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Applicable To:
- ☑ Medicare
- ☑ Medicaid – excluding NE, AZ, and KY

Claims and Payment Policy: Abdominal Aneurysm Screening

Policy Number: CPP-129

Original Effective Date: 1/10/2019
Revised Effective Date(s): N/A

BACKGROUND

Abdominal aortic aneurysm (AAA) can be defined as an enlarged area in the lower part of the major vessel that supplies blood to the body (aorta). The aorta runs from the heart through the center of the chest and abdomen. AAA can be identified by an aortic diameter of 3.0 cm or larger. Prevalence among adults older than 50 years is between 3.9% to 7.2% (males) and 1.0% to 1.3% (females). Screening for AAA is important because most AAAs are asymptomatic until they rupture. While the risk for rupture varies by aneurysm size, the associated risk for death is as high as 75% to 90%. Recent evidence supports that ultrasonography is a safe and accurate screening test for AAA. Early detection of AAA through screening can be life-saving, as it gives the patient an opportunity to undergo elective surgical repair, which is much safer than emergency repair after the aneurysm ruptures.

POSITION STATEMENT

A one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography **is a covered benefit** when the Member meetings the following criteria:

- Male
- Age 65 to 75 years old **
- Has ever smoked
- Has a diagnosis of nicotine dependence

**Ends on 76th birthday

CODING & BILLING

The following list(s) of codes is provided for reference purposes only and may not be all inclusive.

Covered ICD-10 Diagnosis Codes

F17.210	Nicotine dependence, cigarettes, uncomplicated

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F17.211	Nicotine dependence, cigarettes, in remission
F17.213	Nicotine dependence, cigarettes, with withdrawal
F17.218	Nicotine dependence, cigarettes, with other nicotine-induced disorders
F17.219	Nicotine dependence, cigarettes, with unspecified nicotine-induced disorders
Z87.891	Personal history of nicotine dependence

Covered CPT Codes

76706	Ultrasound, abdominal aorta, real time with image documentation, screening study for abdominal aortic

Coding information is provided for informational purposes only. The inclusion or omission of a CPT, HCPCS, or ICD-10 code does not imply member coverage or provider reimbursement. Consult the member's benefits that are in place at time of service to determine coverage (or non-coverage) as well as applicable federal / state laws.

DEFINITIONS

Abdominal Aortic Aneurism (AAA)	An abdominal aortic aneurysm is an enlarged area in the lower part of the major vessel that supplies blood to the body (aorta). The aorta runs from your heart through the center of your chest and abdomen. Abdominal aortic aneurisms can be identified by an aortic diameter of 3.0 cm or larger.

REFERENCES

1. Abdominal Aortic Aneurism. Mayo Clinic Website. https://www.mayoclinic.org/diseases-conditions/abdominal-aortic-aneurysm/symptoms-causes/syc-20350688. Accessed September 13, 2019.
2. Abdominal Aortic Aneurism. Medline Plus https://medlineplus.gov/aorticaneurysm.html . Accessed September 13, 2019.
3. Final Recommendation Statement: Abdominal Aortic Aneurysm: Screening. United States Preventive Services Task Force Website. Updated June 2014 (update in progress). https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/abdominal-aortic-aneurysm-screening. Accessed September 13, 2019.

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IMPORTANT INFORMATION ABOUT THIS DOCUMENT

Claims and Payment Policies (CPPs) are policies regarding claims or claim line processing and/or reimbursement related to the administration of health plan benefits. They are not recommendations for treatment, nor should they be used as treatment guidelines. Providers are responsible for diagnosing, treating, and making clinical recommendations to the member. CPPs are subject to, but not limited to, the following:

- State and federal laws and regulations;
- Policies and procedures promulgated by the Centers for Medicare and Medicaid Services, including National Coverage Determinations and Local Coverage Determinations;
- The health plan's contract with Medicare and/or a state's Medicaid agency, as applicable;
- Other CPPs and clinical policies as applicable including, but not limited to, *Pre-Payment and Post-Payment Review*.
- The provisions of the contract between the provider and the health plan; and
- The terms of a member's particular benefit plan, including those terms outlined in the member's Evidence of Coverage, Certificate of Coverage, and other policy documents.

In the event of a conflict between a CPP and a member's policy documents, the terms of a member's benefit plan will always supersede the CPP.

The use of this policy is neither a guarantee of payment, nor a prediction of how a specific claim will be adjudicated. Any coding information is for informational purposes only. No inference should be made regarding coverage or provider reimbursement as a result of the inclusion, or omission, in a CPP of a CPT, HCPCS, or ICD-10 code. Always consult the member's benefits that are in place at time of service to determine coverage or non-coverage. Claims processing is subject to a number of factors, including the member's eligibility and benefit coverage on the date of service, coordination of benefits, referral/authorization requirements, utilization management protocols, and the health plan's policies. Services must be medically necessary in order to be covered.

References to other sources and links provided are for general informational purposes only, and were accurate at the time of publication. CPPs are reviewed annually but may change at any time and without notice, including the lines of business for which they apply. CPPs are available at www.wellcare.com. Select the "Provider" tab, then "Tools" and then "Payment Guidelines".

RULES, PRICING & PAYMENT COMMITTEE HISTORY AND REVISIONS

Date	Action
10/30/2019	• Approved by RGC

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