## Local Coverage Determination (LCD): Monitored Anesthesia Care (L32628)

### Contractor Information

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<td>Novitas Solutions, Inc.</td>
<td>12502</td>
<td>A and B MAC</td>
<td>J - L</td>
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### LCD Information

**Document Information**

- **LCD ID**: L32628
- **LCD Title**: Monitored Anesthesia Care

**Jurisdiction**

- Pennsylvania

- **Original Effective Date**
  - For services performed on or after 08/13/2012

- **Revision Effective Date**
  - For services performed on or after 04/09/2015

- **Revision Ending Date**
  - N/A

- **Retirement Date**
  - N/A

- **Notice Period Start Date**
  - 02/20/2015

- **Notice Period End Date**
  - 04/08/2015

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**CMS National Coverage Policy**

This LCD supplements but does not replace, modify or supersede existing Medicare applicable National Coverage Determinations (NCDs) or payment policy rules and regulations for monitored anesthesia care services. Federal statute and subsequent Medicare regulations regarding provision and payment for medical services are lengthy. They are not repeated in this LCD. Neither Medicare payment policy rules nor this LCD replace, modify or supersede applicable state statutes regarding medical practice or other health practice professions acts, definitions and/or scopes of practice. All providers who report services for Medicare payment must fully understand and follow all existing laws, regulations and rules for Medicare payment for

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monitored anesthesia care services and must properly submit only valid claims for them. Please review and understand them and apply the medical necessity provisions in the policy within the context of the manual rules. Relevant CMS manual instructions and policies regarding monitored anesthesia care services are found in the following Internet-Only Manuals (IOMs) published on the CMS Web site:

Social Security Act (Title XVIII) Standard References:

- Title XVIII of the Social Security Act, Section 1862(a)(1)(A) states that no Medicare payment shall be made for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury.
- Title XVIII of the Social Security Act, Section 1862(a)(7). This section excludes routine physical examinations.
- Title XVIII of the Social Security Act, Section 1833(e) states that no payment shall be made to any provider for any claim that lacks the necessary information to process the claim.

Coverage Guidance

Coverage Indications, Limitations, and/or Medical Necessity

Compliance with the provisions in this policy may be monitored and addressed through post payment data analysis and subsequent medical review audits.

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

- In keeping with the American Society of Anesthesiologists’ standards for monitoring, MAC should be provided by qualified anesthesia personnel in accordance with individual state licensure. These individuals must be continuously present to monitor the patient and provide anesthesia care.
- During MAC, the patient’s oxygenation, ventilation, circulation and temperature should be evaluated by whatever methods are deemed most suitable by the attending anesthetist. It is anticipated that newer methods of non-invasive monitoring such as pulse oximetry and capnography will be frequently relied upon. Close monitoring is necessary to anticipate the need for general anesthesia administration or for the treatment of adverse physiologic reactions such as hypotension, excessive pain, difficulty breathing, arrhythmias, adverse drug reactions, etc. In addition, the possibility that the surgical procedure may become more extensive and/or result in unforeseen complications requires comprehensive monitoring and/or anesthetic intervention.
- The following CMS requirements for this type of anesthesia should be the same as for general anesthesia with regard to:
  - The performance of preanesthetic examination and evaluation.
  - The prescription of the anesthesia care required.
  - The completion of an anesthesia record.
  - The administration of necessary medications and the provision of indicated postoperative anesthesia care.

- Appropriate documentation must be available to reflect pre- and postanesthetic evaluations and intraoperative monitoring.
- The MAC service rendered must be reasonable, appropriate and medically necessary.
- Anesthesia procedures listed in the “CPT/HCPCS Codes” section of this LCD are examples of those that are usually provided by the attending surgeon and are included in the global fee and are not separately billable. In certain instances; however, MAC provided by anesthesia personnel may be necessary for these procedures if the patient has one or more of the conditions or situations found in the “ICD-9-CM Codes That Support Medical Necessity” section of this LCD. MAC may be necessary for these active and serious accompanying situations or conditions to ensure smooth anesthesia (and surgery) by the prevention of adverse physiologic complications. The use of anesthesia modifiers, when the CPT code is not fully descriptive, is required as follows:
○ **G8 anesthesia modifier** – used to indicate certain deep, complex, complicated or markedly invasive surgical procedures. This modifier is to be applied to the following anesthesia codes only: 00100, 00300, 00400, 00160, 00532 and 00920.

○ **G9 anesthesia modifier** – represents “a history of severe cardiopulmonary disease” and should be utilized whenever the proceduralist feels the need for MAC due to a history of advanced cardiopulmonary disease. The documentation of this clinical decision-making process and the need for additional monitoring must be clearly documented in the medical record.

○ Anesthesia codes utilized to indicate the clinical condition of the patient receiving MAC: **P1** – healthy individual with minimal anesthesia risk, **P2** – mild systemic disease, **P3** – severe systemic disease with intermittent threat of morbidity or mortality, **P4** – severe systemic illness with ongoing threat of morbidity or mortality, **P5** – premorbid condition with high risk of demise unless procedural intervention is performed.

Special conditions and/or criteria must be supported by documentation in the medical record.

- Reimbursement for MAC will be the same amount allowed for full general anesthesia services if all requirements listed under these indications are met. The provision of quality MAC is mandatory and requires the same expertise and the same effort (work) as required in the delivery of a general anesthetic. If the requirements are not fulfilled or the procedures are unnecessary, payment will be denied in full.
- For procedures that do not usually require anesthesia services, MAC could be covered when the patient’s condition requires the presence of qualified anesthesia personnel to perform monitored anesthesia in addition to the physician performing the procedure, and is so documented in the patient’s medical record.
- The presence of an underlying condition alone, as reported by an ICD-9-CM diagnosis code, may not be sufficient evidence that MAC is necessary. The medical condition must be significant enough to impact on the need to provide MAC such as the patient being on medication or being symptomatic, etc. The presence of a stable, treated condition, of itself, is not necessarily sufficient.
- Conditions listed under the “Diagnoses That Support Medical Necessity” section of this LCD, if matched with anesthesia procedures in the “CPT/HCPCS Codes” section of this LCD, could support the need for MAC. Other disease states can also be considered if medical justification is demonstrated.

**Notice:** This LCD imposes diagnosis limitations that support diagnosis to procedure code automated denials. However, services performed for any given diagnosis must meet all of the indications and limitations stated in this policy, the general requirements for medical necessity as stated in CMS payment policy manuals, any and all existing CMS national coverage determinations, and all Medicare payment rules.

As published in CMS IOM 100-08, Chapter 13, Section 13.5.1, in order to be covered under Medicare, a service shall be reasonable and necessary. When appropriate, contractors shall describe the circumstances under which the proposed LCD for the service is considered reasonable and necessary under Section 1862(a)(1)(A). Contractors shall consider a service to be reasonable and necessary if the contractor determines that the service is:

- Safe and effective.
- Not experimental or investigational (exception: routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000, that meet the requirements of the Clinical Trials NCD are considered reasonable and necessary).
- Appropriate, including the duration and frequency that is considered appropriate for the service, in terms of whether it is:
  - Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient’s condition or to improve the function of a malformed body member.
  - Furnished in a setting appropriate to the patient's medical needs and condition.
  - Ordered and furnished by qualified personnel.
  - One that meets, but does not exceed, the patient's medical needs.
  - At least as beneficial as an existing and available medically appropriate alternative.
**Coding Information**

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 policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

- 011x Hospital Inpatient (Including Medicare Part A)
- 012x Hospital Inpatient (Medicare Part B only)
- 013x Hospital Outpatient
- 018x Hospital - Swing Beds
- 021x Skilled Nursing - Inpatient (Including Medicare Part A)
- 083x Ambulatory Surgery Center

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 policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

**Note:** The contractor has identified the Bill Type and Revenue Codes applicable for use with the CPT/HCPCS codes included in this LCD. Providers are reminded that not all the CPT/HCPCS codes listed can be billed with all Bill Type and/or Revenue Codes listed. CPT/HCPCS codes are required to be billed with specific Bill Type and Revenue Codes. Providers are encouraged to refer to the CMS *Internet-Only Manual* (IOM) Pub. 100-04, *Claims Processing Manual*, for further guidance.

- 037X Anesthesia - General Classification

**CPT/HCPCS Codes**

**Group 1 Paragraph: Note:** Providers are reminded to refer to the long descriptors of the CPT codes in their CPT book.

Procedures listed below represent commonly used anesthesia codes that may involve MAC. When these codes are used and MAC has been provided, the QS modifier must be used.

**Group 1 Codes:**

- 00100 Anesth salivary gland
- 00124 Anesth ear exam
- 00148 Anesth eye exam
- 00160 Anesth nose/sinus surgery
- 00164 Anesth biopsy of nose
- 00300 Anesth head/neck/ptrunk
- 00322 Anesth biopsy of thyroid
- 00400 Anesth skin ext/per/atrunk
- 00410 Anesth correct heart rhythm
- 00454 Anesth collar bone biopsy
- 00520 Anesth chest procedure
- 00522 Anesth chest lining biopsy
- 00524 Anesth chest drainage
- 00530 Anesth pacemaker insertion
- 00532 Anesth vascular access
- 00635 Anesth lumbar puncture
- 00640 Anesth spine manipulation
- 00702 Anesth for liver biopsy
ICD-9 Codes that Support Medical Necessity

**Group 1 Paragraph:** It is the provider’s responsibility to select codes carried out to the highest level of specificity and selected from the ICD-9-CM code book appropriate to the year in which the service is rendered for the claim(s) submitted.

**Note:** Providers should continue to submit ICD-9-CM diagnosis codes without decimals on their claim forms and electronic claims.

The CPT/HCPCS codes included in this LCD will be subjected to “procedure to diagnosis” editing. The following lists include only those diagnoses for which the identified CPT/HCPCS procedures are covered. If a covered diagnosis is not on the claim, the edit will automatically deny the service as not medically necessary.

Medicare is establishing the following limited coverage for the CPT codes listed above:

**Covered for:**

**Group 1 Codes:**

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BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) DEPRESSED, UNSPECIFIED - BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) DEPRESSED, IN PARTIAL OR UNSPECIFIED REMISSION

296.50 - 296.55 opens in new window
BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) MIXED, UNSPECIFIED - BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) MIXED, IN PARTIAL OR UNSPECIFIED REMISSION

296.60 - 296.65 opens in new window
BIPOLAR I DISORDER, MOST RECENT EPISODE (OR CURRENT) UNSPECIFIED

296.7
BIPOLAR DISORDER, UNSPECIFIED - ATYPICAL DEPRESSIVE DISORDER

296.80 - 296.82 opens in new window
OTHER AND UNSPECIFIED BIPOLAR DISORDERS, OTHER

296.89
OTHER SPECIFIED EPISODIC MOOD DISORDER

296.90
OTHER SPECIFIED EPISODIC MOOD DISORDER

296.99
PARANOID STATE SIMPLE - SHARED PSYCHOTIC DISORDER

297.0 - 297.3 opens in new window
OTHER SPECIFIED PARANOID STATES - UNSPECIFIED PARANOID STATE

297.8 - 297.9 opens in new window
DEPRESSIVE TYPE PSYCHOSIS - PSYCHOGENIC PARANOID PSYCHOSIS

298.0 - 298.4 opens in new window
OTHER AND UNSPECIFIED REACTIVE PSYCHOSIS - UNSPECIFIED PSYCHOSIS

298.8 - 298.9 opens in new window
AUTISTIC DISORDER, CURRENT OR ACTIVE STATE - AUTISTIC DISORDER, RESIDUAL STATE

299.00 - 299.01 opens in new window
CHILDHOOD DISINTEGRATIVE DISORDER, CURRENT OR ACTIVE STATE - CHILDHOOD DISINTEGRATIVE DISORDER, RESIDUAL STATE

299.10 - 299.11 opens in new window
OTHER SPECIFIED PERSPECTIVE DEVELOPMENTAL DISORDERS, CURRENT OR ACTIVE STATE - OTHER SPECIFIED PERSPECTIVE DEVELOPMENTAL DISORDERS, RESIDUAL STATE

300.00 - 300.02 opens in new window
ANXIETY STATE UNSPECIFIED - GENERALIZED ANXIETY DISORDER

300.09
OTHER ANXIETY STATES

300.10*
HYSTERIA UNSPECIFIED

300.20 - 300.23 opens in new window
PHOBIA UNSPECIFIED - SOCIAL PHOBIA

300.29*
OTHER ISOLATED OR SPECIFIC PHOBIAS

304.00 - 304.03 opens in new window
OPIOID TYPE DEPENDENCE UNSPECIFIED USE - OPIOID TYPE DEPENDENCE IN REMISSION
SEDATIVE, HYPNOTIC OR ANXIOLYTIC DEPENDENCE, UNSPECIFIED - SEDATIVE, HYPNOTIC OR ANXIOLYTIC DEPENDENCE, IN REMISSION

COCAINE DEPENDENCE UNSPECIFIED USE - COCAINE DEPENDENCE IN REMISSION

CANNABIS DEPENDENCE UNSPECIFIED USE - CANNABIS DEPENDENCE IN REMISSION

AMPHETAMINE AND OTHER PSYCHOSTIMULANT DEPENDENCE UNSPECIFIED USE - AMPHETAMINE AND OTHER PSYCHOSTIMULANT DEPENDENCE IN REMISSION

HALUCINOGEN DEPENDENCE UNSPECIFIED USE - HALUCINOGEN DEPENDENCE IN REMISSION

OTHER SPECIFIED DRUG DEPENDENCE UNSPECIFIED USE - OTHER SPECIFIED DRUG DEPENDENCE IN REMISSION

COMBINATIONS OF OPIOID TYPE DRUG WITH ANY OTHER DRUG DEPENDENCE UNSPECIFIED USE - COMBINATIONS OF OPIOID TYPE DRUG WITH ANY OTHER DRUG DEPENDENCE IN REMISSION

COMBINATIONS OF DRUG DEPENDENCE EXCLUDING OPIOID TYPE DRUG UNSPECIFIED USE - COMBINATIONS OF DRUG DEPENDENCE EXCLUDING OPIOID TYPE DRUG IN REMISSION

UNSPECIFIED DRUG DEPENDENCE UNSPECIFIED USE - UNSPECIFIED DRUG DEPENDENCE IN REMISSION

NONDEPENDENT ALCOHOL ABUSE UNSPECIFIED DRINKING BEHAVIOR - NONDEPENDENT ALCOHOL ABUSE EPISODIC DRINKING BEHAVIOR

NONDEPENDENT CANNABIS ABUSE UNSPECIFIED USE - NONDEPENDENT CANNABIS ABUSE EPISODIC USE

NONDEPENDENT HALLUCINOGEN ABUSE UNSPECIFIED USE - NONDEPENDENT HALLUCINOGEN ABUSE EPISODIC USE

SEDATIVE, HYPNOTIC OR ANXIOLYTIC ABUSE, UNSPECIFIED - SEDATIVE, HYPNOTIC OR ANXIOLYTIC ABUSE, EPISODIC

NONDEPENDENT OPIOID ABUSE UNSPECIFIED USE - NONDEPENDENT OPIOID ABUSE EPISODIC USE

NONDEPENDENT COCAINE ABUSE UNSPECIFIED USE - NONDEPENDENT COCAINE ABUSE EPISODIC USE

NONDEPENDENT AMPHETAMINE OR RELATED ACTING SYMPATHOMIMETIC ABUSE UNSPECIFIED USE - NONDEPENDENT AMPHETAMINE OR RELATED ACTING SYMPATHOMIMETIC ABUSE EPISODIC USE

NONDEPENDENT ANTIDEPRESSANT TYPE ABUSE UNSPECIFIED USE - NONDEPENDENT ANTIDEPRESSANT TYPE ABUSE EPISODIC USE

SEVERE INTELLECTUAL DISABILITIES - PROFOUND INTELLECTUAL DISABILITIES

UNSPECIFIED INTELLECTUAL DISABILITIES
INTRACRANIAL ABSCESS
OBSTRUCTIVE SLEEP APNEA (ADULT) (PEDIATRIC)
ALZHEIMER'S DISEASE
CORTICOBASAL DEGENERATION
PARALYSIS AGITANS - SECONDARY PARKINSONISM
AMYOTROPHIC LATERAL SCLEROSIS
MULTIPLE SCLEROSIS
343.9*
345.00 - 345.01 opens in new window
INFANTILE CEREBRAL PALSY UNSPECIFIED
GENERALIZED NONCONVULSIVE EPILEPSY WITHOUT INTRACTABLE EPILEPSY - GENERALIZED NONCONVULSIVE EPILEPSY WITH INTRACTABLE EPILEPSY
GENERALIZED CONVULSIVE EPILEPSY WITHOUT INTRACTABLE EPILEPSY - GENERALIZED CONVULSIVE EPILEPSY WITH INTRACTABLE EPILEPSY
PETIT MAL STATUS EPILEPTIC - GRAND MAL STATUS EPILEPTIC
LOCALIZATION-RELATED (FOCAL) (PARTIAL) EPILEPSY AND EPILEPTIC SYNDROMES WITH COMPLEX PARTIAL SEIZURES, WITHOUT MENTION OF INTRACTABLE EPILEPSY - LOCALIZATION-RELATED (FOCAL) (PARTIAL) EPILEPSY AND EPILEPTIC SYNDROMES WITH COMPLEX PARTIAL SEIZURES, WITH INTRACTABLE EPILEPSY
LOCALIZATION-RELATED (FOCAL) (PARTIAL) EPILEPSY AND EPILEPTIC SYNDROMES WITH SIMPLE PARTIAL SEIZURES, WITHOUT MENTION OF INTRACTABLE EPILEPSY - LOCALIZATION-RELATED (FOCAL) (PARTIAL) EPILEPSY AND EPILEPTIC SYNDROMES WITH SIMPLE PARTIAL SEIZURES, WITH INTRACTABLE EPILEPSY
INFANTILE SPASMS WITHOUT INTRACTABLE EPILEPSY - INFANTILE SPASMS WITH INTRACTABLE EPILEPSY
EPILEPSIA PARTIALIS CONTINUA WITHOUT INTRACTABLE EPILEPSY - EPILEPSIA PARTIALIS CONTINUA WITH INTRACTABLE EPILEPSY
OTHER FORMS OF EPILEPSY AND RECURRENT SEIZURES, WITHOUT MENTION OF INTRACTABLE EPILEPSY - OTHER FORMS OF EPILEPSY AND RECURRENT SEIZURES, WITH INTRACTABLE EPILEPSY
EPILEPSY UNSPECIFIED WITHOUT INTRACTABLE EPILEPSY - EPILEPSY UNSPECIFIED WITH INTRACTABLE EPILEPSY
MYASTHENIA GRAVIS WITHOUT (ACUTE) EXACERBATION
LAMBERT-EATON SYNDROME, UNSPECIFIED - LAMBERT-EATON SYNDROME IN NEOPLASTIC DISEASE
LAMBERT-EATON SYNDROME IN OTHER DISEASES CLASSIFIED ELSEWHERE
OTHER NONDIABETIC PROLIFERATIVE RETINOPATHY
EXUDATIVE SENILE MACULAR DEGENERATION OF RETINA
MACULAR CYST HOLE OR PSEUDOHOLE OF RETINA
MACULAR PUCKERING OF RETINA
ACUTE RHEUMATIC PERICARDITIS - ACUTE RHEUMATIC MYOCARDITIS
MitrAL STENOSIS - MitrAL STENOSIS WITH INSUFFICIENCY
OTHER AND UNSPECIFIED MITRAL VALVE DISEASES
RHEUMATIC DISEASES OF ENDOCARDIUM VALVE UNSPECIFIED
MALIGNANT ESSENTIAL HYPERTENSION
UNSPECIFIED ESSENTIAL HYPERTENSION
MALIGNANT HYPERTENSIVE HEART DISEASE WITHOUT HEART FAILURE - MALIGNANT HYPERTENSIVE HEART DISEASE WITH HEART FAILURE
BENIGN HYPERTENSIVE HEART DISEASE WITHOUT HEART FAILURE - BENIGN HYPERTENSIVE HEART DISEASE WITH HEART FAILURE
UNSPECIFIED HYPERTENSIVE HEART DISEASE WITHOUT HEART FAILURE - UNSPECIFIED HYPERTENSIVE HEART DISEASE WITH HEART FAILURE
HYPERTENSIVE CHRONIC KIDNEY DISEASE, MALIGNANT, WITH CHRONIC KIDNEY DISEASE STAGE V OR END STAGE RENAL DISEASE - HYPERTENSIVE CHRONIC KIDNEY DISEASE, BENIGN, WITH CHRONIC KIDNEY DISEASE STAGE V OR END STAGE RENAL DISEASE
HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE, MALIGNANT, WITHOUT HEART FAILURE AND WITH CHRONIC KIDNEY DISEASE STAGE I THROUGH STAGE IV, OR UNSPECIFIED - HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE, MALIGNANT, WITH HEART FAILURE AND WITH CHRONIC KIDNEY DISEASE STAGE V OR END STAGE RENAL DISEASE

404.11 - 404.13 opens in new window

HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE, BENIGN, WITH HEART FAILURE AND WITH CHRONIC KIDNEY DISEASE STAGE I THROUGH STAGE IV, OR UNSPECIFIED - HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE, BENIGN, WITH HEART FAILURE AND CHRONIC KIDNEY DISEASE STAGE V OR END STAGE RENAL DISEASE

404.91 - 404.93 opens in new window

MALIGNANT RENOVASCULAR HYPERTENSION

405.01

ACUTE MYOCARDIAL INFARCTION OF ANTEROLATERAL WALL EPISODE OF CARE

410.00 - 410.02 opens in new window

ACUTE MYOCARDIAL INFARCTION OF OTHER ANTERIOR WALL EPISODE OF CARE

410.10 - 410.12 opens in new window

ACUTE MYOCARDIAL INFARCTION OF INFEROLATERAL WALL EPISODE OF CARE

410.20 - 410.22 opens in new window

ACUTE MYOCARDIAL INFARCTION OF INFEROPOSTERIOR WALL EPISODE OF CARE

410.30 - 410.32 opens in new window

ACUTE MYOCARDIAL INFARCTION OF OTHER INFERIOR WALL EPISODE OF CARE

410.40 - 410.42 opens in new window

ACUTE MYOCARDIAL INFARCTION OF OTHER LATERAL WALL EPISODE OF CARE

410.50 - 410.52 opens in new window

TRUE POSTERIOR WALL INFARCTION EPISODE OF CARE UNSPECIFIED - TRUE POSTERIOR WALL INFARCTION SUBSEQUENT EPISODE OF CARE

410.70 - 410.72 opens in new window

SUBENDOCARDIAL INFARCTION EPISODE OF CARE UNSPECIFIED - SUBENDOCARDIAL INFARCTION SUBSEQUENT EPISODE OF CARE

410.80 - 410.82 opens in new window

ACUTE MYOCARDIAL INFARCTION OF OTHER SPECIFIED SITES EPISODE OF CARE

410.90 - 410.92 opens in new window

POSTMYOCARDIAL INFARCTION SYNDROME - INTERMEDIATE CORONARY SYNDROME

411.1 opens in new window

ACUTE CORONARY OCCLUSION WITHOUT MYOCARDIAL INFARCTION

411.81

OTHER ACUTE AND SUBACUTE FORMS OF ISCHEMIC HEART DISEASE OTHER

411.89*

OLD MYOCARDIAL INFARCTION

412*

ANGINA DECUBITUS - PRINZMETAL ANGINA

413.0 - 413.1 opens in new window

OTHER AND UNSPECIFIED ANGINA PECTORIS

413.9

CORONARY ATHEROSCLEROSIS OF UNSPECIFIED TYPE OF VESSEL NATIVE OR GRAFT - CORONARY ATHEROSCLEROSIS OF BYPASS GRAFT (ARTERY) (VEIN) OF TRANSPLANTED HEART

414.00 - 414.07 opens in new window

ANEURYSM OF HEART (WALL) - DISSECTION OF CORONARY ARTERY

414.10 - 414.12 opens in new window

OTHER ANEURYSM OF HEART

414.19

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414.2 - 414.4 opens in new window
CHRONIC TOTAL OCCLUSION OF CORONARY ARTERY - CORONARY Atherosclerosis due to calcified coronary lesion

414.8 - 414.9* opens in new window
OTHER SPECIFIED FORMS OF CHRONIC ISCHEMIC HEART DISEASE - CHRONIC ISCHEMIC HEART DISEASE UNSPECIFIED

415.0
ACUTE COR PULMONALE

416.0
PRIMARY PULMONARY HYPERTENSION

416.2
CHRONIC PULMONARY EMBOLISM

416.9*
CHRONIC PULMONARY HEART DISEASE UNSPECIFIED

420.0
ACUTE PERICARDITIS IN DISEASES CLASSIFIED ELSEWHERE

420.90 - 420.91 opens in new window
ACUTE PERICARDITIS UNSPECIFIED - ACUTE IDIOPATHIC PERICARDITIS

420.99
OTHER ACUTE PERICARDITIS

421.0 - 421.1 opens in new window
ACUTE AND SUBACUTE BACTERIAL ENDocarditis - ACUTE AND SUBACUTE INFECTIVE ENDocarditis in diseases classified elsewhere

421.9
ACUTE ENDOCARDITIS UNSPECIFIED

422.0
ACUTE MYOCARDITIS IN DISEASES CLASSIFIED ELSEWHERE

422.90 - 422.93 opens in new window
ACUTE MYOCARDITIS UNSPECIFIED - TOXIC MYOCARDITIS

422.99
OTHER ACUTE MYOCARDITIS

423.0 - 423.2 opens in new window
HEMOPERICARDIUM - CONstrictive PERICARDITIS

423.8 - 423.9 opens in new window
OTHER SPECIFIED DISEASES OF PERICARDIUM - UNSPECIFIED DISEASE OF PERICARDIUM

424.0 - 424.3 opens in new window
MITRAL VALVE DISORDERS - PULMONARY VALVE DISORDERS

424.90 - 424.91 opens in new window
ENDOCARDITIS VALVE UNSPECIFIED UNSPECIFIED CAUSE - ENDOCARDITIS IN DISEASES CLASSIFIED ELSEWHERE

424.99*
OTHER ENDOCARDITIS VALVE UNSPECIFIED

425.0
ENDOMYOCARDIAL FIBROSIS

425.11
HYPERTROPHIC OBSTRUCTIVE CARDIOMYOPATHY

425.18
OTHER HYPERTROPHIC CARDIOMYOPATHY

425.2 - 425.5 opens in new window
OBSCURE CARDIOMYOPATHY OF AFRICA - ALCOHOLIC CARDIOMYOPATHY

425.7 - 425.9* opens in new window
NUTRITIONAL AND METABOLIC CARDIOMYOPATHY - SECONDARY CARDIOMYOPATHY UNSPECIFIED

426.0
ATRIOVENTRICULAR BLOCK COMPLETE

426.10 - 426.13 opens in new window
ATRIOVENTRICULAR BLOCK UNSPECIFIED - OTHER SECOND DEGREE ATRIOVENTRICULAR BLOCK

426.2 - 426.4 opens in new window
LEFT BUNDLE BRANCH HEMIBLOCK - RIGHT BUNDLE BRANCH BLOCK

426.50 - 426.54 opens in new window
BUNDLE BRANCH BLOCK UNSPECIFIED - TRIFASCICULAR BLOCK

426.6 - 426.7 opens in new window
OTHER HEART BLOCK - ANOMALOUS ATRIOVENTRICULAR EXCITATION

426.81 - 426.82 opens in new window
LOWN-GANONG-LEVINE SYNDROME - LONG QT SYNDROME

426.89
OTHER SPECIFIED CONDUCTION DISORDERS
426.9*  CONDUCTION DISORDER UNSPECIFIED
427.0 -  PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA - PAROXYSMAL TACHYCARDIA
427.2 opens in new window  UNSPECIFIED
427.31 -  ATRIAL FIBRILLATION - ATRIAL FLUTTER
427.41 -  VENTRICULAR FIBRILLATION - VENTRICULAR FLUTTER
427.5  CARDIAC ARREST
427.60 -  PREMATURE BEATS UNSPECIFIED - SUPRAVENTRICULAR PREMATURE BEATS
427.69  OTHER PREMATURE BEATS
427.71  SINOATRIAL NODE DYSFUNCTION
427.89*  OTHER SPECIFIED CARDIAC DYSRHYTHMIAS
428.0 -  CONGESTIVE HEART FAILURE UNSPECIFIED - LEFT HEART FAILURE
428.20 -  UNSPECIFIED SYSTOLIC HEART FAILURE - ACUTE ON CHRONIC SYSTOLIC HEART FAILURE
428.30 -  UNSPECIFIED DIASTOLIC HEART FAILURE - ACUTE ON CHRONIC DIASTOLIC HEART FAILURE
428.40 -  UNSPECIFIED COMBINED SYSTOLIC AND DIASTOLIC HEART FAILURE - ACUTE ON CHRONIC COMBINED SYSTOLIC AND DIASTOLIC HEART FAILURE
428.9*  HEART FAILURE UNSPECIFIED
430  INTRACEREBRAL HEMORRHAGE
431  SUBARACHNOID HEMORRHAGE
432.0 -  NONTRAUMATIC EXTRADURAL HEMORRHAGE - SUBDURAL HEMORRHAGE
433.00 -  OCCLUSION AND STENOSIS OF BASILAR ARTERY WITHOUT CEREBRAL INFARCTION - OCCLUSION AND STENOSIS OF BASILAR ARTERY WITH CEREBRAL INFARCTION
433.10 -  OCCLUSION AND STENOSIS OF CAROTID ARTERY WITHOUT CEREBRAL INFARCTION - OCCLUSION AND STENOSIS OF CAROTID ARTERY WITH CEREBRAL INFARCTION
433.20 -  OCCLUSION AND STENOSIS OF VERTEBRAL ARTERY WITHOUT CEREBRAL INFARCTION - OCCLUSION AND STENOSIS OF VERTEBRAL ARTERY WITH CEREBRAL INFARCTION
433.30 -  OCCLUSION AND STENOSIS OF MULTIPLE AND BILATERAL PRECEREBRAL ARTERIES WITHOUT CEREBRAL INFARCTION - OCCLUSION AND STENOSIS OF MULTIPLE AND BILATERAL PRECEREBRAL ARTERIES WITH CEREBRAL INFARCTION
433.40 -  OCCLUSION AND STENOSIS OF OTHER SPECIFIED PRECEREBRAL ARTERY WITHOUT CEREBRAL INFARCTION - OCCLUSION AND STENOSIS OF OTHER SPECIFIED PRECEREBRAL ARTERY WITH CEREBRAL INFARCTION
433.50 -  OCCLUSION AND STENOSIS OF UNSPECIFIED PRECEREBRAL ARTERY WITHOUT CEREBRAL INFARCTION - OCCLUSION AND STENOSIS OF UNSPECIFIED PRECEREBRAL ARTERY WITH CEREBRAL INFARCTION
434.00 -  CEREBRAL THROMBOSIS WITHOUT CEREBRAL INFARCTION - CEREBRAL THROMBOSIS WITH CEREBRAL INFARCTION
434.10 -  CEREBRAL EMBOLISM WITHOUT CEREBRAL INFARCTION - CEREBRAL EMBOLISM WITH CEREBRAL INFARCTION
434.90 -  CEREBRAL ARTERY OCCLUSION UNSPECIFIED WITHOUT CEREBRAL INFARCTION - CEREBRAL ARTERY OCCLUSION UNSPECIFIED WITH CEREBRAL INFARCTION
435  BASILAR ARTERY SYNDROME - VERTEBROBASILAR ARTERY SYNDROME
435.0 - 435.3 opens in new window
OTHER SPECIFIED TRANSIENT CEREBRAL ISCHEMIAS - UNSPECIFIED TRANSIENT CEREBRAL ISCHEMIA

435.8 - 435.9 opens in new window
ACUTE BUT ILL-DEFINED CEREBROVASCULAR DISEASE

436
CEREBRAL ATHEROSCLEROSIS - UNSPECIFIED CEREBROVASCULAR DISEASE

437.0 - 437.9 opens in new window
ACUTE BUT ILL-DEFINED CEREBROVASCULAR DISEASE

437.8 - 437.9
CEREBRAL ATHEROSCLEROSIS - UNSPECIFIED CEREBROVASCULAR DISEASE

490
BRONCHITIS NOT SPECIFIED AS ACUTE OR CHRONIC

492.8
OTHER EMPHYSEMA

496
CHRONIC AIRWAY OBSTRUCTION NOT ELSEWHERE CLASSIFIED

500
COAL WORKERS' PNEUMOCONIOSIS

501
ASBESTOSIS

502
PNEUMOCONIOSIS DUE TO OTHER SILICA OR SILICATES

503
PNEUMOCONIOSIS DUE TO OTHER INORGANIC DUST

504
PNEUMONOPATHY DUE TO InhalATION OF OTHER DUST

505
PNEUMOCONIOSIS UNSPECIFIED

506.0 - 506.4 opens in new window
BRONCHITIS AND PNEUMONITIS DUE TO FUMES AND VAPORS - CHRONIC RESPIRATORY CONDITIONS DUE TO FUMES AND VAPORS

506.9
UNSPECIFIED RESPIRATORY CONDITIONS DUE TO FUMES AND VAPORS

508.0 - 508.2 opens in new window
ACUTE PULMONARY MANIFESTATIONS DUE TO RADIATION - RESPIRATORY CONDITIONS DUE TO SMOKE INHALATION

508.8 - 508.9 opens in new window
RESPIRATORY CONDITIONS DUE TO OTHER SPECIFIED EXTERNAL AGENTS - RESPIRATORY CONDITIONS DUE TO UNSPECIFIED EXTERNAL AGENT

510.0
EMPYEMA WITH FISTULA

510.9
EMPYEMA WITHOUT FISTULA

511.0
PLEURISY WITHOUT EFFUSION OR CURRENT TUBERCULOSIS

511.81
MALIGNANT PLEURAL EFFUSION

511.89
OTHER SPECIFIED FORMS OF EFFUSION, EXCEPT TUBERCULOUS

511.9
UNSPECIFIED PLEURAL EFFUSION

512.0 - 512.2 opens in new window
SPONTANEOUS TENSION PNEUMOTHORAX - POSTOPERATIVE AIR LEAK

513.0
ABSCESS OF LUNG

518.0 - 518.4 opens in new window
PULMONARY COLLAPSE - ACUTE EDEMA OF LUNG UNSPECIFIED

518.51 - 518.53 opens in new window
ACUTE RESPIRATORY FAILURE FOLLOWING TRAUMA AND SURGERY - ACUTE AND CHRONIC RESPIRATORY FAILURE FOLLOWING TRAUMA AND SURGERY

518.7
TRANSFUSION RELATED ACUTE LUNG INJURY (TRALI)

518.81 - 518.82* opens in new window
ACUTE RESPIRATORY FAILURE - OTHER PULMONARY INSUFFICIENCY NOT ELSEWHERE CLASSIFIED

570
ACUTE AND SUBACUTE NECROSIS OF LIVER

571.0 - 571.3 opens in new window
ALCOHOLIC FATTY LIVER - ALCOHOLIC LIVER DAMAGE UNSPECIFIED

571.40 - 571.42 opens in new window
CHRONIC HEPATITIS UNSPECIFIED - AUTOIMMUNE HEPATITIS

571.49
OTHER CHRONIC HEPATITIS

571.5 - 571.6 opens in new window
CIRRHOSIS OF LIVER WITHOUT ALCOHOL - BILIARY CIRRHOSIS

571.8
OTHER CHRONIC NONALCOHOLIC LIVER DISEASE

ABSCESS OF LIVER - HEPATURENAL SYNDROME

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Group 1 Medical Necessity ICD-9 Codes Asterisk Explanation: *Note: Use of the diagnosis codes 038.8–038.9 must be representative of the patient’s acute sepsis condition.

Note: Use of the diagnosis codes 255.8–255.9 must be representative of the patient’s severe metabolic condition (e.g., a greatly elevated blood sugar, such as 300 mg.%).

Note: Use of the diagnosis codes 276.7–276.9 must be representative of the patient’s electrolyte imbalance (e.g., sodium, potassium or calcium levels, etc., significantly outside normal limits).

Note: Use of the diagnosis codes 277.00–277.02 would indicate that the patient has significant respiratory impairment related to this condition.

Note: Use of diagnosis code 278.01 indicates the patient is at least two times ideal body weight.

Note: Use of the diagnosis codes 299.80–299.81 must be representative of the patient’s significant organic brain syndrome/dementia (with confusion or combative behavior) or psychotic condition.

Note: Use of diagnosis code 300.10 must be representative of the patient’s severe anxiety, hysteria or panic attack condition supported by the need for and responses to sedative medication(s).

Note: Use of diagnosis code 300.29 should represent that the patient has a severe phobic condition.

Note: Use of the diagnosis codes 304.90–304.93 must be representative of the patient’s drug dependency acute,
**Note:** Use of the diagnosis codes 305.00–305.02 must be representative of the patient’s acute drunken condition.

**Note:** Use of the diagnosis codes 305.80–305.82 must be representative of the patient’s drug abuse (acute, detoxification state) condition.

**Note:** Use of the diagnosis codes 332.0–332.1 must be representative of the patient’s condition.

**Note:** Use of the diagnosis code 340 would be indicative of the patient’s having significant neurological impairment due to multiple sclerosis.

**Note:** Use of the diagnosis code 343.9 must be representative of the patient’s condition.

**Note:** Use of the diagnosis codes 345.90–345.91 must be representative of the patient’s seizure disorder condition requiring appropriate antiepileptic medication.

**Note:** Use of the diagnosis codes 391.0–391.2 must be representative of the patient’s having an acute and unstable condition related to acute rheumatic cardiac disease.

**Note:** Use of the diagnosis code 397.9 must be representative of the patient’s valvular heart disease condition (acute, symptomatic) supported by medical treatment and cardiac medications.

**Note:** Use of the diagnosis code 401.9 must be representative of the patient’s condition (systolic pressure over 180 or diastolic over 110 and on more than two antihypertensive medications).

**Note:** Use of the diagnosis codes 402.90–402.91 must be representative of the patient’s having an acute and unstable condition requiring multiple medications.

**Note:** Use of the diagnosis code 411.89 must be representative of the patient’s acute and unstable condition.

**Note:** Use of the diagnosis code 412 must be representative of the patient’s acute and unstable (e.g., multiple medications) ischemic heart disease/condition.

**Note:** Use of the diagnosis codes 414.8–414.9 must be representative of the patient’s condition.

**Note:** Use of the diagnosis code 416.9 must be representative of the patient’s severe pulmonary condition.

**Note:** Use of the diagnosis code 424.99 must be representative of the patient’s acute and unstable heart disease/condition requiring multiple medications.

**Note:** 425.7–425.9 Use of the diagnosis codes in the section above must be representative of the patient’s severely impaired condition requiring multiple medications.

**Note:** Use of the diagnosis code 426.9 must be representative of the patient’s significant life threatening arrhythmia condition, such as ventricular rhythms.

**Note:** Use of the diagnosis code 427.89 must be representative of the patient’s significant arrhythmic condition, supported by history and diagnosis and use of appropriate treatment.

**Note:** 428.9 Use of the diagnosis codes in the section above must be representative of the patient’s significant heart failure condition supported by the patient being on pulmonary and/or cardiac medications.

**Note:** Use of the diagnosis codes 437.0–437.9 must be representative of the patient’s acutely impaired condition supported by diagnosis and treatment.

**Note:** Use of the diagnosis codes 518.81–518.82 must be representative of the patient’s condition.

**Note:** Use of the diagnosis codes 577.0–577.1 must be representative of the patient’s hepatic failure condition (serum bilirubin greater than 3).

**Note:** Use of the diagnosis code 578.9 must be representative of massive gastrointestinal bleeding (e.g., more than 500 cc. of acute blood loss).

**Note:** Use of the diagnosis code 586 must be representative of the patient’s condition as acute renal failure or end stage renal disease on a dialysis program (serum creatinine level greater than 2).

**Note:** Use of the diagnosis code 780.1 must be representative of the patient’s condition (supported by history and use of appropriate sedative medication).

**Note:** Use of the diagnosis code 780.39 must be representative of the patient’s unstable condition requiring multiple medications.

**Note:** Use of the diagnosis code 785.59 must be indicative of systolic pressure under 90 mmHg.

**Note:** With V58.69, the medication, duration of use and dosage must be maintained in the medical record.

ICD-9 Codes that DO NOT Support Medical Necessity

**Paragraph:** N/A

N/A

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**General Information**

**Associated Information**

**Diagnoses that Support Medical Necessity**

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Additional diagnoses that do not have a fully descriptive ICD-9-CM code are listed below. By using the diagnosis code(s) listed, the medical records must reflect the conditions as described.

- For combative patients, use ICD-9-CM code 312.9.
- For patients with low pain thresholds or who suffer severe pain, use ICD-9-CM code 997.00.
- For intraoperative expansion of procedure, use ICD-9-CM code 998.9.
- For any condition in a pediatric patient, Medicare eligible and younger than 18 years of age, use ICD-9-CM code 999.9.
- For patients with mental retardation (patients who are uncooperative due to a lack of understanding caused by their mental disability), use ICD-9-CM code 319

If MAC is used for these reasons, clinical records must be available upon request that justify the need for MAC.

**Documentation Requirements**

1. All documentation must be maintained in the patient’s medical record and made available to the contractor upon request.
2. Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, dates of service(s)). The documentation must include the legible signature of the physician or non-physician practitioner responsible for and providing the care to the patient.
3. The submitted medical record must support the use of the selected ICD-9-CM code(s). The submitted CPT/HCPCS code must describe the service performed.
4. The medical record documentation must support the medical necessity of the services as directed in this policy.
5. Hospital, outpatient, ASC or office records should clearly document the reason for the MAC (e.g., the patient’s condition that requires the appropriate anesthesia; indications the procedure performed was deep, complex, complicated or markedly invasive).
6. The medical record should include a pre-anesthesia evaluation including a history and physical exam.
7. The medical record should include evidence of continuous monitoring of the patient’s oxygenation, ventilation, circulation and temperature.
8. The medical record should include a post-anesthesia evaluation of the patient including any unusual events or complications and the patient’s status on discharge.

Sources of Information and Basis for Decision
Contractor is not responsible for the continued viability of websites listed.


CDC Website on Colorectal Cancer @http://www.cid.gov/cancer/colorectal/statistics/state.htm

Contractor Medical Directors
JL LCD L27489 Monitored Anesthesia Care (MAC)

Other Contractor Local Coverage Determinations
“Monitored Anesthesia Care,” TrailBlazer LCD, (00400) L15969, (00900) L16418.
“Monitored Anesthesia Care,” Noridian Administrative Services, LLD LCD, (CO) (L23737).
“Monitored Anesthesia Care,” Arkansas BlueCross BlueShield (Pinnacle) LCD, (NM, OK) L14639.
Novitas Solutions, Inc. – JH Local Coverage Determination (LCD) Consolidation, Narrative Justification – Most Clinically Appropriate LCD

LCDs Compared:
L26520, Monitored Anesthesia Care, TrailBlazer, TX, NM, OK, CO, Indian Health Service, SNF, RHC, WPS legacy provider – A/B

CMD Rationale:
TrailBlazer is the only Contractor with a policy in this region. There is an extensive indications and Limitations section that explains the expectations with this service. There is diagnosis to procedure code editing. This is a policy that should be maintained as this service and the coverage requirements frequently cause confusion.

L26520 is the most clinically appropriate LCD.

Revision History Information

Please note: Most Revision History entries effective on or before 01/24/2013 display with a Revision History Number of "R1" at the bottom of this table. However, there may be LCDs where these entries will display as a separate and distinct row.

<table>
<thead>
<tr>
<th>Revision History Date</th>
<th>Revision History Number</th>
<th>Revision History Explanation</th>
<th>Reason(s) for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>04/09/2015</td>
<td>R6</td>
<td>LCD Posted for Notice 02/20/2015 to become effective 04/09/2015, created from draft DL32628. 05/15/2014 - Draft Posted for Comment</td>
<td>Creation of Uniform LCDs With Other MAC Jurisdiction</td>
</tr>
<tr>
<td>09/01/2014</td>
<td>R5</td>
<td>This revision updates the Novitas Solutions MAC numerical jurisdictional designation to the new MAC Lettered jurisdiction designation(s). No other changes were made to this LCD. LCD updated on 08-13-2014 for administrative purposes only. No content changes have been made to this LCD version.</td>
<td>Change to Lettered Jurisdiction Designation</td>
</tr>
<tr>
<td>08/21/2014</td>
<td>R4</td>
<td>LCD revised for dates of service on and after 01/01/2013 to reflect the annual CPT/HCPCS code updates. The following code descriptor(s) have been revised: 01930.</td>
<td>Other (Administrative purposes.)</td>
</tr>
<tr>
<td>01/01/2013</td>
<td>R3</td>
<td>Diagnoses that Support Medical Necessity inadvertently removed from R2 added back to R3. <em>(This is the only difference between R2 and R3)</em></td>
<td>Revisions Due To CPT/HCPCS Code Changes</td>
</tr>
<tr>
<td>01/01/2013</td>
<td>R2</td>
<td>LCD revised for dates of service on and after 01/01/2013 to reflect the annual CPT/HCPCS code updates. The following code descriptor(s) have been revised: 01930.</td>
<td>Other (Diagnoses that Support Medical Necessity inadvertently removed from previous version added back to LCD.)</td>
</tr>
<tr>
<td>11/19/2012</td>
<td>R1</td>
<td>11/19/2012 (Revision History Number 5) Per CMS Change Request (CR) 7812, this LCD has been updated with the original effective date of 11/19/2012 to add the Novitas Jurisdiction H Part B MAC Contract Numbers 04112, 04212, 04312, and 04412 for Colorado Part B, New Mexico Part B, Oklahoma Part B, Texas Part B, Indian Health Service (IHS)/Tribal/Urban Indian Providers Part B, and Veterans Affairs (VA) Part B. No other changes were made to this LCD.</td>
<td>Revisions Due To CPT/HCPCS Code Changes</td>
</tr>
</tbody>
</table>

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10/29/2012 (Revision History Number 4) Per CMS Change Request (CR) 7812, this LCD has been updated with the original effective date of 10/29/2012 to add the Novitas Jurisdiction H Part A MAC Contract Numbers 04911, 04111, 04211, 04311, and 04411 for Colorado Part A, New Mexico Part A, Oklahoma Part A, Texas Part A, Indian Health Service (IHS)/Tribal/Urban Indian Providers Part A, and Veterans Affairs (VA) Part A. No other changes were made to this LCD.

10/22/2012 (Revision History Number 3) LCD original effective date of 10/22/2012 for Mississippi Part B.

08/20/2012 (Revision History Number 2) LCD original effective date of 08/20/2012 for Arkansas Part A, Louisiana Part A and Mississippi Part A.

08/13/2012 (Revision History Number 1) LCD original effective date of 08/13/2012 for Arkansas Part B and Louisiana Part B. LCD posted for notice on 06/28/2012.

11/25/2012 - For the following CPT/HCPCS codes either the short description and/or the long description was changed. Depending on which description is used in this LCD, there may not be any change in how the code displays in the document:
01930 descriptor was changed in Group 1
01991 descriptor was changed in Group 1
01992 descriptor was changed in Group 1

Associated Documents

Attachments N/A
Related Local Coverage Documents N/A
Related National Coverage Documents N/A
Public Version(s) Updated on 02/13/2015 with effective dates 04/09/2015 - N/A Some older versions have been archived. Please visit the MCD Archive Site opens in new window to retrieve them.

Keywords

N/A Read the LCD Disclaimer opens in new window