UnitedHealthcare®

Reimbursement Policy

Stereotactic Computer Assisted Volumetric and/or Navigational Procedures

Policy Number	SCA06082011RP	Approved By	UnitedHealthcare Medicare Reimbursement Policy Committee	Current Approval Date	06/25/2014

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.

Table of Contents

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 and subsequent medical review. The effective date of changes/additions/deletions to this policy is the committee meeting date unless otherwise indicated.

Summary

Overview

Recent advances in technology have led to numerous advances in imaging technology, more specifically for the purposes of this policy, imaging as related to surgical procedures. This policy is intended to cover those uses of stereotactic computer assisted volumetric and or navigational procedures which could correctly be identified by the use of CPT codes 61781, 61782 and 61783 (add-on codes), recognized for payment by Medicare, when their use is considered medically reasonable and necessary.

Reimbursement Guidelines

Payment is limited to CPT codes 61781, 61782 and 61783 for any one or more of the following indications;

1. Where there is clinical data to support its use.
2. When used in conjunction with most intracerebral procedures, excluding routine shunt procedures.
3. When used for the following extracranial otorhinolarngological/head and neck procedures:
   - Revision endoscopic sinus surgery
   - Frontal or sphenoid sinus surgery when there is documented loss of or altered anatomic and marks, congenital deformities or severe trauma
   - Significantly distorted sinus anatomy of developmental, postoperative or traumatic origin
   - Extensive sino-nasal polyposis of sufficient severity to create a need for the precision localization and navigation assistance
   - Pathology involving the frontal, posterior ethmoid or sphenoid sinuses
   - Disease abutting the skull base, orbit, optic nerve or carotid artery
   - Lateral skull base surgery where navigational planning and assistance is required
   - CSF rhinorrhea or conditions where there is a skull base defect
   - Transsphenoidal surgery
   - Benign and malignant sino-nasal neoplasms of sufficient size or high-risk location

Use of CPTs 61781, 61782 and 61783 with 20985, 0054T and 0055T or other such CPT codes have been determined to be NOT appropriate in cases where screws and/or other hardware are applied to the spine. All spinal procedures will be considered inappropriate for its separate payment, due to the lack of compelling literature support, and such claims will be denied as not proven effective. To date, we have seen no such compelling literature.

In addition, there is currently no convincing literature to support the use of any other clinically-available devices for use in performing joint replacement surgery, either knee or hip. Though it does appear that the technology allows arguably more precise positioning of the joint replacement hardware, there is no long-term data supporting the assertion that this improves patient outcomes or long-term viability of the repair as compared to traditional methods of performing these procedures. Therefore, CPT codes 20985, 0054T and 0055T, or other such CPT codes will be denied as not proven effective.

Documentation Guidelines

When medically reasonable and necessary, the use of a stereotactic guidance system may be reported in addition to the intracranial procedure codes that fall within the range of CPT codes 61304, 61305, 61510, 61512, 61514, 61516. 61517, 61518-61521; 61526-61530; 61541; 61545-61548; 61592; 61608; 61680-

Stereotactic Computer Assisted Volumetric and/or Navigational Procedures

61702 and 62161-62165.

The use of a stereotactic guidance system may be reported in addition to the endoscopic sinus surgery codes that fall within the range 31255-31294 and lateral skull base procedures in appropriately select cases to provide localization and navigation around high-risk anatomical areas when there is documentation of both the medical necessity and the required pre-planning activities.

When codes 61781, 61782 and 61783 are billed in conjunction with any of the above-listed codes noted in the paragraph above, it is expected that documentation will demonstrate both the added work involved in the use of this procedure and the medical necessity for its use when done in conjunction with the primary surgery performed. Failure to document both the description of the use of the stereotactic procedure and the medical necessity for its use may result in denial of claims for CPT codes 61781, 61782 and 61783.

The following paragraph, from an article in CPT Assistant, November 1999, Volume 8, Issue 11, Page 30, regarding the use and documentation of stereotactic computer-assisted (navigational) procedures, may be of help in determining whether acceptable criteria exist in any given case to support the billing for these procedures.

This planning may take approximately one to two hours and includes determination of the coordinates for the target, measurement of the AC-PC line, and angle calculation. Using a computer, various trajectories are determined to assist the physician in choosing the specific trajectory and calculating the entry point (which in the case of some of these procedures is) through the skull. While the last two sentences describe the use of this technology for intracranial procedures, the same additional planning and time would be expected when this technique is used and billed for extracranial or spinal stereotactic procedures.

Documentation must substantiate the high-risk clinical circumstances requiring the precision localization and navigation assistance which the computer guidance provides. Documentation of the pre-planning activities should also provide evidence the procedure has included the work described in the CPT reference noted above.

As a logical extension of the advice in the preceding paragraphs, CPT Codes 61781, 61782 and 61783 are not separately reportable if it is just used for intraoperative localization. The physician must not report the use of image-guided technology for the navigation system used as a routine part of any surgery.

The medical record must be made available to UHC upon request. When the documentation does not meet the criteria for the service rendered or the documentation does not establish the medical necessity for the services, such services will be denied as not reasonable and necessary under Section 1862(a)(1) of the Social Security Act. When requesting a written redetermination, providers must include all relevant documentation with the request.

CPT / HCPCS Codes

Code	Description
0054T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (list separately in addition to code for primary procedure)
0055T	Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (list separately in addition to code for primary procedure)
20985	Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (list separately in addition to code for primary procedure)
61781	Stereotactic computer-assisted (navigational) procedure; cranial, intradural (list separately in addition to code for primary procedure)
61782	Stereotactic computer-assisted (navigational) procedure; cranial, extradural (list separately in addition to code for primary procedure)
61783	Stereotactic computer-assisted (navigational) procedure; spinal (list separately in addition to code for primary procedure)
61781, 61782 or 61783 are covered when billed with any one of the following codes	
31255	Nasal/sinus endoscopy, surgical; with ethmoidectomy, total (anterior and posterior)
31256	Nasal/sinus endoscopy, surgical, with maxillary antrostomy;

Stereotactic Computer Assisted Volumetric and/or Navigational Procedures

31267	Nasal/sinus endoscopy, surgical, with maxillary antrostomy; with removal of tissue from maxillary sinus
31276	Nasal/sinus endoscopy, surgical with frontal sinus exploration, with or without removal of tissue from frontal sinus
31287	Nasal/sinus endoscopy, surgical, with sphenoidotomy;
31288	Nasal/sinus endoscopy, surgical, with sphenoidotomy; with removal of tissue from the sphenoid sinus
31290	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; ethmoid region
31291	Nasal/sinus endoscopy, surgical, with repair of cerebrospinal fluid leak; sphenoid region
31292	Nasal/sinus endoscopy, surgical; with medial or inferior orbital wall decompression
31293	Nasal/sinus endoscopy, surgical; with medial orbital wall and inferior orbital wall decompression
31294	Nasal/sinus endoscopy, surgical; with optic nerve decompression
61304	Craniectomy or craniotomy, exploratory; supratentorial
61305	Craniectomy or craniotomy, exploratory; infratentorial (posterior fossa)
61510	Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma
61512	Craniectomy, trephination, bone flap craniotomy; for excision of meningioma, supratentorial
61514	Craniectomy, trephination, bone flap craniotomy; for excision of brain abscess, supratentorial
61516	Craniectomy, trephination, bone flap craniotomy; for excision or fenestration of cyst, supratentorial
61517	Implantation of brain intracavitary chemotherapy agent (List separately in addition to code for primary procedure)
61518	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull
61519	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; meningioma
61520	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; cerebellopontine angle tumor
61521	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; midline tumor at base of skull
61526	Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor;
61530	Craniectomy, bone flap craniotomy, transtemporal (mastoid) for excision of cerebellopontine angle tumor; combined with middle/posterior fossa craniotomy/craniectomy
61541	Craniotomy with elevation of bone flap; for transection of corpus callosum
61545	Craniotomy with elevation of bone flap; for excision of craniopharyngioma
61546	Craniotomy for hypophysectomy or excision of pituitary tumor, intracranial approach
61548	Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic
61592	Orbitocranial zygomatic approach to middle cranial fossa (cavernous sinus and carotid artery, clivus, basilar artery or petrous apex) including osteotomy of zygoma, craniotomy, extra- or intradural elevation of temporal lobe
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

Stereotactic Computer Assisted Volumetric and/or Navigational Procedures

61680	Surgery of intracranial arteriovenous malformation; supratentorial, simple
61682	Surgery of intracranial arteriovenous malformation; supratentorial, complex
61684	Surgery of intracranial arteriovenous malformation; infratentorial, simple
61686	Surgery of intracranial arteriovenous malformation; infratentorial, complex
61690	Surgery of intracranial arteriovenous malformation; dural, simple
61692	Surgery of intracranial arteriovenous malformation; dural, complex
61697	Surgery of complex intracranial aneurysm, intracranial approach; carotid circulation
61698	Surgery of complex intracranial aneurysm, intracranial approach; vertebrobasilar circulation
61700	Surgery of simple intracranial aneurysm, intracranial approach; carotid circulation
61702	Surgery of simple intracranial aneurysm, intracranial approach; vertebrobasilar circulation
62161	Neuroendoscopy, intracranial; with dissection of adhesions, fenestration of septum pellucidum or intraventricular cysts (including placement, replacement, or removal of ventricular catheter)
62162	Neuroendoscopy, intracranial; with fenestration or excision of colloid cyst, including placement of external ventricular catheter for drainage
62163	Neuroendoscopy, intracranial; with retrieval of foreign body
62164	Neuroendoscopy, intracranial; with excision of brain tumor, including placement of external ventricular catheter for drainage
62165	Neuroendoscopy, intracranial; with excision of pituitary tumor, transnasal or trans-sphenoidal approach

References Included (but not limited to):

CMS NCD

NCD 160.4 Stereotactic Cingulotomy as a Means of Psychosurgery

CMS LCD(s)

Numerous LCDs

UnitedHealthcare Medicare Advantage Coverage Summaries

Radiologic Therapeutic Procedures

UnitedHealthcare Reimbursement Policies

Category III CPT Codes Reimbursement Policy

Stereotactic Cingulotomy as a Means of Psychosurgery (NCD 160.4) Reimbursement Policy

History

Date	Revisions
06/25/2014	Re-review presented to MRPC for approval
06/12/2013	Re-review presented to MRPC for approval
02/15/2013	Administrative updates
09/12/2012	Policy re-reviewed and presented to MRP Committee with no changes to the current policy
06/08/2011	Policy developed and implemented with effective date of 06/08/2011