MEDICAL POLICY

POLICY TITLE	ULTRASOUND DIAGNOSTIC; SKIN, SPINE, AND MUSCULOSKELETAL INDICATIONS
POLICY NUMBER	MP- 5.014

Original Issue Date (Created):	**July 1, 2002**
Most Recent Review Date (Revised):	**September 24, 2013**
Effective Date:	**July 24, 2014**

I. POLICY

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Spinal Ultrasound

Spinal ultrasound may be considered **medically necessary** for use prenatally to detect meningomyeloceles and postnatally to localize these and associated lesions and to assess congenital and developmental abnormalities of the spinal cord.

Ultrasound of the spine as an intraoperative imaging technique may be considered **medically necessary.**

Transdermal ultrasound studies of the spine for the evaluation of radicular pain are considered **investigational,** as there is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with this procedure**.**

Musculoskeletal Ultrasound

Musculoskeletal Ultrasound is considered **medically necessary** for the following indications:

- To assist with joint and bursal injection;
- To assist with guidance of nerve blocks; and
- Evaluation and management of synovitis.

Musculoskeletal Ultrasound for the evaluation and management of soft tissue inflammatory conditions and conditions of muscles and joints, except specifically for injections and synovitis as described above is considered **investigational,** as there is insufficient evidence to support a conclusion concerning the health outcomes of benefits associated with this procedure.

Ultrasonic Evaluation of Skin Lesions

Ultrasonographic evaluation of skin lesions is considered **investigational,** as there is insufficient evidence to support a conclusion concerning the health outcomes or benefits associated with this procedure.

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Ultrasonographic evaluation as a technique to assess photoaging or skin rejuvenation techniques is considered **cosmetic in nature and therefore not medically necessary**.

Note: This policy does not address the potential use of ultrasonographic detection for subcutaneous lesions including lipomas, epidermal cysts or ganglions or for detecting regional lymph nodes and subcutaneous metastases in patients with melanoma.

Cross-reference:

MP-2.066 Total Body Photography and Dermatoscopy for Evaluation of Skin Lesions

II. PRODUCT VARIATIONS

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[N] = No product variation, policy applies as stated

[Y] = Standard product coverage varies from application of this policy, see below

[N] Capital Cares 4 Kids
[N] PPO
[N] HMO
[Y] SeniorBlue HMO**
[Y] SeniorBlue PPO**
[N] Indemnity
[N] SpecialCare
[N] POS
[Y] FEP PPO*

* Regarding Ultrasonic Evaluation of Skin Lesions and Musculoskeletal Ultrasound, the FEP program dictates that all drugs, devices or biological products approved by the U.S. Food and Drug Administration (FDA) may not be considered investigational. Therefore, FDA-approved drugs, devices or biological products may be assessed on the basis of medical necessity.

** Refer to Novitas Solutions Local Coverage Determination (LCD) L34716 Non-Vascular Extermity Untrasound.

III. DESCRIPTION/BACKGROUND

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Ultrasound is a non-invasive imaging technique that examines the deep structures of the body by measuring and recording pulsed, high frequency sound waves. These reflected sound waves are converted into images of the spinal cord. A transducer is applied to the spinal cord or to sterile fluid that is infused directly around the cord. The medical application of ultrasound imaging of the spinal cord is limited. Indications for spinal ultrasound include intraoperative imaging to localize lesions surrounding the spinal cord for the purpose of surgical biopsy or repair. Spinal ultrasound is also used prenatally (before birth) to detect meningomyeloceles and postnatally (after birth) in the localization of these lesions for treatment.

The transdermal use of ultrasound of the adult spine has been used to evaluate the pain associated with radiculopathy syndromes. In most cases, there is insufficient peer supported evidence to validate the clinical value of spinal ultrasound as a screening, diagnostic, or adjunctive imaging tool.

Ultrasonic Evaluation of Skin Lesions

High frequency ultrasound transducers (20-100 MHz), which have limited penetration but high resolution, have been extensively used in ophthalmology and as a component of endoscopic ultrasound. These same parameters make high frequency ultrasound potentially suitable for evaluating skin lesions, where ultrasound can distinguish between the epidermis, dermis, and underlying connective tissue. Lower frequency ultrasound transducers (12-15 MHz) have also been used to evaluate skin layers. Although widely used in Europe, ultrasonography evaluation of skin lesions has not been widely used in this country.

The following applications of ultrasonic evaluation of skin lesions have been proposed:

- To assess the depth of melanomas to aid in surgical planning;
- To assess actinic keratoses to determine if cryosurgery is an appropriate therapeutic option;
- To follow the course of connective diseases of the skin, i.e., scleroderma, by evaluating the amount and location of collagen in the dermis;
- To assess inflammatory skin diseases, such as allergic reactions or psoriasis.

Musculoskeletal Ultrasound

In the last decade, musculoskeletal ultrasound has become a popular radiologic modality to use in aiding with diagnosis or to assist with procedures that involve injections, especially with non-radiology practicing physicians in the office setting. Ultrasound images of the musculoskeletal system provide pictures of muscles, tendons, ligaments, joints and soft tissue throughout the body.

IV. DEFINITIONS

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MENINGOMYELOCELE is a hernia of the spinal cord and membranes through a defect in the vertebral column.
NON-INVASIVE refers to a device or procedure that does not penetrate the skin or enter any orifice in the body.
RADICULOPATHY refers to any disease of a nerve root.

V. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member's contract. Benefit determinations should be based in all cases on the applicable contract language. Medical policies do not constitute a description of benefits. A member's individual or group customer benefits govern which services are covered, which are excluded, and which are subject to benefit limits and which require preauthorization. Members and providers should consult the member's benefit information or contact Capital for benefit information.

VI. DISCLAIMER

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Capital's medical policies are developed to assist in administering a member's benefits, do not constitute medical advice and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. Capital considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.

VII. REFERENCES

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Musculoskeletal Ultrasound

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VIII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

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Covered when medically necessary:

CPT Codes®								
76800	76881	76882	76942	76998	76999			

ICD-9-CM Diagnosis Code*	Description
338.28	OTHER CHRONIC POSTOPERATIVE PAIN
338.29	OTHER CHRONIC PAIN
338.4	CHRONIC PAIN SYNDROME
727.00	UNSPECIFIED SYNOVITIS AND TENOSYNOVITIS
727.01	SYNOVITIS AND TENOSYNOVITIS IN DISEASES CLASSIFIED ELSEWHERE
727.02	GIANT CELL TUMOR OF TENDON SHEATH
727.03	TRIGGER FINGER (ACQUIRED)
727.04	RADIAL STYLOID TENOSYNOVITIS
727.05	OTHER TENOSYNOVITIS OF HAND AND WRIST
727.06	TENOSYNOVITIS OF FOOT AND ANKLE
727.09	OTHER SYNOVITIS AND TENOSYNOVITIS
729.1	UNSPECIFIED MYALGIA AND MYOSITIS
741.00	SPINA BIFIDA WITH HYDROCEPHALUS, UNSPECIFIED REGION
741.01	SPINA BIFIDA WITH HYDROCEPHALUS, CERVICAL REGION
741.02	SPINA BIFIDA WITH HYDROCEPHALUS, DORSAL (THORACIC) REGION
741.03	SPINA BIFIDA WITH HYDROCEPHALUS, LUMBAR REGION
741.90	SPINA BIFIDA WITHOUT MENTION OF HYDROCEPHALUS, UNSPECIFIED REGION
741.91	SPINA BIFIDA WITHOUT MENTION OF HYDROCEPHALUS, CERVICAL REGION
741.92	SPINA BIFIDA WITHOUT MENTION OF HYDROCEPHALUS, DORSAL (THORACIC) REGION
741.93	SPINA BIFIDA WITHOUT MENTION OF HYDROCEPHALUS, LUMBAR REGION
V22.0	SUPERVISION OF NORMAL FIRST PREGNANCY
V22.1	SUPERVISION OF OTHER NORMAL PREGNANCY
V23.8	OTHER HIGH-RISK PREGNANCY
V23.9	UNSPECIFIED HIGH-RISK PREGNANCY

*If applicable, please see Medicare LCD or NCD for additional covered diagnoses.

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IX. POLICY HISTORY

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MP 5.014	**CAC 7/27/04**
	CAC 8/30/05
	CAC 9/27/05
	CAC 9/26/06
	CAC 9/25/07
	CAC 11/25/08
	CAC 11/24/09 Medicare variation was added. No change to policy statement for non-medicare products.
	CAC 11/30/10 Consensus review
	CAC 11/22/11 Consensus review
	7/29/13 Admin coding review complete--rsb
	CAC 9/24/13 Consensus, no change to policy statements. References updated.
	7/24/14 Administrative change for the Medicare variation - For Novitas MAC jurisdictions, the LCD has been assigned a new number. Non-Vascular Extremity Ultrasound LCD changed from L30271 to L34716.

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