STEREOTACTIC COMPUTER ASSISTED VOLUMETRIC AND/OR NAVIGATIONAL PROCEDURES

Guideline Number: MPG292.03

TERMS AND CONDITIONS

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication, and is provided on an "AS IS" basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines 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 or guarantee claims payment.

Medicare Advantage Policy Guidelines are the property of UnitedHealthcare. Unauthorized copying, use and distribution of this information are strictly prohibited.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.

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PURPOSE

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers’ submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.
UnitedHealthcare follows Medicare guidelines such as LCDs, NCDs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

POLICY 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. An add-on code is a HCPCS/CPT code that describes a service that is always performed in conjunction with another primary service. An add-on code is eligible for payment only if it is reported with an appropriate primary procedure performed by the same practitioner. An add-on code is never eligible for payment if it is the only procedure reported by a practitioner.

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

- Where there is clinical data to support its use.
- When used in conjunction with most intracerebral procedures, excluding routine shunt procedures.
- When used for the following extracranial otorhinolaryngological/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 sinonasal 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.

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 (primary) procedure code.

The use of a stereotactic guidance system may be reported in addition to the endoscopic sinus (primary) surgery code 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 primary CPT codes, 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.
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 UnitedHealthcare 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.

### APPLICABLE CODES

The following list(s) of codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

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<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>0054T</td>
<td>Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on fluoroscopic images (list separately in addition to code for primary procedure) (Not Covered)</td>
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<tr>
<td>0055T</td>
<td>Computer-assisted musculoskeletal surgical navigational orthopedic procedure, with image-guidance based on CT/MRI images (list separately in addition to code for primary procedure) (Not Covered)</td>
</tr>
<tr>
<td>20985</td>
<td>Computer-assisted surgical navigational procedure for musculoskeletal procedures, image-less (list separately in addition to code for primary procedure) (Not Covered)</td>
</tr>
<tr>
<td>61781</td>
<td>Stereotactic computer-assisted (navigational) procedure; cranial, intradural (list separately in addition to code for primary procedure) (Not Covered)</td>
</tr>
<tr>
<td>61782</td>
<td>Stereotactic computer-assisted (navigational) procedure; cranial, extradural (list separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>61783</td>
<td>Stereotactic computer-assisted (navigational) procedure; spinal (list separately in addition to code for primary procedure)</td>
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### CPT Codes 61781, 61782 or 61783

**Coding Clarification:** CPT codes 61781, 61782 or 61783 are covered when billed with any one of the following primary codes.

- Primary CPT Codes 61781, 61782, 61783

### REFERENCES

**CMS National Coverage Determinations (NCDs)**

- **NCD 160.4 Stereotactic Cingulotomy as a Means of Psychosurgery** Retired 12/18/2014

**CMS Local Coverage Determinations (LCDs)**

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<th>Medicare Part A</th>
<th>Medicare Part B</th>
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<td>L33932 (Category III CPT Codes) NGS</td>
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<td>L33777 (Noncovered Services) First Coast</td>
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<td>L35008 (Noncovered Services) Noridian</td>
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Stereotactic Computer Assisted Volumetric and/or Navigational Procedures
UnitedHealthcare Medicare Advantage Policy Guideline
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Approved 07/12/2017
### LCD

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<th>Code</th>
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<td>L36219 (Non Covered Services)</td>
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<td>CA, AS, GU, HI, MP, NV</td>
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<td>Noridian</td>
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<td>L35094 (Services That are Not Considered Reasonable and Necessary)</td>
<td>AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX</td>
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<td>Norovitas</td>
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<td>L35133 (Stereotactic Computer Assisted Volumetric &amp;/or Navigational Procedure)</td>
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### CMS Claims Processing Manual

**Chapter 12; § 30D Coding Services Supplemental to Principal Procedure (Add-On Codes)**

### CMS Transmittals

**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**

### MLN Matters

**Article SE1320, Add-on HCPCS/CPT Codes Without Primary Codes**

### Others

**Add-on Code Edits, CMS Website**

**Title XVIII of the Social Security Act:**

- 1862(a)(1)(A)
- 1833(e)

### GUIDELINE HISTORY/REVISION INFORMATION

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

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<td>Updated policy template:</td>
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<td></td>
<td>o Removed and replaced Instructions for Use; added Terms and Conditions and Purpose language</td>
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<tr>
<td></td>
<td>o Updated Guideline History/Revision Information; added disclaimer language to indicate revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question</td>
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