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1.0 Description of the Procedure

Aortic aneurysms can develop anywhere along the length of the aorta, but three-fourths of aneurysms are located in the abdominal aorta. Thoracic aortic aneurysms, including those that extend from the descending thoracic aorta into the upper abdomen, account for one-fourth of aortic aneurysms.

Endovascular stent grafting of the vascular system has emerged as a therapeutic modality for aortic aneurysms. Their safety and efficacy has been explored in the treatment of thoracic aortic aneurysms, abdominal aortic aneurysms, and peripheral arterial aneurysms.

Endovascular graft repair is performed under general, spinal or regional anesthesia. During the procedure, a prosthetic endograft is introduced with radiographic guidance through the femoral artery, iliac artery or the abdominal aorta. The device is advanced to the aneurysm site, deployed, and attached to the normal aorta with a self-expandable stent system. While both thoracic and abdominal aneurysms can be surgically repaired using stents and grafts, these open procedures are associated with considerable morbidity and mortality. Endovascular repair was developed to provide a minimally invasive approach, using a catheter inserted through a small groin incision to place the stent/graft across the aneurysm site. Patients requiring aortic aneurysm artery repair often have very significant co-morbid conditions including cardiac, pulmonary, and renal disease or insufficiency, and the comorbidities significantly increase the risk for major perioperative complications following open surgical repair.

A thoracic aortic aneurysm (TAA) is a potentially life-threatening disorder involving a structural weakness of the aortic wall. Progressive arterial dilation and possible rupture may occur. Standard treatment for thoracic aortic aneurysms is an open surgical resection and replacement of the diseased aorta with a graft.

An abdominal aortic aneurysm (AAA) is usually asymptomatic until it expands or ruptures. Presence of a pulsatile abdominal mass is virtually diagnostic but is found in less than half of cases. Rupture is uncommon if aneurysms are less than 5 cm in diameter, but ruptures are dramatically more common for aneurysms greater than 6 cm in diameter. Without prompt intervention, ruptured aneurysms are often fatal.

Endovascular stent grafting for the repair of descending thoracic aorta (DTA) and AAA is an option for treatment of aneurysms and may be covered for patients who meet the required criteria.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

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2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if** the service is **medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination** (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

a. that is unsafe, ineffective, or experimental/investigational.
b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

****EPSDT and Prior Approval Requirements**

a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does NOT eliminate the requirement for prior approval.
b. IMPORTANT ADDITIONAL INFORMATION about EPSDT and prior approval is found in the Basic Medicaid Billing Guide, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

Basic Medicaid Billing Guide**:** http://www.ncdhhs.gov/dma/medbillcaguide.htm

EPSDT provider page: http://www.ncdhhs.gov/dma/EPSDTprovider.htm

3.0 When the Procedure Is Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows

how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

3.1 Abdominal Aortic Aneurysm

Endovascular stent grafting for abdominal aortic aneurysm is considered medically necessary for high-risk patients when **ALL** of the following criteria are met:

a. The endoprosthesis is FDA approved for the treatment of abdominal aortic aneurysms;
b. The risks of an open repair of the aneurysm are unacceptable;
c. There is adequate iliac/femoral access; and
d. The risk of aneurysm rupture is high, as indicated by any one of the following criteria:
    1. An aneurysmal diameter greater than 5 cm
    2. An aneurysmal diameter of 4 cm o-5 cm that has increased in size by 0.5 cm in the last six months
    3. An aneurysmal diameter that measures twice the size of the normal infrarenal aorta

3.2 Thoracic Aortic Aneurysm

Endovascular stent grafting for descending thoracic aortic aneurysm is considered medically necessary for high-risk patients when **ALL** of the following criteria are met:

a. The endoprosthesis is FDA approved for the treatment of descending thoracic aortic aneurysm;
b. The risks of an open repair of the aneurysm are unacceptable;
c. There is adequate iliac/femoral access;
d. Aortic inner diameter in the range of 23mm to 37mm; and
e. 2 cm or greater non-aneurysmal aorta proximal and distal to the aneurysm

4.0 When the Procedure Is Not Covered

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

Endovascular repair of aortic aneurysms is not covered when:

a. the recipient does not meet the eligibility requirements listed in **Section 2.0;**
b. the recipient does not meet the medical necessity criteria listed in **Section 3.0;**
c. the procedure duplicates another provider's procedure;
d. the procedure is experimental, investigational, or part of a clinical trial; or
e. the procedure is performed without an FDA-approved device.

5.0 Requirements for and Limitations on Coverage

IMPORTANT NOTE: EPSDT allows a recipient less than 21 years of age to receive services in excess of the limitations or restrictions below and without meeting the specific criteria in this section when such services are **medically necessary health care services** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem]; that is, documentation shows how the service, product, or procedure will correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

EPSDT DOES NOT ELIMINATE THE REQUIREMENT FOR PRIOR APPROVAL IF PRIOR APPROVAL IS REQUIRED. For additional information about EPSDT and prior approval requirements, see **Section 2.0** of this policy.

5.1 Prior Approval

Prior approval is not required.

5.2 Limitations

Medicaid only covers one procedure per date of service.

6.0 Providers Eligible to Bill for the Procedure

Providers who meet Medicaid's qualifications for participation and are currently enrolled with the N.C. Medicaid program are eligible to bill for endovascular repair of aortic aneurysms when the procedure is within the scope of their practice.

7.0 Additional Requirements

Documentation clearly supporting the medical necessity of the procedure should be legible, maintained in the patient's medical record, and made available to Medicaid upon request.

8.0 Policy Implementation/Revision Information

Original Effective Date: January 1, 2001

Revision Information:

Date	Section Revised	Change
12/1/06	Throughout policy	The policy was updated to include coverage of repairs of thoracic aortic aneurysms.
5/1/07	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
5/1/07	Attachment A	Added UB-04 as an accepted claims form.

Attachment A: Claims-Related Information

Reimbursement requires compliance with all Medicaid guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid managed care programs.

A. Claim Type

1. CMS 1500 Claim Form

Providers enrolled in the N.C. Medicaid program bill professional services on the CMS-1500 claim form.

2. UB-92 or UB-04 Claim Form

Hospital providers enrolled in the N.C. Medicaid program bill facility charges on the UB-92 or UB-04 claim form and professional charges on the CMS-1500 claim form.

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

1. CPT Procedure Codes

The CPT procedure codes listed below are subject to the multiple surgery guidelines.

33880	33881	33883	33884	34808
33889	33891	34800	34825	34826
34812	34813	34820	33886	34900
34830 through 34834		34802 through 34805		

2. ICD-9-CM Procedure Codes

For inpatient billing on a UB-92 or UB-04 claim form, bill the appropriate ICD-9-CM procedure code:

39.50	39.71	39.73	39.79

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Place of Service

Allowable places of service for endovascular repair procedures are inpatient hospitals and outpatient hospital settings.

F. Reimbursement

Providers must bill usual and customary charges.

G. Billing Guidelines

Codes 33880 through 33891 and 34800 through 34826 represent a family of procedures to report placement of an endovascular graft for repair of the aorta. These codes include all device

introduction, manipulation, positioning and deployment. All balloon angioplasty and/or stent deployment within the target treatment zone for the endoprosthesis, either before or after endograft deployment, are not reported separately.

The following procedure codes, when applicable, are reported separately:

34812	34820	34833	34834
36140	35226	35286	
36245 through 36248		36200 through 36218	

For radiological supervision and interpretation, use:

1. 75952 in conjunction with 34800 through 34808
2. 75953 in conjunction with 34825 through 34826
3. 75954 in conjunction with 34900
4. 75956 in conjunction with 33880
5. 75957 in conjunction with 33881
6. 75958 in conjunction with 33883
7. 75959 in conjunction with 33886

Do not report 33881, 33883 when extension placement converts repair to cover left subclavian origin. Use only 33880.

Do not report 33886 in conjunction with 33880, 33881.

Report 33886 once, regardless of number of modules deployed.

Do not report 33889 in conjunction with 35694.

Do not report 33891 in conjunction with 35509, 35601.

Report 34812, 34820, 34833, 34844 as appropriate, in addition to 34800-34808.

Use 34826 in conjunction with 34825.

Use 34825, 34826 in addition to 34800-34808, 34900 as appropriate.

Do not report 34833 in addition to 34820.

For placement of extension prosthesis during endovascular iliac artery repair, use 34825.