422.137 (a).
  - 1. A plan may not use utilization management policies for either basic or supplemental benefits unless those policies and procedures have been reviewed and approved by the UM committee. <42 C.F.R. § 422.137 (b)>
  - 2. The utilization management policies and procedures, including for prior authorization, must be reviewing at least annually, considering the services and any coverage decisions and guidelines for traditional Medicare (e.g., NCDs, LCDs, regulations, and laws) and relevant clinical guidelines. <42 C.F.R. § 422.137 (d)>

#### VI. Prior Authorization for Hospital Outpatient Services under Part B

- A. For specified services, CMS requires a prior authorization as a condition of payment. The provider must submit a request for and receive a provisional affirmation of coverage for the specified service to be covered and paid. <42 C.F.R. 419.82; 84 Fed. Reg. 61447, 85 Fed. Reg. 86236-248>

Although CMS refers to this process as the “prior authorization” process in regulations and other guidance, they refer to the actual approval as a “provisional affirmation”.

- 1. CMS has published a “Prior Authorization (PA) Program for Certain Hospital Outpatient Department (OPD) Services Operational Guide”, referred to in this section as the Operational Guide, available on the CMS website.

Link: [Prior Authorization for Hospital Outpatient Procedures under Medicare -Related Sites - Hospital](#)

- B. The prior authorization process only applies to services paid through Medicare Fee-for-Service and provided in hospital outpatient departments. <84 Fed. Reg. 61453>
- C. The prior authorization process does not apply to:
  - 1. Services provided outside a hospital outpatient department (e.g., ASC or physician office) <84 Fed. Reg. 61453>;

2. Services paid through a Medicare Advantage plan or Medicare Advantage IME only claims <84 Fed. Reg. 61453; Operational Guide, Section 9.2>;
  3. Critical Access Hospital (CAH) outpatient departments <Prior Authorization Process for Certain Hospital Outpatient Department (OPD) Services, Frequently Asked Questions, Q12>;
  4. Part A/B rebilling claims (presumably 12X with CCW2) <Operational Guide, Section 9.2>;
  5. Emergency department claims with modifier ET or revenue code 45X <Operational Guide, Section 9.2>;
  6. Part A and Part B Demonstration, Veterans Affairs (VA), or Indian Health Services (IHS) claims. <Operational Guide, Section 9.2>
- D. The list of CPT/HCPCS codes requiring prior authorization can be found in Appendix A of the Operational Guide or posted on the Prior Authorization website and are included in the materials behind the outline.
1. Categories of services requiring prior authorization are:
    - a. Blepharoplasty, Blepharoptosis and Brow Ptosis Repair (July 1, 2020);
    - b. Rhinoplasty (July 1, 2020);
    - c. Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy) (July 1, 2020);
    - d. Botulinum Toxin Injections (July 1, 2020);
      - i. Prior authorization is only required when one of the listed Botulinum Toxin codes is billed with one of the listed injection codes. Botulinum Toxin billed with other procedure codes will not require prior authorization. <Operational Guide, Section 6.2.2>
    - e. Vein ablation (July 1, 2020);
    - f. Cervical Fusion with Disc Removal (July 1, 2021);
    - g. Implanted Spinal Neurostimulators (July 1, 2021): and
      - i. If a trial and permanent implantation are performed, a PAR should be request for the trial and the Unique Tracking Number (UTN) for the trial should be reported for both the trial and permanent implantation. <Operational Guide, Section 6.3.2.2>

h. Facet Joint Interventions (July 1, 2023).

## E. Prior Authorization Process

### 1. Responsibility for Obtaining Prior Authorization

a. CMS has determined that the hospital is ultimately responsible for obtaining prior authorization as a condition of payment, although they allow for either physicians or hospitals to obtain the prior authorization. <84 *Fed. Reg.* 61453>

2. The provider must submit a prior authorization request (PAR) to the MAC before the service is provided to the beneficiary, including all documentation necessary to show the service meets all applicable Medicare coverage, coding and payment rules. <42 *C.F.R.* 419.82; 84 *Fed. Reg.* 61454; Operational Guide, Section 3>

a. The prior authorization Operational Guide provides general documentation requirements for each service requiring prior authorization and refers providers to their MAC's LCDs and LCAs for more detailed requirements. <Operational Guide, Section 6>

b. For services requiring prior authorization that do not have specific NCDs or LCDs, contractors may make individual claim determinations to assess whether or not the services are reasonable and necessary. <84 *Fed. Reg.* 61459>

### 3. Timeframes for MAC Decision

a. The MAC must issue a decision within 10 business days in normal circumstances; or

b. Within 2 business days, if a delay in the service may jeopardize the beneficiary's life, health, or ability to regain maximum function. <42 *C.F.R.* 419.82; 84 *Fed. Reg.* 61454; Operational Guide, Section 4, 4.2>

4. The MAC reviews the PAR, assigns a UTN, and makes one of the following determinations:

#### a. Rejected PAR

i. If the MAC is unable to process the request due to errors such as the wrong MAC, invalid beneficiary or provider number, or provider exemptions the MAC rejects the PAR. <Operational Guide, Section 4.1.3>

- ii. The MAC will notify the provider of the reason for the rejection so they can correct and resubmit the PAR, with all the original documentation, if applicable. <Operational Guide, Section 4.1.3>

b. Provisional Affirmation

- i. If the MAC makes a provisional affirmation decision, the MAC will issue a decision letter to the provider and the beneficiary. <Operational Guide, Section 4.3>
- ii. A provisional affirmation is valid for 120 days from the date of the decision. <Operational Guide, Section 7.1>
- iii. Claims receiving a provisional affirmation may later be denied based on technical requirements that can only be evaluated after the claim has been submitted or information not available at the time of the PAR. <84 Fed. Reg. 61447; Operational Guide, Section 8.1>

c. Provisional Non-Affirmation

- i. If the MAC makes a provisional non-affirmation decision, the MAC will provide detailed information about all missing or non-compliant information. <Operational Guide, Section 4; 84 Fed. Reg. 61461>
- ii. The provider may resubmit the PAR with additional or updated documentation any number of times until a provisional affirmation is received. <Operational Guide, Section 4.1.2>
- iii. A provisional non-affirmation is not an initial claim determination and cannot be appealed. <Operational Guide, Section 11>
- iv. If the provider receives a non-affirmation and believes the service is not medically necessary, the provider should issue an Advanced Beneficiary Notice (ABN) to transfer liability to the patient for the non-covered service. <Operational Guide, 9.1>
  - a) CMS also “encourages” providers to issue an ABN to the patient if the provider believes the service will be denied under the statutory exclusion for purely cosmetic services. <Operational Guide, 9.1>

F. Claims Submission

1. To be paid, the provider must submit a Unique Tracking Number (UTN) corresponding to a provisional affirmation on any claim submitted for a service requiring prior authorization. <84 Fed. Reg. 61453>

2. Claims for services requiring prior authorization submitted without a UTN or a UTN corresponding to a provisional non-affirmation will be automatically denied. <84 Fed. Reg. 61447; Operational Guide, Section 8.3>
  - a. When a service that requires prior authorization is denied, CMS “intends” to deny claims for codes associated with or related to the service (e.g., anesthesiologist’s or surgeon’s services). <84 Fed. Reg. 61453, Operational Guide, Section 8.4.1>
    - i. CMS published a list of codes associated with the services requiring prior authorization in Appendix B of the Operational Guide.
  - b. The denial of a claim for lack of prior authorization is considered an initial claim determination and may be appealed by the provider, however, CMS has instructed MACs to deny the appeal as a failure to comply with a mandatory condition of payment, even if the item or service otherwise meets coverage requirements. <Operational Guide, Section 11, Prior Authorization Process for Certain Hospital Outpatient Department (OPD) Services, Frequently Asked Questions, Q28>
  - c. If the provider issued an ABN to transfer liability to the patient, the claim should be submitted with modifier -GA if the provider believes the denial is based on medical necessity or modifier -GX if the provider believes the denial is based on the statutory exclusion for purely cosmetic services. <Operational Guide, Section 9.1>
    - i. Claims for services requiring prior authorization reported with an ABN modifier will be stopped by the MAC for an additional documentation request and review of the validity of the ABN. <Operational Guide, Section 9.1>
  - d. If the beneficiary has secondary insurance, including Medicaid, this process can be used to obtain a denial from Medicare for submission to secondary insurance. For more information see the Operational Guide, Section 10.1.

#### G. Exemption from Prior Authorization

1. CMS may exempt a provider from the prior authorization process when a provider demonstrates compliance by achieving a 90% provisional affirmation rate with at least 10 submitted claims. <42 C.F.R. 419.83(c); 84 Fed. Reg. 61448; Medicare Program Integrity Manual, Chapter 3 § 3.10.2, Operational Guide, Section 5>

- a. The exemption applies for the full calendar year and applies to all services requiring prior authorization, regardless of whether they were part of the sample used to determine compliance and grant the exemption. <Operational Guide, Section 5.1>
- b. PARs submitted by exempt providers will be rejected. <Operational Guide, Section 5.1>
- c. Providers will receive a notification of continued exemption or withdrawal of exemption 60 days prior to the effective date, generally by November 1. <Operational Guide, Section 5.1; 42 C.F.R. 419.83(c)(2)>
  - i. Providers may opt out of the exemption by submitting a request to their MAC no later than November 30. <Operational Guide, Section 5.1>
- d. Retaining exemption from the prior year:
  - i. A provider with an exemption must have 10 claims submitted by June 30. The MAC will sample 10 claims beginning August 1. Providers must demonstrate a 90% claim approval rate on the 10-claim review to retain their exemption. <Operational Guide, Section 5.1>
- e. Gaining exemption if not exempt in prior year:
  - i. The MAC will calculate the affirmation rate of initial PARs beginning in January and notify providers in October if they have achieved the required 90% affirmation rate to qualify for an exemption for the following year. <Operational Guide, Section 5.1>
- f. See the Operational Guide, Section 5.1 for details on timeframes and the process for exemption for calendar year 2024.

### Case Study 1

**Facts:** A Medicare patient is scheduled for a first diagnostic joint injection procedure described by HCPCS code 64635 (Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint) at a pain clinic that is an outpatient department of a PPS hospital.

The following documentation is in the pain clinic electronic record for the patient:

1. Pain clinic nursing assessment showing pain level 6/10.
2. Bilateral hip, sacroiliac (SI) joint, and lower back x-rays.
3. H&P signed by the pain clinic physician detailing the intended procedure, referencing x-rays, and referencing the nursing pain assessment.

Turn to the *LCD – Facet Joint Interventions for Pain Management L38765* and *Article – Billing and Coding: Facet Joint Interventions for Pain Management (A58350)* in the materials behind the outline and review the requirements for coverage of the procedure. What additional documentation is needed to demonstrate coverage?

Version 01/23/2024  
Check for Updates

## CASE STUDIES WITH ANALYSIS

### Case Study 1

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Turn to the LCD – *Facet Joint Interventions for Pain Management L38765*) and Article – *Billing and Coding: Facet Joint Interventions for Pain Management (A58350)* in the materials behind the outline and review the requirements for coverage of the procedure. What additional documentation is needed to demonstrate coverage?

**Analysis:** The pain clinic physician must document that there is no untreated radiculopathy or neurogenic claudication and no non-facet pathology that could explain the source of the patient’s pain, as required by the LCD.

In addition to the pain assessment, the LCD requires a disability scale at baseline for functional assessment. The notes section lists some acceptable disability scales.

The patient’s history of pain and conservative care that has been tried must also be documented. The LCD requires the patient has had pain for a minimum of 3 months with documented failure of conservative management, defined in the policy as use of NSAIDs, acetaminophen, physical therapy, acupuncture, or spinal manipulation.

The provider must also document that the patient has a covered diagnosis, supported by the medical record. The Article contains a list of covered diagnosis codes.

**Note:** This procedure requires prior authorization when performed in a PPS hospital outpatient department beginning July 1, 2023.

**Note:** This case study is based on a Palmetto LCD, and billing and coding Article provided for illustrative purposes only. The LCDs and billing and coding Articles for facet joint injections vary by jurisdiction, including the documentation required to demonstrate coverage. Verify coverage, including documentation requirements, with the LCD for the applicable jurisdiction and timeframe when determining coverage.

**LCD - Facet Joint Interventions for Pain Management (L38765)**

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	STATES
Palmetto GBA	A and B MAC	10111 - MAC A	J - J	Alabama
Palmetto GBA	A and B MAC	10112 - MAC B	J - J	Alabama
Palmetto GBA	A and B MAC	10211 - MAC A	J - J	Georgia
Palmetto GBA	A and B MAC	10212 - MAC B	J - J	Georgia
Palmetto GBA	A and B MAC	10311 - MAC A	J - J	Tennessee
Palmetto GBA	A and B MAC	10312 - MAC B	J - J	Tennessee
Palmetto GBA	A and B and HHH MAC	11201 - MAC A	J - M	South Carolina
Palmetto GBA	A and B and HHH MAC	11202 - MAC B	J - M	South Carolina
Palmetto GBA	A and B and HHH MAC	11301 - MAC A	J - M	Virginia
Palmetto GBA	A and B and HHH MAC	11302 - MAC B	J - M	Virginia
Palmetto GBA	A and B and HHH MAC	11401 - MAC A	J - M	West Virginia
Palmetto GBA	A and B and HHH MAC	11402 - MAC B	J - M	West Virginia
Palmetto GBA	A and B and HHH MAC	11501 - MAC A	J - M	North Carolina
Palmetto GBA	A and B and HHH MAC	11502 - MAC B	J - M	North Carolina

**LCD Information****Document Information****LCD ID**

L38765

**LCD Title**

Facet Joint Interventions for Pain Management

**Proposed LCD in Comment Period**[DL38765](#)**Source Proposed LCD**[DL38765](#)**AMA CPT / ADA CDT / AHA NUBC Copyright Statement**

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**Original Effective Date**

For services performed on or after 04/25/2021

**Revision Effective Date**

For services performed on or after 05/18/2023

**Revision Ending Date**

N/A

**Retirement Date**

N/A

**Notice Period Start Date**

03/11/2021

**Notice Period End Date**

04/24/2021

**Issue****Issue Description**

This LCD outlines limited coverage for this service with specific details under **Coverage Indications, Limitations and/or Medical Necessity**.

**CMS National Coverage Policy**

Title XVIII of the Social Security Act, §1861(s)(2) addresses medical and other health services.

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

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

Title XVIII of the Social Security Act, §1862(a)(14) defines other than physician services.

42 CFR §410.74 defines physician assistants' services, §410.75 defines nurse practitioners' services, §410.76 defines clinical nurse specialists' services, and §419.22 defines hospital services excluded from payment under the hospital outpatient prospective payment system.

CMS Internet-Only Manual, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, §50 Drugs and Biologicals

CMS Internet-Only Manual, Pub. 100-03, Medicare National Coverage Determinations (NCD) Manual, Chapter 1, Part 1, §30.3 Acupuncture; Part 2, §150.7 Prolotherapy, Joint Sclerotherapy, and Ligamentous Injections with Sclerosing Agents; and Part 4, §220.1 Computed Tomography (CT)

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## Coverage Guidance

### Coverage Indications, Limitations, and/or Medical Necessity

#### Covered Indications Facet Joint Interventions:

Facet joint interventions generally consist of 4 types of procedures: intra-articular (IA) facet joint injections, medial branch blocks (MBB), and radiofrequency ablations (RFA) and facet cyst rupture/aspiration.

Facet joint interventions are considered medically reasonable and necessary for the diagnosis and treatment of chronic pain in patients who meet **ALL** the following criteria:



1. Moderate-to-severe chronic neck or low back pain, predominantly axial, that causes functional deficit measured on pain or disability scale\*
2. Pain present for minimum of 3 months with documented failure to respond to non-invasive conservative management (as tolerated)
3. Absence of untreated radiculopathy or neurogenic claudication (except for radiculopathy caused by facet joint synovial cyst)
4. There is no non-facet pathology per clinical assessment or radiology studies that could explain the source of the patient's pain, including but not limited to fracture, tumor, infection, or significant deformity

\*Pain assessment must be performed at baseline, after each diagnostic procedure using the **same** pain or disability scale for each assessment. A disability scale must also be obtained at baseline to be used for functional assessment (if patient qualifies for treatment).

#### A. Diagnostic Facet Joint Procedures (IA or MBB):

The primary indication of a diagnostic facet joint procedure is to diagnose whether the patient has facet syndrome. IA facet block(s) are considered reasonable and necessary as a diagnostic test only if MBBs cannot be performed due to specific documented anatomic restrictions or there is an indication to proceed with therapeutic IA injections. These restrictions must be clearly documented in the medical record and made available upon request.

Diagnostic procedures should be performed with the intent that if successful, RFA procedure would be considered the primary treatment goal at the diagnosed level(s).

A second diagnostic facet procedure is considered medically necessary to confirm validity of the initial diagnostic facet procedure when administered at the same level. The second diagnostic procedure may only be performed a minimum of 2 weeks after the initial diagnostic procedure. Clinical circumstances that necessitate an exception to the 2-week duration may be considered on an individual basis and must be clearly documented in the medical record.

- a. For the first diagnostic facet joint procedure to be considered medically reasonable and necessary, the patient must meet the criteria outlined under indications for facet joint interventions.
- b. A second confirmatory diagnostic facet joint procedure is considered medically reasonable and necessary in patients who meet **ALL** the following criteria:

- i. The patient meets the criteria for the first diagnostic procedure; **AND**
- ii. After the first diagnostic facet joint procedure, there must be a consistent positive response of at least 80% relief of primary (index) pain (with the duration of relief being consistent with the agent used)

Frequency Limitation: For each covered spinal region no more than 4 diagnostic joint sessions will be reimbursed per rolling 12 months, in recognition that the pain generator cannot always be identified with the initial and confirmatory diagnostic procedure.

#### B. Therapeutic Facet Joint Procedures (IA):

Therapeutic facet joint procedures are considered medically reasonable and necessary for patients who meet **ALL** of the following criteria:

- a. The patient has had 2 medically reasonable and necessary diagnostic facet joint procedures with each 1 providing a consistent minimum of 80% relief of primary (index) pain (with the duration of relief being consistent with the agent used) **AND**
- b. Subsequent therapeutic facet joint procedures at the same anatomic site results in at least consistent 50% pain relief for at least 3 months from the prior therapeutic procedure **or** at least 50% consistent improvement in the ability to perform previously painful movements and activities of daily living (ADLs) as compared to baseline measurement using the same scale; **AND**
- c. Documentation of why the patient is not a candidate for RFA (such as established spinal pseudarthrosis, implanted electrical device)

Frequency Limitation: For each covered spinal region no more than 4 therapeutic facet joint (IA) sessions will be reimbursed per rolling 12 months.

#### C. Facet Joint Denervation:

The thermal radiofrequency destruction of cervical, thoracic, or lumbar paravertebral facet joint (medial branch (MB)) nerves are considered medically reasonable and necessary for patients who meet **ALL** the following criteria:

- a. Initial thermal RFA:
  - i. After the patient has had at least 2 medically reasonable and necessary diagnostic MBBs, with each 1 providing a consistent minimum of 80% sustained relief of primary (index) pain (with the duration of relief being consistent with the agent used); **AND**
  - ii. Repeat thermal facet joint RFA at the same anatomic site is considered medically reasonable and necessary provided the patient had a minimum of consistent 50% improvement in pain for at least 6 months **or** at least 50% consistent improvement in the ability to perform previously painful movements and ADLs as compared to baseline measurement using the same scale

Frequency Limitation: For each covered spinal region no more than 2 radiofrequency sessions will be reimbursed per rolling 12 months.

#### D. Facet Cyst Aspiration/Rupture:

IA facet joint injection performed with synovial cyst aspiration is considered medically necessary when both of the following criteria are met:

- 1. Advanced diagnostic imaging study (e.g., magnetic resonance imaging (MRI)/ computed tomography (CT)/myelogram) confirms compression or displacement of the corresponding nerve root by a facet joint synovial cyst; **AND**

## 2. Clinical and physical symptoms related to synovial facet cyst are documented

Frequency Limitation: Cyst aspiration/rupture may be repeated **once** and only if there is 50% or more consistent improvement in pain for at least 3 months.



### Limitations

1. Facet joint interventions done without CT or fluoroscopic guidance are considered not reasonable and necessary. This includes facet joint interventions done without any guidance, performed under ultrasound guidance, or with MRI.
2. General anesthesia is considered not reasonable and necessary for facet joint interventions. Neither conscious sedation nor monitored anesthesia care (MAC) is routinely necessary for IA facet joint injections or MBBs and are not routinely reimbursable. Individual consideration may be given on redetermination (appeal) for payment in rare, unique circumstances if the medical necessity of sedation is unequivocal and clearly documented in the medical record. Frequent reporting of these services together may trigger focused medical review.
3. It is not expected that patients will routinely present with pain in both cervical/thoracic and lumbar spinal regions. Therefore, facet joint interventions (both diagnostic and therapeutic) are limited to 1 spinal region per session.
4. It is not routinely necessary for multiple blocks (e.g., epidural injections, sympathetic blocks, trigger point injections, etc.) to be provided to a patient on the same day as facet joint procedures. Multiple blocks on the same day could lead to improper or lack of diagnosis. If performed, the medical necessity of each injection (at the same or at different level[s]) must be clearly documented in the medical record. For example, the performance of both paravertebral facet joint procedure(s) and a transforaminal epidural steroid injection (TFESI) at the same or close spinal level at the same encounter would not be expected unless a synovial cyst is compressing the nerve root. In this situation, TFESI may provide relief for the radicular pain, while the facet cyst rupture allows nerve root decompression. Frequent reporting of multiple blocks on the same day may trigger a focused medical review.
5. Facet joint IA injections and MBBs may involve the use of anesthetic, corticosteroids, anti-inflammatories and/or contrast agents, and does not include injections of biologicals or other substances not United States Food and Drug Administration (FDA) designated for this use.
6. One to 2 levels, either unilateral or bilateral, are allowed per session per spine region. The need for a 3 or 4-level procedure bilaterally may be considered under unique circumstances and with sufficient documentation of medical necessity on appeal. A session is a time period, which includes all procedures (i.e., MBBs, IA injections, facet cyst ruptures, and RFAs) that are performed during the same day.
7. If there is an extended time, 2 years or more, since the last RFA and/or there is a question as to the source of the recurrent pain then diagnostic procedures must be repeated.
8. Therapeutic IA facet injections are not covered unless there is documentation on why RFA cannot be performed. Facet joint procedures in patients for the indication of generalized pain conditions (such as fibromyalgia) or chronic centralized pain syndromes are considered not reasonable and necessary. Individual consideration may be considered under unique circumstances and with sufficient documentation of medical necessity on appeal.
9. In patients with implanted electrical devices, providers must follow manufacturer instructions and extra planning as indicated to ensure safety of procedure.

The following are considered not reasonable and necessary and therefore, will be denied:

1. IA and extra-articular facet joint prolotherapy
2. Non-thermal modalities for facet joint denervation including chemical, low-grade thermal energy (less than 80 degrees Celsius), laser neurolysis, and cryoablation
3. Intra-facet implants

4. Facet joint procedure performed after anterior lumbar interbody fusion (ALIF).
5. Definitive clinical and/or imaging findings pointing to a specific diagnosis other than facet joint syndrome
6. Diagnostic injections or MBB at the same level as the previously successful RFA procedure

**Note:** The scales used for measurement of pain and/or disability must be documented in the medical record. Acceptable scales include but are not limited to: verbal rating scales, Numerical Rating Scale (NRS) and Visual Analog Scale (VAS) for pain assessment, and Pain Disability Assessment Scale (PDAS), Oswestry Disability Index (ODI), Oswestry Low Back Pain Disability Questionnaire (OSW), Quebec Back Pain Disability Scale (QBPDS), Roland Morris Pain Scale (RDQ), Back Pain Functional Scale (BPFS), and the Patient-Reported Outcomes Measurement Information System (PROMIS®) profile domains to assess function.

**Notice:** Services performed for any given diagnosis must meet all the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, all existing CMS national coverage determinations, and all Medicare payment rules.

### **Provider Qualifications:**

Medicare Program Integrity Manual states services will be considered medically reasonable and necessary only if performed by appropriately trained providers.

Patient safety and quality of care mandate that healthcare professionals who perform facet injections/procedures are appropriately trained and/or credentialed by a formal residency/fellowship program and/or are certified by either an accredited and nationally recognized organization or by a post-graduate training course accredited by an established national accrediting body or accredited professional training program. If the practitioner works in a hospital facility at any time and/or is credentialed by a hospital for any procedure, the practitioner must be credentialed to perform the same procedure in the outpatient setting. At a minimum, training must cover and develop an understanding of anatomy and drug pharmacodynamics and kinetics as well as proficiency in diagnosis and management of disease, the technical performance of the procedure, and utilization of the required associated imaging modalities.

In addition to the above requirements, non-physician providers, such as certified nurse anesthetists, with certain exceptions, may certify, order and establish the plan of care as authorized by state law. (See Sections 1861[s][2] and 1862[a][14] of Title XVIII of the Social Security Act; 42 CFR, Sections 410.74, 410.75, 410.76 and 419.22; 58 FR 18543, April 7, 2000.) Each practitioner must provide only those services within the scope of practice for each state.

### **Definitions**

**Acute pain** - The temporal definition of pain persisting for up to 4 weeks after the onset of the pain.

**Axial** - Relating to or situated in the central part of the body, in the head and trunk as distinguished from the limbs, e.g., axial skeleton.

**Biopsychosocial model** - Interdisciplinary model that looks at the interconnection between biology, pathology and socioenvironmental factors.

**Central neuropathic pain** - Pain, which is causally related to a lesion or disease of the central somatosensory nerves.

**Centralized pain** - A neurological chronic pain syndrome of the central nervous system (brain, brainstem, and

# Article - Billing and Coding: Facet Joint Interventions for Pain Management (A58350)

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## Contractor Information

CONTRACTOR NAME	CONTRACT TYPE	CONTRACT NUMBER	JURISDICTION	STATES
Palmetto GBA	A and B MAC	10111 - MAC A	J - J	Alabama
Palmetto GBA	A and B MAC	10112 - MAC B	J - J	Alabama
Palmetto GBA	A and B MAC	10211 - MAC A	J - J	Georgia
Palmetto GBA	A and B MAC	10212 - MAC B	J - J	Georgia
Palmetto GBA	A and B MAC	10311 - MAC A	J - J	Tennessee
Palmetto GBA	A and B MAC	10312 - MAC B	J - J	Tennessee
Palmetto GBA	A and B and HHH MAC	11201 - MAC A	J - M	South Carolina
Palmetto GBA	A and B and HHH MAC	11202 - MAC B	J - M	South Carolina
Palmetto GBA	A and B and HHH MAC	11301 - MAC A	J - M	Virginia
Palmetto GBA	A and B and HHH MAC	11302 - MAC B	J - M	Virginia
Palmetto GBA	A and B and HHH MAC	11401 - MAC A	J - M	West Virginia
Palmetto GBA	A and B and HHH MAC	11402 - MAC B	J - M	West Virginia
Palmetto GBA	A and B and HHH MAC	11501 - MAC A	J - M	North Carolina
Palmetto GBA	A and B and HHH MAC	11502 - MAC B	J - M	North Carolina

## Article Information

### General Information

**Article ID**

A58350

**Article Title**

Billing and Coding: Facet Joint Interventions for Pain Management

**Article Type**

Billing and Coding

**Original Effective Date**
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04/13/2023

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**CMS National Coverage Policy**

Title XVIII of the Social Security Act, §1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

CMS Internet-Only Manual, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 16, §180 Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare.

CMS Internet-Only Manual, Pub. 100-04, Medicare Claims Processing Manual, Chapter 13, §10.1 Billing Part B Radiology Services and Other Diagnostic Procedures and §20 Payment Conditions for Radiology Services.

**Article Guidance**

**Article Text**

The information in this article contains billing, coding or other guidelines that complement the Local Coverage Determination (LCD) for Facet Joint Interventions for Pain Management L38765.

The Current Procedural Terminology (CPT®)/Healthcare Common Procedure Coding System (HCPCS) code(s) may be subject to National Correct Coding Initiative (NCCI) edits. Please refer to NCCI for correct coding guidelines and specific applicable code combinations prior to billing Medicare.

**General Guidelines for Claims submitted to Part A or Part B MAC:**

Procedure codes may be subject to NCCI edits or Hospital Outpatient Prospective Payment System (OPPS) packaging edits. Refer to NCCI and OPPS requirements prior to billing Medicare. For services requiring a referring/ordering physician, the name and National Provider Identifier (NPI) of the referring/ordering physician must be reported on

the claim. A claim submitted without a valid ICD-10-CM diagnosis code will be returned to the provider as an incomplete claim under Section 1833(e) of the Social Security Act. The diagnosis code(s) must best describe the patient's condition for which the service was performed. For diagnostic tests, report the result of the test if known; otherwise, the symptoms prompting the performance of the test should be reported.

**Coding Guidance:** Providers should refer to the applicable AMA CPT® Manual to assist with proper reporting of these services.

This article applies only to cervical/thoracic or lumbar facet procedures and does not apply to other joint procedures (such as sacral injections, sacroiliitis, epidural or other spinal procedures).

#### Diagnostic and Therapeutic Injections:

Each facet level in the spinal region is composed of bilateral facet joints (i.e., there are 2 facet joints per level, 1 on the right side and 1 on the left). Unilateral or bilateral facet interventions may be performed during the facet joint procedure (a diagnostic nerve block, a therapeutic facet joint (intra-articular) injection, a medial branch block injection, or the medial branch radiofrequency ablation (neurotomy) in 1 session. A bilateral intervention is still considered a single level intervention.

Each unilateral or bilateral intervention at any level should be reported as 1 unit, with bilateral intervention signified by appending the modifier -50.

One medial branch block is counted as 2 facet joint injections.

#### Regions:

An anatomic spinal region for paravertebral facet joint block (diagnostic or therapeutic), is defined as cervical\thoracic (CPT® codes 64490, 64491, 64492) or lumbar\sacral (CPT® codes 64493, 64494, 64495) per the American Medical Association (AMA) CPT® Manual.

#### Levels:

64490 (cervical or thoracic) or 64493 (lumbar or sacral) reports a single level injection performed with image guidance (fluoroscopy or computed tomography (CT)). Procedures performed under ultrasound guidance are not covered.

64491 or 64494 describes a second level which should be reported separately in addition to the code for the primary procedure. 64491 should be reported in conjunction with 64490 and 64494 should be reported in conjunction with 64493.

64492 or 64495 describes a third and additional levels and should be listed separately in addition to the code for the primary procedure and the second level procedure and cannot be reported more than once per day. 64492 should be reported in conjunction with 64490/64491 and 64495 should be reported in conjunction with 64493/64494.

#### Laterality:

Bilateral paravertebral facet injection procedures 64490 through 64495 should be reported with modifier 50.

One to 2 levels, either unilateral or bilateral, are allowed per session per spine region (i.e., 2 unilateral or 2 bilateral levels per session).

For services performed in the Ambulatory Surgery Center (ASC), physicians must continue using modifier 50. Only the ASC facility itself must report the applicable procedure code on 2 separate lines, with 1 unit each and append the -RT and -LT modifiers to each line.

KX modifier requirements:

The KX modifier should be appended to the line for all diagnostic injections. In most cases the KX modifier will only be used for the 2 initial diagnostic injections. If the initial diagnostic injections do not produce a positive response as defined by the related LCD and indicative of identification of the pain generator, and it is necessary to perform additional diagnostic injections, append the KX modifier to the line. Aberrant use of the KX modifier may trigger focused medical review.

Therapeutic injections:

Documentation of why patient is not a candidate for radiofrequency ablation (RFA) must be submitted for therapeutic treatment.

Chemodenervation of nerve:

Codes 64633, 64634, 64635, 64636 are reported per joint, not per nerve. Although 2 nerves innervate each facet joint, only 1 unit per code may be reported for each joint denervated, regardless of the number of nerves treated (AMA CPT<sup>®</sup> Manual 2020).

Each unilateral or bilateral intervention at any level should be reported as 1 unit, with bilateral intervention signified by appending the modifier -50.

Region:

An anatomic spinal region for thermal facet joint denervation is defined as cervical/thoracic (CPT<sup>®</sup> codes 64633 and 64634) or lumbar/sacral (CPT<sup>®</sup> codes 64635 and 64636) per the AMA CPT<sup>®</sup> Manual.

For neurolytic destruction of the nerves innervating the T12-L1 paravetebral facet joint, use 64633.

Levels:

64633 or 64635 describes a single level destruction by neurolytic agent performed with image guidance (fluoroscopy or CT).

64634 or 64636 describes each additional level which should be reported separately in addition to the code for the primary procedure. 64634 should be used in conjunction with 64633 and 64636 should be used in conjunction with 64635.

Laterality:

For bilateral procedures report modifier 50 on each line in which the intervention was of a bilateral nature.

For services performed in the ASC, physicians must continue using modifier 50. Only the ASC facility itself must report the applicable procedure code on 2 separate lines, with 1 unit each and append the -RT and -LT modifiers to each line.

Non-thermal facet joint denervation (including chemical, low grade thermal energy (<80 degrees Celsius or any other form of pulsed radiofrequency) should not be reported with CPT<sup>®</sup> codes 64633, 64634, 64635 or 64636. These services should be reported with CPT<sup>®</sup> code 64999. Code 64999 is non-covered when used to report non-thermal facet joint denervation.

If facet joints are injected with biologicals or other substances not designated for this use the entire claim will deny per Medicare Benefit Policy Manual, chapter 16, §180.

Use of moderate or deep sedation, general anesthesia, and monitored anesthesia care (MAC) is usually unnecessary or rarely indicated for these procedures and not routinely reimbursable and, therefore, may be denied. In exceptional circumstances if the medical necessity of sedation is unequivocal and clearly documented in the medical record, individual consideration may be considered on appeal.

### Documentation Requirements



The patient's medical record should include, but is not limited to:

- The assessment of the patient by the performing provider as it relates to the complaint of the patient for that visit
- Relevant medical history
- Results of pertinent tests/procedures
- Signed and dated office visit record/operative report (Please note that all services ordered or rendered to Medicare beneficiaries must be signed.)

## Coding Information

### CPT/HCPCS Codes

#### Group 1 Paragraph:

N/A

#### Group 1 Codes: (8 Codes)

CODE	DESCRIPTION
64490	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), CERVICAL OR THORACIC; SINGLE LEVEL

CODE	DESCRIPTION
64491	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), CERVICAL OR THORACIC; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
64493	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; SINGLE LEVEL
64494	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
64633	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE(S), WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); CERVICAL OR THORACIC, SINGLE FACET JOINT
64634	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE(S), WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); CERVICAL OR THORACIC, EACH ADDITIONAL FACET JOINT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
64635	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE(S), WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, SINGLE FACET JOINT
64636	DESTRUCTION BY NEUROLYTIC AGENT, PARAVERTEBRAL FACET JOINT NERVE(S), WITH IMAGING GUIDANCE (FLUOROSCOPY OR CT); LUMBAR OR SACRAL, EACH ADDITIONAL FACET JOINT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

**Group 2 Paragraph:**

The following CPT/HCPCS codes are non-covered\*:

\*This is not an inclusive list of non-covered codes.

**\*Note:** 64492 or 64495 describes a third and additional levels and should be listed separately in addition to the code for the primary procedure and the second level procedure and cannot be reported more than once per day. 64492 should be reported in conjunction with 64490/64491 and 64495 should be reported in conjunction with 64493/64494. Codes 64492 and 64495 will only be covered upon appeal if sufficient documentation of medical necessity is present.

**Group 2 Codes:** (12 Codes)

CODE	DESCRIPTION
64492	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE

CODE	DESCRIPTION
	GUIDANCE (FLUOROSCOPY OR CT), CERVICAL OR THORACIC; THIRD AND ANY ADDITIONAL LEVEL(S) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
64495	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH IMAGE GUIDANCE (FLUOROSCOPY OR CT), LUMBAR OR SACRAL; THIRD AND ANY ADDITIONAL LEVEL(S) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0213T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, CERVICAL OR THORACIC; SINGLE LEVEL
0214T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, CERVICAL OR THORACIC; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0215T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, CERVICAL OR THORACIC; THIRD AND ANY ADDITIONAL LEVEL(S) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0216T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, LUMBAR OR SACRAL; SINGLE LEVEL
0217T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, LUMBAR OR SACRAL; SECOND LEVEL (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0218T	INJECTION(S), DIAGNOSTIC OR THERAPEUTIC AGENT, PARAVERTEBRAL FACET (ZYGAPOPHYSEAL) JOINT (OR NERVES INNERVATING THAT JOINT) WITH ULTRASOUND GUIDANCE, LUMBAR OR SACRAL; THIRD AND ANY ADDITIONAL LEVEL(S) (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)
0219T	PLACEMENT OF A POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; CERVICAL
0220T	PLACEMENT OF A POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; THORACIC
0221T	PLACEMENT OF A POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; LUMBAR
0222T	PLACEMENT OF A POSTERIOR INTRAFACET IMPLANT(S), UNILATERAL OR

CODE	DESCRIPTION
	BILATERAL, INCLUDING IMAGING AND PLACEMENT OF BONE GRAFT(S) OR SYNTHETIC DEVICE(S), SINGLE LEVEL; EACH ADDITIONAL VERTEBRAL SEGMENT (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)

**CPT/HCPCS Modifiers****Group 1 Paragraph:**

N/A

**Group 1 Codes:**

N/A

**ICD-10-CM Codes that Support Medical Necessity****Group 1 Paragraph:**

**Note:** It is the provider's responsibility to select codes carried out to the highest level of specificity and selected from the ICD-10-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

Medicare is establishing the following limited coverage for CPT/HCPCS codes: **64490, 64491, 64493, 64494, 64633, 64634, 64635, and 64636.**

**Note:** ICD-10-CM Codes M71.30 or M71.38 are allowed for facet cyst rupture procedures only.

**Group 1 Codes:** (20 Codes)

CODE	DESCRIPTION
M47.812	Spondylosis without myelopathy or radiculopathy, cervical region
M47.813	Spondylosis without myelopathy or radiculopathy, cervicothoracic region
M47.814	Spondylosis without myelopathy or radiculopathy, thoracic region
M47.815	Spondylosis without myelopathy or radiculopathy, thoracolumbar region
M47.816	Spondylosis without myelopathy or radiculopathy, lumbar region
M47.817	Spondylosis without myelopathy or radiculopathy, lumbosacral region
M47.892	Other spondylosis, cervical region
M47.893	Other spondylosis, cervicothoracic region
M47.894	Other spondylosis, thoracic region
M47.895	Other spondylosis, thoracolumbar region

CODE	DESCRIPTION
M47.896	Other spondylosis, lumbar region
M47.897	Other spondylosis, lumbosacral region
M48.12	Ankylosing hyperostosis [Forestier], cervical region
M48.13	Ankylosing hyperostosis [Forestier], cervicothoracic region
M48.14	Ankylosing hyperostosis [Forestier], thoracic region
M48.15	Ankylosing hyperostosis [Forestier], thoracolumbar region
M48.16	Ankylosing hyperostosis [Forestier], lumbar region
M48.17	Ankylosing hyperostosis [Forestier], lumbosacral region
M71.30	Other bursal cyst, unspecified site
M71.38	Other bursal cyst, other site

#### ICD-10-CM Codes that DO NOT Support Medical Necessity

N/A

#### ICD-10-PCS Codes

N/A

#### Additional ICD-10 Information

N/A

#### Bill Type Codes

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

CODE	DESCRIPTION
012x	Hospital Inpatient (Medicare Part B only)
013x	Hospital Outpatient
071x	Clinic - Rural Health
073x	Clinic - Freestanding
083x	Ambulatory Surgery Center
085x	Critical Access Hospital

**Revenue Codes**

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

CODE	DESCRIPTION
032X	Radiology - Diagnostic - General Classification
036X	Operating Room Services - General Classification
045X	Emergency Room - General Classification
049X	Ambulatory Surgical Care - General Classification
051X	Clinic - General Classification
052X	Freestanding Clinic - General Classification
076X	Specialty Services - General Classification

**Other Coding Information**

N/A

**Revision History Information**

REVISION HISTORY DATE	REVISION HISTORY NUMBER	REVISION HISTORY EXPLANATION
04/13/2023	R3	Under <b>CMS National Coverage Policy</b> added regulation section headings and the following regulation: "CMS Internet-Only Manual, Pub. 100-02, Medicare Benefit Policy Manual, Chapter 16, §180 Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare." Under <b>Article Text</b> in the fifth paragraph verbiage was changed from "This policy applies..." to "This article applies...." Formatting, punctuation and typographical errors were corrected throughout the article. Acronyms were inserted where appropriate throughout the article.
11/06/2022	R2	Under <b>Article Text</b> revised verbiage regarding physician use of modifier 50 when services are performed in an ASC, and added language regarding the use of moderate or deep sedation, general anesthesia, and monitored anesthesia (MAC).
05/01/2022	R1	Under <b>Article Text</b> deleted the verbiage "This information does not take precedence over NCCI edits" from the second paragraph.



**Medicare National Coverage  
Determinations (NCD)  
Coding Policy Manual and  
Change Report (ICD-10-CM)  
\*January 2024**



***Clinical Diagnostic Laboratory Services***

**U.S. Department of Health & Human Services  
Centers for Medicare & Medicaid Services**

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TDD 410.786.0727

**Fu Associates, Ltd.**



**Medicare National Coverage Determinations (NCD)  
Coding Policy Manual and Change Report (ICD-10-CM)**

## NCD Manual Changes

CR Date	Reason	Release	Change	Edit
*01/01/24	*Per CR 13350 add the specified ICD-10-CM codes from the list of ICD-10-CM codes that are covered for the Urine Culture, Bacterial (190.12) NCD.  *Transmittal #12219	*2024100		*190.12 Urine Culture, Bacterial
*01/01/24	*Per CR 13350 add the specified ICD-10-CM codes from the list of ICD-10-CM codes that are denied for the Urine Culture, Bacterial (190.12) NCD.  *Transmittal #12219	*2024100		*190.12 Urine Culture, Bacterial
*01/01/24	*Per CR 13350 add the specified ICD-10-CM codes from the list of ICD-10-CM codes that are denied for the Human Immunodeficiency Virus (HIV) Testing (Prognosis Including Monitoring) (190.13) NCD.  *Transmittal #12219	*2024100		*190.13 Human Immunodeficiency Virus (HIV) Testing (Prognosis Including Monitoring)

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## **Non-covered ICD-10-CM Codes for All Lab NCDs**

This section lists codes that are never covered by Medicare for a diagnostic lab testing service. If a code from this section is given as the reason for the test, the test may be billed to the Medicare beneficiary without billing Medicare first because the service is not covered by statute, in most instances because it is performed for screening purposes and is not within an exception. The beneficiary, however, does have a right to have the claim submitted to Medicare, upon request.

The ICD-10-CM codes in the table below can be viewed on CMS' website as part of  
Downloads: Lab Code List, at  
<http://www.cms.gov/Medicare/Coverage/CoverageGenInfo/LabNCDsICD10.html>

Code	Description
R99	Ill-defined and unknown cause of mortality
Z00.00	Encounter for general adult medical examination without abnormal findings
Z00.01	Encounter for general adult medical examination with abnormal findings
Z00.110	Health examination for newborn under 8 days old
Z00.111	Health examination for newborn 8 to 28 days old
Z00.121	Encounter for routine child health examination with abnormal findings
Z00.129	Encounter for routine child health examination without abnormal findings
Z00.5	Encounter for examination of potential donor of organ and tissue
Z00.6	Encounter for examination for normal comparison and control in clinical research program
Z00.70	Encounter for examination for period of delayed growth in childhood without abnormal findings
Z00.71	Encounter for examination for period of delayed growth in childhood with abnormal findings
Z00.8	Encounter for other general examination
Z02.0	Encounter for examination for admission to educational institution
Z02.1	Encounter for pre-employment examination
Z02.2	Encounter for examination for admission to residential institution
Z02.3	Encounter for examination for recruitment to armed forces
Z02.4	Encounter for examination for driving license
Z02.5	Encounter for examination for participation in sport
Z02.6	Encounter for examination for insurance purposes
Z02.71	Encounter for disability determination
Z02.79	Encounter for issue of other medical certificate

**\*January 2024 Changes  
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**Medicare National Coverage Determinations (NCD)  
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Code	Description
Z02.81	Encounter for paternity testing
Z02.82	Encounter for adoption services
Z02.83	Encounter for blood-alcohol and blood-drug test
<b>*Z02.84</b>	<b>*Encounter for child welfare exam</b>
Z02.89	Encounter for other administrative examinations
Z02.9	Encounter for administrative examinations, unspecified
Z04.6	Encounter for general psychiatric examination, requested by authority
Z04.81	Encounter for examination and observation of victim following forced sexual exploitation
Z04.82	Encounter for examination and observation of victim following forced labor exploitation
Z04.89	Encounter for examination and observation for other specified reasons
Z04.9	Encounter for examination and observation for unspecified reason
Z11.0	Encounter for screening for intestinal infectious diseases
Z11.1	Encounter for screening for respiratory tuberculosis
Z11.2	Encounter for screening for other bacterial diseases
Z11.3	Encounter for screening for infections with a predominantly sexual mode of transmission
Z11.4	Encounter for screening for human immunodeficiency virus [HIV]
Z11.51	Encounter for screening for human papillomavirus (HPV)
Z11.52	Encounter for screening for COVID-19
Z11.59	Encounter for screening for other viral diseases
Z11.6	Encounter for screening for other protozoal diseases and helminthiases
Z11.7	Encounter for testing for latent tuberculosis infection
Z11.8	Encounter for screening for other infectious and parasitic diseases
Z11.9	Encounter for screening for infectious and parasitic diseases, unspecified
Z12.0	Encounter for screening for malignant neoplasm of stomach
Z12.10	Encounter for screening for malignant neoplasm of intestinal tract, unspecified
Z12.13	Encounter for screening for malignant neoplasm of small intestine
Z12.2	Encounter for screening for malignant neoplasm of respiratory organs
Z12.6	Encounter for screening for malignant neoplasm of bladder
Z12.71	Encounter for screening for malignant neoplasm of testis
Z12.72	Encounter for screening for malignant neoplasm of vagina
Z12.73	Encounter for screening for malignant neoplasm of ovary
Z12.79	Encounter for screening for malignant neoplasm of other genitourinary organs
Z12.81	Encounter for screening for malignant neoplasm of oral cavity

**\*January 2024 Changes  
ICD-10-CM Version – Red**



**Medicare National Coverage Determinations (NCD)  
Coding Policy Manual and Change Report (ICD-10-CM)**

Code	Description
Z12.82	Encounter for screening for malignant neoplasm of nervous system
Z12.83	Encounter for screening for malignant neoplasm of skin
Z12.89	Encounter for screening for malignant neoplasm of other sites
Z12.9	Encounter for screening for malignant neoplasm, site unspecified
Z13.0	Encounter for screening for diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z13.21	Encounter for screening for nutritional disorder
Z13.220	Encounter for screening for lipid disorders
Z13.228	Encounter for screening for other metabolic disorders
Z13.29	Encounter for screening for other suspected endocrine disorder
Z13.30	Encounter for screening examination for mental health and behavioral disorders, unspecified
Z13.31	Encounter for screening for depression
Z13.32	Encounter for screening for maternal depression
Z13.39	Encounter for screening examination for other mental health and behavioral disorders
Z13.40	Encounter for screening for unspecified developmental delays
Z13.41	Encounter for autism screening
Z13.42	Encounter for screening for global developmental delays (milestones)
Z13.49	Encounter for screening for other developmental delays
Z13.5	Encounter for screening for eye and ear disorders
Z13.71	Encounter for nonprocreative screening for genetic disease carrier status
Z13.79	Encounter for other screening for genetic and chromosomal anomalies
Z13.810	Encounter for screening for upper gastrointestinal disorder
Z13.811	Encounter for screening for lower gastrointestinal disorder
Z13.818	Encounter for screening for other digestive system disorders
Z13.820	Encounter for screening for osteoporosis
Z13.828	Encounter for screening for other musculoskeletal disorder
Z13.83	Encounter for screening for respiratory disorder NEC
Z13.84	Encounter for screening for dental disorders
Z13.850	Encounter for screening for traumatic brain injury
Z13.858	Encounter for screening for other nervous system disorders
Z13.88	Encounter for screening for disorder due to exposure to contaminants
Z13.89	Encounter for screening for other disorder
Z13.9	Encounter for screening, unspecified

**\*January 2024 Changes  
ICD-10-CM Version – Red**



**Medicare National Coverage Determinations (NCD)  
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Code	Description
Z36.0	Encounter for antenatal screening for chromosomal anomalies
Z36.1	Encounter for antenatal screening for raised alphafetoprotein level
Z36.2	Encounter for other antenatal screening follow-up
Z36.3	Encounter for antenatal screening for malformations
Z36.4	Encounter for antenatal screening for fetal growth retardation
Z36.5	Encounter for antenatal screening for isoimmunization
Z36.81	Encounter for antenatal screening for hydrops fetalis
Z36.82	Encounter for antenatal screening for nuchal translucency
Z36.83	Encounter for fetal screening for congenital cardiac abnormalities
Z36.84	Encounter for antenatal screening for fetal lung maturity
Z36.85	Encounter for antenatal screening for Streptococcus B
Z36.86	Encounter for antenatal screening for cervical length
Z36.87	Encounter for antenatal screening for uncertain dates
Z36.88	Encounter for antenatal screening for fetal macrosomia
Z36.89	Encounter for other specified antenatal screening
Z36.8A	Encounter for antenatal screening for other genetic defects
Z36.9	Encounter for antenatal screening, unspecified
Z40.00	Encounter for prophylactic removal of unspecified organ
Z40.01	Encounter for prophylactic removal of breast
Z40.02	Encounter for prophylactic removal of ovary(s)
Z40.09	Encounter for prophylactic removal of other organ
Z40.8	Encounter for other prophylactic surgery
Z40.9	Encounter for prophylactic surgery, unspecified
Z41.1	Encounter for cosmetic surgery
Z41.2	Encounter for routine and ritual male circumcision
Z41.3	Encounter for ear piercing
Z41.8	Encounter for other procedures for purposes other than remedying health state
Z41.9	Encounter for procedure for purposes other than remedying health state, unspecified
Z46.1	Encounter for fitting and adjustment of hearing aid
Z56.0	Unemployment, unspecified
Z56.2	Threat of job loss
Z56.3	Stressful work schedule
Z56.4	Discord with boss and workmates

**\*January 2024 Changes  
ICD-10-CM Version – Red**



**Medicare National Coverage Determinations (NCD)  
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Code	Description
Z56.5	Uncongenial work environment
Z56.6	Other physical and mental strain related to work
Z56.81	Sexual harassment on the job
Z56.82	Military deployment status
Z56.89	Other problems related to employment
Z56.9	Unspecified problems related to employment
Z57.0	Occupational exposure to noise
Z57.1	Occupational exposure to radiation
Z57.2	Occupational exposure to dust
Z57.31	Occupational exposure to environmental tobacco smoke
Z57.39	Occupational exposure to other air contaminants
Z57.4	Occupational exposure to toxic agents in agriculture
Z57.5	Occupational exposure to toxic agents in other industries
Z57.6	Occupational exposure to extreme temperature
Z57.7	Occupational exposure to vibration
Z57.8	Occupational exposure to other risk factors
Z57.9	Occupational exposure to unspecified risk factor
Z58.6	Inadequate drinking-water supply
Z58.81	Basic services unavailable in physical environment
Z58.89	Other problems related to physical environment
Z59.00	Homelessness unspecified
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.10	Inadequate housing, unspecified
Z59.11	Inadequate housing environmental temperature
Z59.12	Inadequate housing utilities
Z59.19	Other inadequate housing
Z59.2	Discord with neighbors, lodgers and landlord
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.5	Extreme poverty
Z59.6	Low income

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**Medicare National Coverage Determinations (NCD)  
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Code	Description
Z59.7	Insufficient social insurance and welfare support
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.819	Housing instability, housed unspecified
Z59.82	Transportation insecurity
Z59.86	Financial insecurity
Z59.87	Material hardship due to limited financial resources, not elsewhere classified
Z59.89	Other problems related to housing and economic circumstances
Z59.9	Problem related to housing and economic circumstances, unspecified
Z60.2	Problems related to living alone
Z62.21	Child in welfare custody
Z71.0	Person encountering health services to consult on behalf of another person
Z74.1	Need for assistance with personal care
Z74.2	Need for assistance at home and no other household member able to render care
Z74.3	Need for continuous supervision
Z74.8	Other problems related to care provider dependency
Z74.9	Problem related to care provider dependency, unspecified
Z75.5	Holiday relief care
Z76.0	Encounter for issue of repeat prescription
Z76.1	Encounter for health supervision and care of foundling
Z76.2	Encounter for health supervision and care of other healthy infant and child
Z76.3	Healthy person accompanying sick person
Z76.4	Other boarder to healthcare facility
Z76.81	Expectant parent(s) prebirth pediatrician visit
Z80.1	Family history of malignant neoplasm of trachea, bronchus and lung
Z80.2	Family history of malignant neoplasm of other respiratory and intrathoracic organs
Z80.49	Family history of malignant neoplasm of other genital organs
Z80.51	Family history of malignant neoplasm of kidney
Z80.52	Family history of malignant neoplasm of bladder
Z80.59	Family history of malignant neoplasm of other urinary tract organ
Z80.6	Family history of leukemia
Z80.7	Family history of other malignant neoplasms of lymphoid, hematopoietic and related tissues

**\*January 2024 Changes  
ICD-10-CM Version – Red**



**Medicare National Coverage Determinations (NCD)  
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Code	Description
Z80.8	Family history of malignant neoplasm of other organs or systems
Z80.9	Family history of malignant neoplasm, unspecified
Z81.0	Family history of intellectual disabilities
Z81.1	Family history of alcohol abuse and dependence
Z81.2	Family history of tobacco abuse and dependence
Z81.3	Family history of other psychoactive substance abuse and dependence
Z81.4	Family history of other substance abuse and dependence
Z81.8	Family history of other mental and behavioral disorders
Z82.0	Family history of epilepsy and other diseases of the nervous system
Z82.1	Family history of blindness and visual loss
Z82.2	Family history of deafness and hearing loss
Z82.3	Family history of stroke
Z82.41	Family history of sudden cardiac death
Z82.49	Family history of ischemic heart disease and other diseases of the circulatory system
Z82.5	Family history of asthma and other chronic lower respiratory diseases
Z82.61	Family history of arthritis
Z82.62	Family history of osteoporosis
Z82.69	Family history of other diseases of the musculoskeletal system and connective tissue
Z82.71	Family history of polycystic kidney
Z82.79	Family history of other congenital malformations, deformations and chromosomal abnormalities
Z82.8	Family history of other disabilities and chronic diseases leading to disablement, not elsewhere classified
Z83.0	Family history of human immunodeficiency virus [HIV] disease
Z83.1	Family history of other infectious and parasitic diseases
Z83.2	Family history of diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism
Z83.3	Family history of diabetes mellitus
Z83.41	Family history of multiple endocrine neoplasia [MEN] syndrome
Z83.49	Family history of other endocrine, nutritional and metabolic diseases
Z83.511	Family history of glaucoma
Z83.518	Family history of other specified eye disorder
Z83.52	Family history of ear disorders
Z83.6	Family history of other diseases of the respiratory system

**\*January 2024 Changes  
ICD-10-CM Version – Red**



**Medicare National Coverage Determinations (NCD)  
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<b>Code</b>	<b>Description</b>
Z83.710	Family history of adenomatous and serrated polyps
Z83.711	Family history of hyperplastic colon polyps
Z83.718	Other family history of colon polyps
Z83.719	Family history of colon polyps, unspecified
Z83.79	Family history of other diseases of the digestive system
Z84.0	Family history of diseases of the skin and subcutaneous tissue
Z84.1	Family history of disorders of kidney and ureter
Z84.2	Family history of other diseases of the genitourinary system
Z84.3	Family history of consanguinity
Z84.81	Family history of carrier of genetic disease
Z84.89	Family history of other specified conditions

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**\*January 2024 Changes  
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## **Reasons for Denial for All Lab NCDs**

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**NOTE:** This section includes CMS's interpretation of its longstanding policies pertaining to nationally covered laboratory services, and is included for informational purposes.

- Tests for screening purposes that are performed in the absence of signs, symptoms, complaints, or personal history of disease or injury are not covered except as explicitly authorized by statute.
- Tests for administrative purposes, including exams required by insurance companies, business establishments, government agencies, or other third parties, are not covered.
- Tests that are not reasonable and necessary for the diagnosis or treatment of an illness or injury are not covered by statute.
- Failure to provide documentation of the medical necessity of tests might result in denial of claims. The documentation may include notes documenting relevant signs, symptoms, or abnormal findings that substantiate the medical necessity for ordering the tests. In addition, failure to provide independent verification that the test was ordered by the treating physician (or qualified nonphysician practitioner) through documentation in the physician's office might result in denial.
- A claim for a test for which there is a national coverage policy will be denied as not reasonable and necessary if the claim is submitted without an ICD-10-CM code or narrative diagnosis listed as covered in the policy unless other medical documentation justifying the necessity is submitted with the claim.
- If a national coverage policy identifies a frequency expectation, a claim for a test that exceeds that expectation may be denied as not reasonable and necessary, unless it is submitted with documentation justifying increased frequency.
- Tests that are not ordered by a treating physician or other qualified treating nonphysician practitioner acting within the scope of their license and in compliance with Medicare requirements will be denied as not reasonable and necessary.
- Failure of the clinical laboratory performing the test to have the appropriate Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate will result in denial of claims.

**\*January 2024 Changes  
ICD-10-CM Version – Red**



## **Coding Guidelines for All Lab NCDs**

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1. On and after the implementation date for ICD-10-CM coding of Medicare billing claims, a claim for a clinical diagnostic laboratory service must include a valid ICD-10-CM diagnosis code. When a diagnosis has not been established by the physician, codes that describe symptoms and signs, as opposed to diagnoses, should be provided (see also bullet #5 below).

Please note that ICD-10-CM codes for diagnoses are not required (and will not be effective) for Medicare billing transactions prior to October 1, 2015. Please use ICD-9-CM codes for diagnoses prior to that date.

Please check the CMS website [www.cms.gov/ICD10](http://www.cms.gov/ICD10) for more information on the implementation of ICD-10-CM codes.

2. Medicare distinguishes 'screening' from 'diagnostic uses' of tests. 'Screening' is testing for disease or disease precursors so that early detection and treatment can be provided for those who test positive for the disease. Screening tests are performed when no specific sign, symptom, or diagnosis is present and the beneficiary has not been exposed to a disease.

In contrast, 'diagnostic' testing is testing to rule out or to confirm a suspected diagnosis because of a sign and/or symptom in the beneficiary. In these cases, the sign or symptom should be used to explain the reason for the test.

Some laboratory tests are covered by the Medicare program for screening purposes (for example, NCD # 210.1, Prostate Cancer Screening Tests). However, this manual focuses only on coding policies for diagnostic uses of laboratory services (for example, the test for prostate specific antigen (PSA)).

3. When the reason for performing a test is because the beneficiary has had contact with, or exposure to, a communicable disease, the appropriate code from category Z20, 'Contact with or exposure to communicable diseases', should be assigned. However, on review, the test might still be considered screening and not covered by Medicare.
4. All digits required by ICD-10-CM coding conventions must be used. A code is invalid if it has not been coded with all digits/characters required for that code.
5. The beneficiary's condition(s) and/or diseases should be coded in ICD-10-CM to the highest degree of certainty for that encounter/visit, such as signs, symptoms, abnormal test results, or other reasons for the visit. When a non-specific ICD-10-CM code is submitted, the underlying sign, symptom, or condition must be related to the indications for the test.

**\*January 2024 Changes  
ICD-10-CM Version – Red**



## ***Additional Coding Guideline(s)***

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Note: For any additional guideline(s) about ICD-10-CM coding for a specific diagnostic test service, please see the section “Limitations” in each NCD following the code list table.

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ICD-10-CM Version – Red**

### Final List of Outpatient Department Services That Require Prior Authorization

<b>Beginning for service dates on or after July 1, 2020</b>	
Code	(i) Blepharoplasty, Blepharoptosis Repair, and Brow Ptosis Repair <sup>1</sup>
15820	Blepharoplasty, lower eyelid
15821	Blepharoplasty, lower eyelid; with extensive herniated fat pad
15822	Blepharoplasty, upper eyelid
15823	Blepharoplasty, upper eyelid; with excessive skin weighting down lid
67900	Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)
67901	Repair of blepharoptosis; frontalis muscle technique with suture or other material (eg, banked fascia)
67902	Repair of blepharoptosis; frontalis muscle technique with autologous fascial sling (includes obtaining fascia)
67903	Repair of blepharoptosis; (tarso) levator resection or advancement, internal approach
67904	Repair of blepharoptosis; (tarso) levator resection or advancement, external approach
67906	Repair of blepharoptosis; superior rectus technique with fascial sling (includes obtaining fascia)
67908	Repair of blepharoptosis; conjunctivo-tarso-Muller's muscle-levator resection (eg, Fasanella-Servat type)
Code	(ii) Botulinum Toxin Injection
64612	Chemodenerivation of muscle(s); muscle(s) innervated by facial nerve, unilateral (eg, for blepharospasm, hemifacial spasm)
64615	Chemodenerivation of muscle(s); muscle(s) innervated by facial, trigeminal, cervical spinal and accessory nerves, bilateral (eg, for chronic migraine)
J0585	Injection, onabotulinumtoxina, 1 unit
J0586	Injection, abobotulinumtoxina, 5 units
J0587	Injection, rimabotulinumtoxinb, 100 units
J0588	Injection, incobotulinumtoxin a, 1 unit
Code	(iii) Panniculectomy, Excision of Excess Skin and Subcutaneous Tissue (Including Lipectomy), and related services
15830	Excision, excessive skin and subcutaneous tissue (includes lipectomy); abdomen, infraumbilical panniculectomy
15847	Excision, excessive skin and subcutaneous tissue (includes lipectomy), abdomen (eg, abdominoplasty) (includes umbilical transposition and fascial plication)
15877	Suction assisted lipectomy; trunk

<sup>1</sup> CPT 67911 (Correction of lid retraction) was removed on January 7, 2022.

Code	(iv) Rhinoplasty, and related services <sup>2</sup>
20912	Cartilage graft; nasal septum
21210	Graft, bone; nasal, maxillary or malar areas (includes obtaining graft)
30400	Rhinoplasty, primary; lateral and alar cartilages and/or elevation of nasal tip
30410	Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip
30420	Rhinoplasty, primary; including major septal repair
30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)
30435	Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)
30450	Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only
30462	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip, septum, osteotomies
30465	Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft
Code	(v) Vein Ablation, and related services
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites

<sup>2</sup> CPT 21235 (Obtaining ear cartilage for grafting) was removed on June 10, 2020

<b>Beginning for service dates on or after July 1, 2021</b>	
Code	(i) Cervical Fusion with Disc Removal
22551	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophyctomy and decompression of spinal cord and/or nerve roots; cervical below C2, each additional interspace
Code	(ii) Implanted Spinal Neurostimulators <sup>3</sup>
63650	Percutaneous implantation of neurostimulator electrode array, epidural
<b>Beginning for service dates on or after July 1, 2023</b>	
Code	Facet Joint Interventions
64490	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; single level
64491	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; second level
64492	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), cervical or thoracic; third and any additional level(s)
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; single level
64494	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; second level
64495	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT), lumbar or sacral; third and any additional level(s)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint

<sup>3</sup> CPT codes 63685 (Insertion or replacement of spinal neurostimulator pulse generator or receiver) and 63688 (Revision or removal of implanted spinal neurostimulator pulse generator or receiver) were temporarily removed from the list of OPD services that require prior authorization, as finalized in the CY 2021 OP/ASC final rule with comment period.

64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint

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