Microsurgery

Policy Number	MIC05222013RP	Approved By	UnitedHealthcare Medicare Reimbursement Policy Committee	Current Approval Date	08/13/2014

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general resource regarding UnitedHealthcare's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee's benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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Application

This reimbursement policy applies to services reported using the Health Insurance Claim Form CMS-1500 or its electronic equivalent or its successor form, and services reported using facility claim form CMS-1450 or its electronic equivalent or its successor form. This policy applies to all products, all network and non-network physicians, and other health care professionals.

The HCPCS/CPT code(s) may be subject to Correct Coding Initiative (CCI) edits. This policy does not take precedence over CCI edits. Please refer to the CCI for correct coding guidelines and specific applicable code combinations prior to billing UnitedHealthcare. It is not enough to link the procedure code to a correct, payable ICD-9-CM diagnosis code. The diagnosis must be present for the procedure to be paid. Compliance with the provisions in this policy is subject to monitoring by pre-payment review and/or post-payment data analysis

Microsurgery

Summary

Overview

Microsurgical technique is the use of an operating microscope during a surgical procedure.

Reimbursement Guidelines

Use of an operating microscope, reported with Current Procedural Terminology (CPT®) codes 64727 and 69990, is a reimbursable service in specified instances:

- CPT code 64727 will only be reimbursed when submitted with internal neurolysis codes on the "Services Allowed with CPT 64627" list.
- CPT code 69990 will only be reimbursed when submitted with certain nervous system surgery services on the “Services Allowed with CPT 69990” list.

The Centers for Medicare and Medicaid Services (CMS) Medicare Claims Processing Manual and the Correct Coding Initiative (CCI) state that CPT code 69990 is not to be reported in addition to CPT code 64727.

CPT / HCPCS Codes

<table>
<tr><th>Code</th><th colspan="2">Description</th></tr>
<tr><td rowspan="14">Services allowed with CPT 64727</td><td colspan="2">This list contains the CPT codes for the surgeries which allow separate reimbursement for the use of a microscope with add-on CPT code 64727.</td></tr>
<tr><td>Code</td><td>Description</td></tr>
<tr><td>64702</td><td>Neuroplasty; digital, 1 or both, same digit</td></tr>
<tr><td>64704</td><td>Neuroplasty; nerve of hand or foot</td></tr>
<tr><td>64708</td><td>Neuroplasty, major peripheral nerve, arm or leg, open; other than specified</td></tr>
<tr><td>64712</td><td>Neuroplasty, major peripheral nerve, arm or leg, open; sciatic nerve</td></tr>
<tr><td>64713</td><td>Neuroplasty, major peripheral nerve, arm or leg, open; brachial plexus</td></tr>
<tr><td>64714</td><td>Neuroplasty, major peripheral nerve, arm or leg, open; lumbar plexus</td></tr>
<tr><td>64716</td><td>Neuroplasty and/or transposition; cranial nerve (specify)</td></tr>
<tr><td>64718</td><td>Neuroplasty and/or transposition; ulnar nerve at elbow</td></tr>
<tr><td>64719</td><td>Neuroplasty and/or transposition; ulnar nerve at wrist</td></tr>
<tr><td>64721</td><td>Neuroplasty and/or transposition; median nerve at carpal tunnel</td></tr>
<tr><td>64722</td><td>Decompression; unspecified nerve(s) (specify)</td></tr>
<tr><td>64726</td><td>Decompression; plantar digital nerve</td></tr>
<tr><td>Services allowed with CPT 69990</td><td colspan="2">This list (attachment) contains the CPT codes for the surgeries which allow separate reimbursement for the use of a microscope with add-on CPT code 69990.
 
Microsurgery with add-on CPT 69990

*Below is a listing of the groupings and their general descriptions of the codes listed in the attachment.</td></tr>
</table>

Microsurgery

	Code	Description
	61304-61546	Craniectomy(s)
	61550-61711	Surgery of Aneurysms
	62010-62100	Cranioplasty(s)
	63081-63308	Vertebral corpectomy(s)
	63704-63710	Repair of meningocele(s)
	64831	Suture of digital nerve, hand or foot; 1 nerve
	64834-64836	Sutures of nerves
	64840-64858	Sutures of nerves
	64861-64871	Sutures of nerves
	64885-64891	Nerve grafts
	64905-64907	Nerve pedicle transfers

CPT / HCPCS Codes-Add-On-Codes required in order for payment to be considered

Code	Description
64727	Internal neurolysis, requiring use of operating microscope (List separately in addition to code for neuroplasty) (Neuroplasty includes external neurolysis)
69990	Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)

Definitions

Term	Description
Add-On Codes	These describe additional intra-service work associated with the primary procedure. They are performed by the same physician on the same date of service as the primary service/procedure, and must never be reported as a stand-alone code.
Microsurgery	The use of a microscope during a surgical procedure to perform microsurgical technique
Microsurgical Technique	A surgical technique for dissecting tissues under a microscope
Same Individual Physician or Other Health Care Professional	The same individual rendering health care services reporting the same Federal Tax Identification number

Questions and Answers

Q:	Why does UnitedHealthcare include add-on codes in the "Services Allowed with 69990 List" when CMS National Correct Coding Initiative (NCCI) Policy does not include these add-on codes in the range of services in which CPT code 69990 is allowable?
A:	CMS guidelines state: "In general, NCCI procedure to procedure edits do not include edits with most add-on codes because edits related to the primary procedure(s) are adequate to prevent inappropriate payment for an add-on coded procedure." UnitedHealthcare aligns with CMS and allows reimbursement of CPT code 69990 reported with add-on codes when the primary procedure codes are allowable. For example, primary procedure code 61608 (Resection or excision of neoplastic, vascular or infectious lesion of parasellar area, cavernous sinus, clivus or midline skull base; intradural, including dural repair, with or without graft) is allowable and, therefore, add-on code 61609 (Transection or ligation, carotid artery in cavernous sinus; without repair (List separately in addition to code for primary procedure) is also allowable.

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References Included (but not limited to)

CMS Claims Processing Manual

Chapter 12; § 20.4.5 Allowable Adjustments

CMS Transmittal

Transmittal 2636, Change Request 7501, Dated 01/16/2013 (National Correct Coding Initiative (NCCI) Add-On Codes Replacement of Identical Letter, Dated December 19, 1996 with Subject Line, Correct Coding Initiative Add-On (ZZZ) Codes - ACTION)

History

Date	Revisions
08/13/2014	• Annual Review • No change
06/12/2013	• New policy presented to MRPC for approval • Approved