LOWER EXTREMITY VASCULAR ANGIOGRAPHY

Policy Number: CS166.A

Effective Date: October 1, 2019

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APPLICATION

This Medical Policy does not apply to the states of Kansas, Louisiana, Mississippi, and Tennessee.
• For the state of Tennessee, refer to the Medical Policy titled Lower Extremity Vascular Angiography (for Tennessee Only).

COVERAGE RATIONALE

Lower extremity vascular angiography is proven and medically necessary for evaluating arterial disease of the lower extremity. For medical necessity clinical coverage criteria, see MCG™ Care Guidelines, 23rd edition, 2019, Lower Extremity Angiography, ACG: A-0002 (AC).

Click here to view the MCG™ Care Guidelines.

Note: This policy does not apply to upper extremities.

APPLICABLE CODES

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy 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 federal, state or contractual requirements 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 Coverage Determination Guidelines may apply.

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<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>75710</td>
<td>Angiography, extremity, unilateral, radiological supervision and interpretation</td>
</tr>
<tr>
<td>75716</td>
<td>Angiography, extremity, bilateral, radiological supervision and interpretation</td>
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CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Medicare does not have a National Coverage Determination (NCD) specifically for lower extremity vascular angiography. Local Coverage Determinations (LCDs) that mention lower extremity vascular angiography exist. See the LCDs for Aortography and peripheral angiography, Diagnostic Abdominal Aortography and Renal Angiography and Non-Invasive Abdominal/Visceral Vascular Studies. (Accessed June 5, 2019)

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POLICY HISTORY/REVISION INFORMATION

<table>
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<th>Date</th>
<th>Action/Description</th>
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<td>12/04/2019</td>
<td>Coverage Rationale</td>
</tr>
<tr>
<td>10/01/2019</td>
<td>• Added reference link to MCG™ Care Guidelines</td>
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<td>• New Medical Policy</td>
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INSTRUCTIONS FOR USE

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.