Effective February 26, 2018
Policy Replaced by LCD L33449

BlueCross BlueShield of Alabama

Name of Blue Advantage Policy:

Videofluoroscopic/Cineradiography Evaluation of Velopharyngeal Dysfunction

Policy #: 320
Category: Surgery

Latest Review Date: July 1, 2010
Policy Grade: **Active Policy but no longer scheduled for regular literature reviews and updates.**

Background:

Blue Advantage *medical policy does not conflict with Local Coverage Determinations (LCDs), Local Medical Review Policies (LMRPs) or National Coverage Determinations (NCDs) or with coverage provisions in Medicare manuals, instructions or operational policy letters. In order to be covered by Blue Advantage the service shall be reasonable and necessary under Title XVIII of the Social Security Act, Section 1862(a)(1)(A). The service is considered reasonable and necessary if it is determined that the service is:*

1. *Safe and effective;*
2. *Not experimental or investigational*;*
3. *Appropriate, including duration and frequency that is considered appropriate for the service, in terms of whether it is:*
   - *Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;*
   - *Furnished in a setting appropriate to the patient's medical needs and condition;*
   - *Ordered and furnished by qualified personnel;*
   - *One that meets, but does not exceed, the patient's medical need; and*
   - *At least as beneficial as an existing and available medically appropriate alternative.*

Routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000 which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary by Medicare. Providers should bill* ***Original Medicare* *for covered services that are related to* ***clinical trials*** *that meet Medicare requirements (Refer to Medicare National Coverage Determinations Manual, Chapter 1, Section 310 and Medicare Claims Processing Manual Chapter 32, Sections 69.0-69.11).*

Description of Procedure or Service:

Velopharyngeal dysfunction (VPD) refers to excessive nasal resonance or hypernasality during speech as the consequence of anatomical abnormalities of the velopharyngeal sphincter involving the velum (soft palate) and/or pharyngeal walls that compromise the seal between the nasopharynx and oral cavity. Normal phonation requires the generation of a column of air that flows from the subglottis into the upper airway. When (VPD) is present, air escapes through the nose during speech, resulting in the characteristic nasal resonancy. VPD is most commonly associated with cleft palate; it may be the only sign of a submucous cleft palate, or may persist after closure of an overt cleft palate.

Velopharyngeal dysfunction can usually be diagnosed by the speech/language pathologist based on the presence of hypernasal speech, compensatory misarticulations, escape of air through the nose, insufficient oral pressure for consonant production, and aberrant facial movements. Imaging options include fiberoptic nasoendoscopy and videofluoroscopy. Videofluoroscopy is a noninvasive radiologic technique intended to assess the competency of velopharyngeal closure. Videotape recording produces a continuous record of the velopharyngeal mechanism. Videofluoroscopy may also be referred to as cineradiography. A barium coating of the pharyngeal structures can be used to provide contrast in the videofluoroscopic image. Frontal and basal viewing angles can be used alone or in combination. The procedure is used to assess various forms of velopharyngeal insufficiency, including cleft palate. Videofluoroscopy is frequently performed as an adjunct to surgical planning in patients who do not respond to conservative treatment such as speech therapy.

Policy:

Effective for dates of service on or after August 9, 2008 and prior to February 26, 2018:
Blue Advantage will treat **videofluoroscopic/cineradiography evaluation of velopharyngeal dysfunction** as a **covered benefit** when used for difficult to diagnose patients with **suspected oropharyngeal dysphagia and possible aspiration during swallowing resulting from surgery, disease, or congenital defects and/or to evaluate the degree of velopharyngeal closure during speech in patients with velopharyngeal dysfunction, including but not limited to cleft palate patients**.

Blue Advantage does not approve or deny procedures, services, testing, or equipment for our members. Our decisions concern coverage only. The decision of whether or not to have a certain test, treatment or procedure is one made between the physician and his/her patient. Blue Advantage administers benefits based on the members' contract and medical policies. Physicians should always exercise their best medical judgment in providing the care they feel is most appropriate for their patients. Needed care should not be delayed or refused because of a coverage determination.

Key Points:

Videofluoroscopy of velopharyngeal closure has been performed for many years, and in many articles and textbooks, it is identified as a standard component of surgical planning for velopharyngeal insufficiency. In 1988, an international working group established a system for

quantifying, recording, and describing movements of the relevant anatomy. A recommendation was also made that suggested that all patients with velopharyngeal deficiency be studied with both videofluoroscopy and nasopharyngoscopy ,and the Ad Hoc Committee of the American Cleft Palate-Craniofacial Association suggest videofluoroscopy as one technique that may be helpful in evaluating velopharyngeal insufficiency. For example, it is thought that defining the velopharyngeal closure pattern is particularly important to determine the appropriate surgical intervention. The three most common surgical approaches to velopharyngeal dysfunction include pharyngoplasty, pharyngeal flap, or posterior wall augmentation.

In 2004, the American Speech-Language-Hearing Association (ASHA established the following indications for performing videofluoroscopic swallowing studies (VFSS):

- To identify normal and abnormal anatomy and physiology of the swallow;
- To evaluate the integrity of airway protection before, during and after swallowing;
- To evaluate the effectiveness of postures, maneuvers, bolus modifications, and sensory enhancement in improving swallowing safety and efficiency;
- To provide recommendations regarding the optimum delivery of nutrition and hydration (e.g., oral versus nonoral, method of delivery, positioning, therapeutic interventions)
- To determine appropriate therapeutic techniques for oral, pharyngeal and/or laryngeal disorders;
- To obtain information in order to collaborate with and educate other team members, referral sources, caregivers, and patients regarding recommendations for optimum swallow safety and efficiency.

July 2010 Update
This policy will no longer be reviewed for updates but will remain active.

Key Words:
Videofluoroscopic swallowing studies, VFSS, velopharyngeal dysfunction

Approved by Governing Bodies:
FDA approved

Benefit Application:
Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

Coding:
CPT Codes: **70371** Complex dynamic pharyngeal and speech evaluation by cine or video Recording

References:

1. American Speech-Language-Hearing Association. Guidelines for speech-language pathologists performing videofluoroscopic swallowing studies. ASHA 2204:Supplement 24.
2. Center for Practice and Technology Assessment, Agency for Health Care Policy and Research. Diagnosis and treatment of swallowing disorders (dysphagia) in acute care stroke patients. AHCPR. Evidence Report/Technology Assessment. 1999.
3. Dalston RM, Marsh JL, VIg KW et al. Minimal standards for reporting the results of surgery on patients with cleft lip, cleft palate; a proposal. Cleft palate J 1998; 25(1):3-7.
4. Golding-Kushner KF, Argamaso RV, Cotton RT et al. Standardization for the reporting of nasopharyngoscopy and multiview videofluoroscopy: a report from an international working group. Cleft Palate J 1990; 27(4):337-48.
5. Ysunza A, Pamplona C, Ramierz E et al. Velopharyngeal surgery: a prospective randomized study of pharyngeal flaps and sphincter pharyngoplasties. Plast Reconstr Surg 2002; 110(6):1401-7.

Policy History:

Adopted for Blue Advantage, June 2008
Available for comment June 25-August 1, 2008
Medical Policy Group, July 2008
Available for comment August 2-September 15, 2008
Medical Policy Group, July 2010
Policy no longer subject to regular literature review effective July 1, 2010
Medical Policy Group, January 2018
