FIRST COAST SERVICE OPTIONS
MAC - PART A/B
LOCAL COVERAGE DETERMINATION

LCD Database ID Number
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Contractor Name
First Coast Service Options, Inc.

Contractor Number
09101 - Florida
09201 – Puerto Rico/Virgin Islands
09102 – Florida
09202 – Puerto Rico
09302 – Virgin Islands

Contractor Type
MAC – Part A and B

LCD Title
Anorectal Manometry and EMG of the Urinary and Anal Sphincters

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Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

CMS Manual System, Pub 100-02, Medicare Benefit Policy Manual, Chapter 15, Sections 60 and 80
CMS Manual System, Pub 100-04, Medicare Claims Processing Manual, Chapter 1, Sections 10 and 30.2
CMS Manual System, Pub. 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.4.1.2 and Chapter 13, Section 13.5.1
Indications and Limitations of Coverage and/or Medical Necessity

Fecal incontinence is the involuntary loss of stool (gas, liquid or solid). Fecal incontinence is caused by a disruption of the normal function of both the lower digestive tract and the nervous system. Fecal incontinence can be caused by several factors:

- Constipation
- Damage to the anal sphincter muscle (e.g., childbirth or hemorrhoid surgery)
- Damage to the nerves of the anal sphincter muscles of the rectum (e.g., childbirth, straining to pass stool, stroke, physical disability due to injury, diabetes or multiple sclerosis)
- Loss of the storage capacity in the rectum
- Diarrhea
- Pelvic floor dysfunction

Urinary incontinence is the involuntary leakage of urine. Male and females have different risk factors in developing urinary incontinence. The risk of urinary incontinence increases with age in both men and women, but women are more likely to develop urinary incontinence due to anatomical differences in the pelvic region and due to changes caused by pregnancy and childbirth. There are several types of urinary incontinence:

- Stress incontinence
- Urge incontinence
- Overflow incontinence
- Mixed incontinence

Some causes of these different types of urinary incontinence are medications, vaginal atrophy, decreased lubrication, weakness of the pelvic floor and supporting structures, pelvic fracture, pelvic surgeries, neurological deficits and radical prostatectomy.
Anorectal Manometry and EMG of the Urinary and Anal Sphincters

Typically, the causes of urinary or fecal incontinence can be diagnosed upon completion of a thorough history and physical exam performed by the physician or non-physician practitioner. When a thorough history and physical does not point to one or more causes of urinary or fecal incontinence, diagnostic testing may be indicated.

In addition, other pelvic floor disorders present symptoms such as dysfunctional voiding, incomplete bladder and/or rectal elimination and sexual dysfunction. Many of these disorders are characterized by spasticity of the pelvic floor and floor hypertonicity, which are abnormal contractions of the muscles of the pelvic floor. These conditions may also be detected on a physical examination, but in cases that are indeterminate, diagnostic testing may aid the diagnosis.

Indications

Anorectal Manometry (91122) is a diagnostic test that measures the anal sphincter pressures and provides an assessment of rectal sensation, rectoanal reflexes, and rectal compliance. EMG of the anal or urethral sphincter (51784/51785) are diagnostic tests that measure muscle activity and are used to assist in evaluating fecal or urinary incontinence, dysfunctional elimination of bowel and bladder and neurogenic bladder dysfunction leading to functional abnormalities of the muscular sphincter.

Anorectal manometry will be considered medically reasonable and necessary when it is necessary to evaluate a diagnosis of fecal incontinence and dysfunctional anorectal elimination and the results are to be used in the management of the patient’s condition.

EMG of the anal or urethral sphincters will be considered medically reasonable and necessary when it is necessary to evaluate a diagnosis of fecal or urinary incontinence, dysfunctional bladder elimination and interstitial cystitis respectively, and to identify possible underlying neurological disease and the results are to be used in the management of the patient’s condition.

Limitations

A diagnostic test is medically necessary when there has been an appropriate evaluation and justification prior to the tests being performed and when the results of the diagnostic test is likely to affect the course of treatment.

There must be a complete history and physical exam documented before the decision to perform one of the diagnostic tests described above is made. See the documentation requirements section of this LCD for a complete description of the requirements. Potential treatable problems should be identified and treatment implemented if possible before ordering diagnostic tests (e.g., UTI should be treated, medication management for drugs that cause urinary retention or frequency).

CPT codes 91122 or 51784/51785 would only be expected to be billed during the initial diagnostic evaluation only when the cause of the fecal incontinence or urinary incontinence cannot be determined from the physicians evaluation and that the physician has determined that diagnostic testing is needed to make a diagnosis. It would not be expected to see 91122 billed when the physician is trying to evaluate urinary incontinence. There may be rare occasions when the physician feels one of these diagnostic tests are needed after a course of treatment has been completed. In this instance, it would be expected that the medical record would reflect that the results of the additional test are needed to determine additional therapy or treatment. The routine performance of 91122, 51784/51785 during the course of treatment or at the end of a course of treatment may prompt medical review of claims.

Type of Bill Code

Hospital- outpatient – 13x

Special facility or ASC surgery-rural primary care hospital – 85x

Revenue Codes

75X Gastro-Intestinal services

76X Specialty Services

92X Other Diagnostic Services
Anorectal Manometry and EMG of the Urinary and Anal Sphincters

**CPT/HCPCS Codes**

51784  Electromyography studies (EMG) of anal or urethral sphincter, other than needle, any technique

51785  Electromyography studies (EMG) of anal or urethral sphincter, any technique

91122  Anorectal manometry

**ICD-10 Codes that Support Medical Necessity**

**For CPT code 91122**

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
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<tbody>
<tr>
<td>G35</td>
<td>Multiple sclerosis</td>
</tr>
<tr>
<td>G04.1</td>
<td>Topical spastic paraplegia</td>
</tr>
<tr>
<td>G81.00 -G81.94</td>
<td>Hemiplegia and hemiparesis</td>
</tr>
<tr>
<td>G82.20 – G82.22</td>
<td>Paraplegia</td>
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<tr>
<td>G82.50 – G82.54</td>
<td>Quadriplegia</td>
</tr>
<tr>
<td>G83.0 – G83.4</td>
<td>Other paralytic syndromes</td>
</tr>
<tr>
<td>I67.89</td>
<td>Other cerebrovascular disease</td>
</tr>
<tr>
<td>K59.00 – K59.09</td>
<td>Constipation</td>
</tr>
<tr>
<td>K59.4</td>
<td>Anal spasm</td>
</tr>
<tr>
<td>R15.0 – R15.9</td>
<td>Fecal incontinence</td>
</tr>
</tbody>
</table>

**For CPT code 51784 and 51785**

<table>
<thead>
<tr>
<th>Code</th>
<th>Diagnosis</th>
</tr>
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<tbody>
<tr>
<td>G35</td>
<td>Multiple sclerosis</td>
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<td>Constipation</td>
</tr>
<tr>
<td>K59.4</td>
<td>Anal spasm</td>
</tr>
<tr>
<td>M25.78</td>
<td>Osteophyte, vertebrae</td>
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<tr>
<td>M47.011 – M47.9</td>
<td>Spondylosis</td>
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<tr>
<td>M48.10 – M48.19</td>
<td>Ankylosing hyperostosis [Forestier]</td>
</tr>
<tr>
<td>M48.20 – M48.27</td>
<td>Kissing spine</td>
</tr>
<tr>
<td>M48.30 – M48.38</td>
<td>Traumatic spondylopathy</td>
</tr>
<tr>
<td>M48.9</td>
<td>Spondylopathy, unspecified</td>
</tr>
<tr>
<td>N30.10 – N30.11</td>
<td>Interstitial cystitis (chronic)</td>
</tr>
<tr>
<td>N31.0 – N31.9</td>
<td>Neuromuscular dysfunction of bladder, not elsewhere classified</td>
</tr>
<tr>
<td>N36.42</td>
<td>Intrinsic sphincter deficiency (ISD)</td>
</tr>
<tr>
<td>N36.43</td>
<td>Combined hypermobility of urethra and intrinsic sphincter deficiency</td>
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<tr>
<td>N36.44</td>
<td>Muscular disorders of urethra</td>
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<tr>
<td>N36.8</td>
<td>Other specified disorder of urethra</td>
</tr>
<tr>
<td>N39.3</td>
<td>Stress incontinence (female) (male)</td>
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<tr>
<td>N39.41 – N39.498</td>
<td>Other specified urinary incontinence</td>
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<tr>
<td>R15.0 – R15.9</td>
<td>Fecal incontinence</td>
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<tr>
<td>R32</td>
<td>Unspecified urinary incontinence</td>
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<tr>
<td>R33.0 – R33.9</td>
<td>Retention of urine</td>
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<tr>
<td>R35.0</td>
<td>Frequency of micturition</td>
</tr>
<tr>
<td>R39.14</td>
<td>Feeling of incomplete bladder emptying</td>
</tr>
</tbody>
</table>

**Diagnoses that Support Medical Necessity**

N/A
Anorectal Manometry and EMG of the Urinary and Anal Sphincters

ICD-10 Codes that DO NOT Support Medical Necessity

N/A

Diagnoses that DO NOT Support Medical Necessity

N/A

Associated Information

Documentation Requirements

A complete history and physical containing the following minimum requirements must be in the medical record: complete history to include the following areas- duration and characteristics of the urinary or fecal incontinence, frequency, timing and amount of continent voids and incontinent episodes, precipitants of incontinence, other urinary symptoms, bowel habits daily fluid intake, alteration in sexual function due to urinary or fecal incontinence, amount and type of perineal pads or protective devices, previous treatments for urinary or fecal incontinence and the effects of that treatment on the incontinence; neurological exam; physical exam of the patient that is usually guided by the history and reason for being seen. This could include a pelvic exam in women to assess for skin condition, genital atrophy, pelvic organ prolapse, pelvic masses, paravaginal muscle tone and any other abnormalities; abdominal exam, genital exam in men, rectal exam to assess perineal sensation, resting and active sphincter tone, fecal impaction, presence of masses and in men, the consistency and contour of the prostate; past surgeries and pregnancy history in females.

The medical record must reflect that the physician was unable to make a definitive diagnosis based on the history and physical if ordering one of these diagnostic tests. In addition the medical record must reflect how the results will likely affect current course of therapy or future therapy.

The medical record must reflect if there are treatable causes of incontinence identified and if treatment for those causes has been completed before the diagnostic test is performed.

Utilization Guidelines

These tests should not be performed on a routine basis. It would only be expected to see these tests billed in the initial diagnostic evaluation. In the rare occasion that the physician feels additional testing is needed to determine additional or future therapy, then the medical record must reflect the patients response to the current therapy prescribed based on the initial diagnostic test results and the rationale for performing an additional diagnostic test.

Diagnostic testing is not a medically necessary part of a physical therapy, rehabilitation, biofeedback, or exercise program.

CPT codes 51784/51785 and 91122 should not be confused with the procedure described by CPT code 90911. Please refer to the LCD for biofeedback therapy for a complete description of the coverage criteria for CPT code 90911 and other biofeedback codes.

The routine performance of one or more of these tests on patients may lead to medical review.

It is expected that if a treatable cause of the patient’s incontinence is identified through the history and physical, then the treatment should be initiated and the course of treatment be completed before the decision to perform one of these diagnostic tests is made.

All supervision requirements as set forth in CFR 410.32 regarding diagnostic tests apply. For procedure codes 51784 and 91122, the supervision level is equal to 2, meaning direct supervision requirements apply for these codes. For procedure code 51785, the supervision level is equal to 3, meaning personal supervision requirements apply for this code. Per 42 CFR §410.32, all diagnostic tests must be ordered by the physician/nonphysician practitioner who is treating the patient, that is, the physician/nonphysician practitioner who furnishes a consultation or treats a patient for a specific medical problem and who uses the results in the management of the patient’s specific medical problem. Tests not ordered by the physician/nonphysician practitioner who is treating the patient are not reasonable and necessary.
Anorectal Manometry and EMG of the Urinary and Anal Sphincters

Sources of Information and Basis for Decision

FCSO reference LCD number(s) – L28763, L29060, L29078


Start Date of Comment Period

N/A

End Date of Comment Period

N/A

Start Date of Notice Period

04/01/2014

Revision Number: Original

This LCD replaces all previous LCD versions (refer to “Sources of Information and Basis for Decision” section of the LCD) and publications on this subject to comply with ICD-10-CM based on Change Request 8112. The effective date of this LCD is based on date of service.

Related Documents

N/A

LCD Attachments

N/A