



# Geisinger Health Plan Policies and Procedure Manual

**Policy: MP172**

**Section: Medical Benefit Policy**

**Subject: MicroVas Vascular Treatment System**

## Applicable Lines of Business

|                   |          |             |          |
|-------------------|----------|-------------|----------|
| <b>Commercial</b> | <b>X</b> | <b>CHIP</b> | <b>X</b> |
| <b>Medicare</b>   | <b>X</b> | <b>ACA</b>  | <b>X</b> |
| <b>Medicaid</b>   | <b>X</b> |             |          |

### I. Policy: MicroVas Vascular Treatment System

#### II. Purpose/Objective:

To provide a policy of coverage regarding MicroVas Vascular Treatment System

#### III. Responsibility:

- A. Medical Directors
- B. Medical Management

#### IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

#### V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

#### Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.

- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

**DESCRIPTION:**

MicroVas Vascular Treatment System is a form of electrical stimulation thought to cause muscle fasciculation and contraction-relaxation cycles that effectively increases blood flow and tissue oxygenation, which would enhance wound healing. According to manufacturer's website, MicroVas is also indicated for the treatment of peripheral vascular disease, ischemic rest pain, diabetic neuropathy, pressure ulcers, and chronic low back pain.

**MEDICARE BUSINESS SEGMENT:** Microvascular Therapy (MVT) being used as an adjunct to usual care for peripheral neuropathies is a covered service.

**EXCLUSIONS:** There is insufficient evidence in the current peer-reviewed, published medical literature to support the use of the MicroVas Vascular Treatment System as a monotherapy for any application at this time. Unless otherwise noted, the use of this device as a monotherapy is considered **experimental, investigational, and unproven** and is **NOT COVERED**.

**Note:** Electrical stimulation devices approved by the FDA, may be considered medically necessary when used as an adjunctive therapy which is part of an overall treatment plan, when prior authorized by Medical Management. Criteria for use of electrical stimulation as an adjunctive therapy for wound healing therapy is outlined in MP113 **Electrical and Electromagnetic Stimulation to Promote Wound Healing**

**Medicaid Business Segment:**

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

**Note:** A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

**CODING ASSOCIATED WITH:** MicroVas

*The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at [www.cms.gov](http://www.cms.gov) or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.*

97139 (Unlisted therapeutic procedure)

G0281 Electrical stimulation, (unattended), to one or more areas, for chronic Stage III and Stage IV pressure ulcers, arterial ulcers, diabetic ulcers, and venous stasis ulcers not demonstrating measurable signs of healing after 30 days of conventional care, as part of a therapy plan of care

G0282 Electrical stimulation, (unattended), to one or more areas, for wound care other than described in G0281)

G0283 Electrical stimulation, (unattended), to one or more areas, for indication(s) other than wound care, as part of a therapy plan of care

Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL

**LINE OF BUSINESS:**

**Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.**

**REFERENCES:**

MicroVas Technologies, INC. (website). Tulsa, OK: MicroVas;2002. Available at: <http://www.microvas.com> Accessed on December 2, 2005.

Davis J. The MicroVas Vascular Treatment System. Int Rev Modern Surg, February 2002. Available at: <http://www.microvas.com/surgerymag.html> Accessed on December 2, 2005.

Food and Drug Administration (FDA) [website]. Device Listing Database- MicroVas. December 12, 2004 Available at: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/search/search.cfm?db=LST&ID=78869> Accessed on December 2, 2005.

Novitas Solutions. Local Coverage Article: Microvascular Therapy (MVT) (A54343) [http://www.novitas-solutions.com/webcenter/faces/oracle/webcenter/page/scopedMD/sad60252a\\_5537\\_4c5d\\_9350\\_ca405e36e159/Page133.jsp?contentId=00093961&\\_afLoop=1861103970338000#!%40%40%3F\\_afLoop%3D1861103970338000%26contentId%3D00093961%26\\_adf.ctrl-state%3D3c820q0z0\\_25](http://www.novitas-solutions.com/webcenter/faces/oracle/webcenter/page/scopedMD/sad60252a_5537_4c5d_9350_ca405e36e159/Page133.jsp?contentId=00093961&_afLoop=1861103970338000#!%40%40%3F_afLoop%3D1861103970338000%26contentId%3D00093961%26_adf.ctrl-state%3D3c820q0z0_25)

This policy will be revised as necessary and reviewed no less than annually.

**Devised:** 02/20/06

**Revised:** 7/15 (added Medicare coverage)

**Reviewed:** 2/07, 2/08, 2/09, 2/10, 3/11, 3/12, 3/13, 3/14, 2/15, 2/16, 2/17, 2/18, 2/19, 2/20, 2/21, 2/22, 2/23, 2/24

**CMS UM Oversight Committee Approval:** 12/23

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.