Coding Guidelines

LCD Database ID Number
L30143

LCD Title
Treatment of Varicose Veins of the Lower Extremities

Contractor's Determination Number
GSURG-041

CMS National Coverage Policy

Title XVIII of the Social Security Act section §1862 (a) (10) Cosmetic surgery is excluded from coverage

> **Medicare Benefit Policy Manual (CMS PUB 100-02)**
> Cosmetic surgery or expenses incurred in connection with such surgery is not covered. Cosmetic surgery includes any surgical procedure directed at improving appearance, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member. For example, this exclusion does not apply to surgery in connection with treatment of severe burns or repair of the face following a serious automobile accident, or to surgery for therapeutic purposes which coincidentally also serves some cosmetic purpose.
>
> **Medicare Benefit Policy Manual (CMS Pub. 100-02) §180 - Services Related to and Required as a Result of Services Which Are Not Covered Under Medicare.**
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> Services "related to" cosmetic surgery including services related to follow-up care and complications of noncovered services which require treatment during a hospital stay, in which the noncovered service was performed, are not covered services under Medicare**.**
>
> After a beneficiary has been discharged from the hospital stay in which the beneficiary received noncovered services, medical and hospital services required to treat a condition or complication that arises as a result of the prior noncovered services may be covered when they are reasonable and necessary in all other respects.
>
> Thus, coverage could be provided for subsequent inpatient stays or outpatient treatment ordinarily covered by Medicare, even if the need for treatment arose because of a previous noncovered procedure.
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> However, any subsequent services that could be expected to have been incorporated into a global fee are not covered. Thus, where a patient undergoes cosmetic surgery and the treatment regimen calls for a series of postoperative visits to the surgeon for evaluating the patient's progress, these visits are not covered.

Title XVIII of the Social Security Act section 1862 (a) (7). This section excludes routine physical examinations and services.

Title XVIII of the Social Security Act section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Coding Information

General

1. A Claim submitted without a valid ICD-9-CM code will be returned as an incomplete claim under Title XVIII of the Social Security Act Section 1833(e).

2. All claims must be submitted with a valid ICD-9-CM diagnosis code and coded to the highest level of specificity. Truncated diagnosis codes are not accepted.

3. A claim submitted with out one of the ICD-9-CM codes listed in the ICD-9-CM Codes that Support Medical Necessity of this policy will be denied under Title XVIII of the Social Security Act Section 1862 (a)(1)(A).

4. It is not enough to link the procedure code to a correct, payable ICD-9-CM code. The diagnosis or clinical suspicion must be present for the procedure to be paid.

5. When performing ligation/ablation on the opposite leg during the postoperative (90 day global) period, bill the appropriate CPT code with the 79 modifier

6. Use of unlisted CPT code 37799 when less than 10 **stab phelebectomies** are done. Provide a description of what was done and number of stab phelebectomies in Item 19 on the CMS-1500 claim form or in the equivalent field for electronic submissions.

7. When reporting **surgical ligation** procedures (37700, 37718, 38822, 37780, 37785) performed bilaterally, report the appropriate code with the 50 modifier. When reporting any combination of surgical ligation procedures performed on opposite legs, report the appropriate CPT codes with a RT or LT modifier on separate lines.

8. When reporting **sclerotherapy** procedures performed on opposite legs, report CPT code 36470 one vein) or 36471 (multiple veins) on separate lines using the RT and LT modifiers. Only one service should be reported for each leg regardless of how many veins are treated. When the procedure is performed for cosmetic purpose, use code V50.1

   Please be advised that the practice expense for CPT codes 36470 and 36471 already contain the reimbursement for the sclerosing solution. Providers should not bill separately for the sclerosing solution.

9. When reporting **ERFA** use CPT code 36475 for the first vein on each extremity. Use CPT code 36476 to report to report the second and subsequent veins treated in a single extremity ***only when treated through separate access sites.***

Effective Date
11/15/2009

Revision Effective Date
07/16/2012

Revision History Number/Explanation
06/01/2012 - This guideline is effective for J-8 providers in Michigan MAC B 07/16/12, Michigan MAC A 07/23/12, Indiana MAC A 07/23/12 and Indiana MAC B 08/20/12.